Congregate Living & Social Services Licensing Board

Tuesday, October 25, 2022 6:00 PM
City Hall, 2nd Floor Council Chambers

AGENDA

I. **Call to Order:** Roll Call

II. **Minutes of Previous Meeting:** September 27, 2022

III. **Unfinished Business:**

IV. **Applications:**

Continued LB 22-01: Applicant, Samuel L. Lake, Executive Director, of the Keene Serenity Center, located at 34 Mechanic St., Keene, which is in the Downtown Limited District and owned by DEW Properties, LLC; is requesting a Congregate Living & Social Services License for a Group Resource Center as defined in Chapter 46, Article X of the Keene City Ordinances.

LB 22-06: Applicant, Christine Allen, Executive Director of the Monadnock Peer Support Agency, which is in the Downtown Core District, is requesting a Congregate Living & Social Services License for a Large Group Home, located at 32-34 Washington St., as defined in Chapter 46, Article X of the Keene City Ordinances.

LB 22-07: Applicant, Thomas Hanna of BCM Environmental & Land Law, representing The Home for Little Wanderers, Inc., of Boston, MA, is requesting a Congregate Living & Social Services License for a Small Group Home, located at 39 Summer St., which is in the Downtown Transition District and as defined in Chapter 46, Article X of the Keene City Ordinances.

V. **New Business:**

VI. **Non Public Session:** (if required)

VII. **Adjournment:**

Page intentionally left blank

City of Keene
New Hampshire

CONGREGATE LIVING AND SOCIAL SERVICES LICENSING BOARD MEETING MINUTES

Tuesday, September 27, 2022 **6:00 PM** **Council Chambers, City Hall**

Members Present:
Andrew Oram, Chair
Medard Kopczynski, Vice Chair
Allison Welsh
Thomas Savastano

Staff Present:
John Rogers, Building & Health Official
Corinne Marcou, Board Clerk
Don Farquhar, Fire Chief

Members Not Present:
All Present

I. Call to Order – Roll Call

Chair Oram called the meeting to order at 6:00 PM.

II. Minutes of Previous Meeting – February 22, 2022 & June 28, 2022

No changes were proposed to the February 22 and June 28, 2022 minutes as presented.

A motion by Mr. Kopczynski to approve the February 22, 2022 minutes as presented was duly seconded by Mr. Savastano and the motion carried unanimously.

A motion by Mr. Savastano to approve the June 28, 2022 minutes as presented was duly seconded by Mr. Kopczynski and the motion carried unanimously.

III. Unfinished Business:

There was no unfinished business.

IV. Public Hearings:

A) Continued LB 22-01: Applicant, Samuel L. Lake, Executive Director, of the Keene Serenity Center, located at 34 Mechanic St., Keene, which is in the Downtown Limited District and owned by DEW Properties, LLC; is requesting a Congregate Living & Social Services License for a Group Resource Center as defined in Chapter 46, Article X of the Keene City Ordinances.

This hearing was continued again as the Board awaits more information.

B) LB 22-02: Applicant, Mindy Cambiar, Executive Director of Hundred Nights, Inc., 27 Main St., Keene, which is in the Downtown Core District and owned by Eighty-Eight Lambert Avenue Nominee Trust, is requesting a Congregate Living & Social Services License for a Homeless Shelter, located at 17 Lamson St., as defined in Chapter 46, Article X of the Keene City Ordinances.

Chair Oram heard the presentations for LB 22-02 and LB 22-03 together, and the Board would vote on each application separately.

Chair Oram welcomed the applicant, Mindy Cambiar, Executive Director of Hundred Nights, Inc., who said she had no presentation beyond what was in the application. She welcomed questions.

Mr. Rogers said that Staff reviewed both applications LB 22-02 and LB 22-03 and determined that both were complete. He pointed out one potential area for the Board's consideration was under "evidence that all required licenses, permits, and other authority documents be obtained," stating that the Board and Staff needed to discuss how to deal with that question. Otherwise, the rest of the material was a part of the complete submission packets. He said that under the inspection portion of the application, the Board would notice that at the time of the agenda, the inspections had not been completed. The inspections had ensued since and on September 14 there were some minor things found but nothing that would constitute issues with this license being approved and Mr. Rogers asked the Fire Chief, Don Farquhar, to speak to anything he found during inspections.

Chief Farquhar said they did the inspection and both buildings did really well. He continued that there were a few minor issues documented that are common. Nothing was found that would prohibit this license being granted. He added that for a building with a high density of individuals, they are very clean, and the Staff does an amazing job and he is grateful for the job they do for the City.

Ms. Welsh did not doubt the truth of the application but noted the resource center did not say anything about sprinklers; she asked if they are required. Chief Farquhar said no, not with how the building is currently constructed.

Vice Chair Kopczynski asked the Fire Chief, whether he was testifying that there was no reason to withhold these licenses and that both buildings were well in compliance in terms of life safety. The Fire Chief replied in the affirmative that he signed off on these applications.

Vice Chair Kopczynski asked Ms. Cambiar whether there is an active communication agreement with the other community agencies and at what frequency those communications occur. Ms. Cambiar said she thinks they have grown a lot over the years toward solid communication,

including with the City's Human Services Department. Vice Chair Kopczynski asked whether there was a reasonably good communication mechanism with providers and the City. Ms. Cambiar replied in the affirmative. She continued that they do not always have solutions—it had been a tough year figuring out what to do with people and no beds open. Vice Chair Kopczynski complimented the applicant for their extremely helpful and complete responses to the application, especially as one of the first to go through this process; he recognized the effort that went into the application. Ms. Cambiar thanked her Board Chair, Charles Mobilia, for his help and research toward this effort. She said they started researching as soon as the Board Clerk issued the paperwork, drawing from shelters across the nation, so they had a solid base to start with. Ms. Welsh and the Chairman agreed with the Vice Chair's compliments, noting how helpful the attention to detail and clear outlay of information was for learning about the organization.

The Chair posed three questions: (1) Was this a valuable process that the applicants learned from? (2) How much time was invested? (3) Is there anything the City could have done in the process to make it work better for the applicants? Mr. Mobilia replied that they did learn a lot from the process because they were forced to look at all items, like life safety, and to think about what they would do and put that on paper. The Board Clerk was very helpful in the process, and he never felt like he was bothering her for information. He was surprised how easy it was to get it done besides the research required that was laid out well. Mr. Mobilia thinks it was worthwhile and he learned a lot about what they do and how to communicate better with stakeholders. Ms. Cambiar said they learned clear definitions, such as the difference between a life safety plan and a health and safety plan. Mr. Mobilia said there were many helpful websites with clear definitions to help.

Vice Chair Kopczynski said that when the City crafted this Ordinance, they did a lot of research to find the correct aspects of licensing procedures based on best practices, so the applicants' feedback was important and indicated that some things were drafted correctly and that it was not a terrible process to endure. Mr. Mobilia agreed it was not terrible though it initially appeared daunting.

Mr. Savastano agreed that it was a well-done application, which he appreciated. He posed some questions. He noted that occasionally they house families. Ms. Cambiar said they have not had families in the building since November 2021. Since they received the CARES Act funding that was for November 1, 2021–April 30, 2022, they chose to put all families in hotel rooms. But, come April there was no housing and they were grateful to Southwestern Community Services for stepping up with their NH Rental Assistance money for some of those families. She said everything would change in the new building, where families would be on a separate floor. Mr. Savastano asked if they are not intending to have families in the building during the next season. Ms. Cambiar said they would take-in a family if there was an opening but there are usually not four beds available most nights, it is usually only two beds available and it is usually because they are holding a bed for someone who cannot arrive until the next day. Ms. Cambiar said that when families were in the building, they typically had two families per room with a room divider

and doors on each side of the room would lock from the inside. They expect the new building to be complete by the end of March 2023 and to start moving people in in May 2023.

Mr. Savastano referred to the neighbor relations plan, in which the applicant tied the peoples to that in terms of rules and expecting them to be aware and respectful of neighbors, but he did not see much reference to that in the rules, except for smoking and such. When it comes to the new building, he thought it might be good to connect the two in their next plan. Ms. Cambiar thought that in the new building, everything has the possibility of changing for the good. They have already reached out to their Cityside neighbors and will have pre-open house to meet with all neighbors to hear their concerns about the facility, which is the start of a new neighborhood plan; people will be invited to tour the building before people move in. They are trying to address concerns before they are actual problems. Right now, they do not control space outside of the buildings and can only control what is inside the walls.

Ms. Welsh commended the applicant on addressing a controversial topic in their application, which is advocating for providing shelter for sex offenders, and she said the applicants added it well. She said there are few safe places, and this was really well done. She appreciated the applicants' efforts to ensure everyone has somewhere to go. Ms. Cambiar said it had not always been easy.

Chair Oram opened the public hearing and heard no comments. As such, the Board proceeded to deliberation of the criteria for approving this application.

The licensing board shall consider the following criteria when evaluating whether to approve,renew, or deny a congregate living and social services license application.

Criteria 1: *The use is found to be in compliance with the submitted operations and management plan, including but not limited to compliance with all applicable building, fire, and life safety codes.*

Hearing no Board comments, Chair Oram entertained a motion by Vice Chair Kopczynski, which was duly seconded by Ms. Welsh.

On a vote of 4–0, application LB 22-02 was found to be in compliance with Criteria 1.

Criteria 2: *The use is of a character that does not produce noise, odors, glare, and/or vibration that adversely affects the surrounding area.*

Vice Chair Kopczynski stated that there was no testimony by Staff or the public alleging any problem with noise, odor, glare, or vibration effecting the surrounding area.

Chair Oram entertained a motion by Vice Chair Kopczynski, which was duly seconded by Mr. Savastano.

On a vote of 4–0, application LB 22-02 was found to be in compliance with Criteria 2.

Criteria 3: *The use does not produce public safety or health concerns in connection with traffic, pedestrians, public infrastructure, and police or fire department actions.*

Mr. Rogers stated that the Police were also a part of the inspection process, and they had no issues with either location.

Mr. Kopczynski said the Board heard no testimony from the public or Public Service Officials expressing any concern with traffic, pedestrians, public infrastructure, and police or fire actions.

Chair Oram entertained a motion by Vice Chair Kopczynski, which was duly seconded by Ms. Welsh.

On a vote of 4–0, application LB 22-02 was found to be in compliance with Criteria 3.

Chair Oram entertained a motion on the whole of application LB 22-02 from Mr. Savastano, which was duly seconded by Ms. Welsh.

On a vote of 4–0, the Congregate Living and Social Services Licensing Board accepted application LB 22-02 as presented.

C) LB 22-03: Applicant, Mindy Cambiar, Executive Director of Hundred Nights, Inc., 27 Main St., Keene, which is in the Downtown Core District and owned by Eighty-Eight Lambert Avenue Nominee Trust, is requesting a Congregate Living & Social Services License for a Resource Center, located at 25 Lamson St. as defined in Chapter 46, Article X of the Keene City Ordinances.

The discussion of application LB 22-03 is presented under agenda item IV.B. The Board proceeded to deliberation of the criteria for approving this application.

The licensing board shall consider the following criteria when evaluating whether to approve, renew, or deny a congregate living and social services license application.

Criteria 1: *The use is found to be in compliance with the submitted operations and management plan, including but not limited to compliance with all applicable building, fire, and life safety codes.*

Chair Oram entertained a motion by Vice Chair Kopczynski, which was duly seconded by Ms. Welsh.

On a vote of 4–0, application LB 22-03 was found to be in compliance with Criteria 1.

Criteria 2: *The use is of a character that does not produce noise, odors, glare, and/or vibration that adversely affects the surrounding area.*

Chair Oram entertained a motion by Vice Chair Kopczynski, which was duly seconded by Ms. Welsh.

On a vote of 4–0, application LB 22-03 was found to be in compliance with Criteria 2.

Criteria 3: *The use does not produce public safety or health concerns in connection with traffic, pedestrians, public infrastructure, and police or fire department actions.*
#3.

Mr. Rogers stated that like the last application, the Police were involved in the inspection.

Chair Oram entertained a motion by Vice Chair Kopczynski, which was duly seconded by Ms. Welsh.

On a vote of 4–0, application LB 22-03 was found to be in compliance with Criteria 3.

Chair Oram entertained a motion on the whole of application LB 22-03 from Mr. Savastano, which was duly seconded by Ms. Welsh.

On a vote of 4–0, the Congregate Living and Social Services Licensing Board accepted application LB 22-03 as presented.

D) LB 22-04: Applicant, Beth Daniels, Chief Executive Officer of Southwestern Community Services, 63 Community Way, which is in the High Density District is requesting a Congregate Living & Social Services License for a Homeless Shelter, located at 32 Water St. as defined in Chapter 46, Article X of the Keene City Ordinances.

Chair Oram heard the presentations for LB 22-04 and LB 22-05 together, and the Board would vote on each application separately.

Chair Oram welcomed a representative of the applicant, Craig Henderson, Director of Housing Stabilization Services, which runs the local Southwestern Community Services (SCS) shelters in Keene. He had no formal presentation. Mr. Henderson stated that they have operated shelters in Keene for more than 30 years and this was new to them. He said he has collaborative meetings with the other shelters like Hundred Nights every two weeks, they work with the City of Keene, and they have a coordinated entry system. He thinks they are surpassing everything he could have imagined five years ago. They are a part of the Cheshire County Emergency Housing Collaborative and they get funding through Monadnock United Way. He said all these agencies work together.

Mr. Rogers said the inspections of both these facilities were completed and both facilities were approved by Police, Code, and Fire. There were some minor issues that would not prevent approving this application.

Fire Chief, Don Farquhar, said that both buildings are in great shape, with good sprinkler and alarm systems. There were some minor issues, but nothing that would alter the impression of well-kept buildings and staff doing great work there. Procedurally, they do the inspection, and then sit down with the owner explaining what action needs to be taken, which is an opportunity to talk more about fire and life safety procedures, leading to better interactions and partnerships. The Fire Department fully supported both licenses without any issue.

Vice Chair Kopczynski said this is to understand how things work and are run so in the future, application questions are solicited better. He said that the property on Water Street surprisingly has a maximum capacity of 23, because throughout the years, he has rarely seen more than just a few people there. He asked the mechanism to manage the people, which could be useful to others offering similar services. He knew SCS recently made a lot of updates to that building. Mr. Henderson agreed that there was new siding, a roof, heating, and more. He said they typically provide housing for fewer people per square foot. A spirit of their philosophy over time has been that 95% of the population would not realize they are driving past a shelter building and that is how they interact with their clients. Confidentiality of location is key. For the most part, the operation had run rather problem free. He thought there was the belief that you must have management over people, but with fewer people per room, there are fewer issues overall. Vice Chair Kopczynski asked whether the goal is to move people from homelessness to sheltered to their own housing. The Vice Chair knew there was a housing shortage in Keene and that the Community Development Department was working to create more opportunities; he asked if that was a positive action from the SCS perspective. Mr. Henderson replied in the affirmative, stating that during the first six months of 2022, they served as many people as the whole of 2021, so he said they are in a sad trajectory of being woefully ill prepared for the homeless population.

Mr. Savastano was surprised at the density and asked if all 23 beds were often full. Mr. Henderson said it ebbs, flows, and wanes because there could be a bed out for maintenance, for example. He said they had lower capacity in 2021 because they could not find bunkbeds or mattresses, which had been resolved this year, allowing 95–98% capacity at all times. In terms of emergency exits, Mr. Savastano asked whether the building could handle that number of people. Mr. Henderson said yes, the Fire Department confirmed that for both units. Mr. Henderson's biggest concern was that when you operate for 30 years, things change like this application, while the building has not changed in that time. He was concerned with rules that had changed over time that they perhaps did not comply with, despite Fire Department inspection over the year. The Fire Department had inspected the building over the years, but he wondered if this would open a can of worms having never done this before. Chief Farquhar said Mr. Henderson was correct. He said people are always concerned that they would be shut down when the Fire Department comes in, which is rare. He clarified that the Fire Code is never grandfathered, the building is new or existing. In the case of these applications, the buildings did well. Fire Code is

broken down by how many beds there are and sometimes when there are code issues it is because beds were added, which moves into a different part of the Fire Code. So, when doing new work, consult with the Fire Department and other Departments to ensure the project starts out in compliance.

Ms. Welsh asked, hypothetically, what happens when granting this annual license and there could be structural changes in that time. Mr. Rogers said many of those would require building and fire permits addressed at that time through the permitting process. They check things like sprinklers and exits. Any of those concerns during the period between licenses would require a permit for any new work and the building, fire, and life safety codes would be reviewed at that time.

Mr. Savastano noted an error in the wording on the agenda. For LB 22-04, it identifies in the high-density district, and he asked which application that applied too. Ms. Marcou said Water Street was in the high-density district. Mr. Savastano believed the Water Street location was actually in the downtown transition district. Ms. Marcou acknowledged that error. Mr. Rogers did not believe it would require a substantial change that would mean continuing this meeting. Mr. Savastano imagined it would be grandfathered in. Mr. Rogers said that was absolutely right, all applications are existing for decades, and this is not a new use, which is why it did not require a Planning Board Conditional Use Permit, just this licensing process.

Ms. Welsh appreciated the applicant's honesty in the narrative and said that it is a work in progress for all of us. She said the feedback is helpful and gives the Board a sense of where we are all going.

Chair Oram asked the Fire Chief whether under the current Fire Code requirements, that both locations meet the current standards. Chair Farquhar said that was 100% correct.

Hearing no public comments, the Board proceeded with deliberation and vote on the three criteria for approving application LB 22-04.

The licensing board shall consider the following criteria when evaluating whether to approve, renew, or deny a congregate living and social services license application.

Criteria 1: *The use is found to be in compliance with the submitted operations and management plan, including but not limited to compliance with all applicable building, fire, and life safety codes.*

Vice Chair Kopczynski made the following motion, which Ms. Welsh duly seconded.

On a vote of 4-0, application LB 22-04 was found to be in compliance with Criteria 1.

Criteria 2: *The use is of a character that does not produce noise, odors, glare, and/or vibration that adversely affects the surrounding area.*

Vice Chair Kopczynski said there was no testimony to any issues with the matters listed in the criteria. The Vice Chair made the following motion, which Mr. Savastano duly seconded.

On a vote of 4-0, application LB 22-04 was found to be in compliance with Criteria 2.

Criteria 3: *The use does not produce public safety or health concerns in connection with traffic, pedestrians, public infrastructure, and police or fire department actions.*

Mr. Kopczynski said they Board heard no testimony from the public or Public Service Officials expressing any concern with traffic, pedestrians, public infrastructure, and police or fire actions.

Mr. Savastano asked whether the Police were consulted on this application. Mr. Rogers said that both locations were inspected by the Police.

Vice Chair Kopczynski made the following motion, which Ms. Savastano duly seconded.

On a vote of 4-0, application LB 22-04 was found to be in compliance with Criteria 3.

On the overall approval of application LB 22-04, Chair Oram heard a motion from Vice Chair Kopczynski, which was duly seconded by Ms. Welsh.

On a vote of 4-0, the Congregate Living and Social Services Licensing Board approved application LB 22-04 for a homeless shelter as defined in Chapter 46, Article 10.

E) LB 22-05: Applicant, Beth Daniels, Chief Executive Officer of Southwestern Community Services, 63 Community Way, which is in the High Density District is requesting a Congregate Living & Social Services License for a Homeless Shelter, located at 139 Roxbury St. as defined in Chapter 46, Article X of the Keene City Ordinances.

The discussion of application LB 22-05 is presented under agenda item IV.D. The Board proceeded to deliberation of the criteria for approving this application.

The licensing board shall consider the following criteria when evaluating whether to approve, renew, or deny a congregate living and social services license application.

Criteria 1: *The use is found to be in compliance with the submitted operations and management plan, including but not limited to compliance with all applicable building, fire, and life safety codes.*

Chair Oram entertained a motion by Vice Chair Kopczynski, which was duly seconded by Ms. Welsh.

On a vote of 4–0, application LB 22-05 was found to be in compliance with Criteria 1.

Criteria 2: *The use is of a character that does not produce noise, odors, glare, and/or vibration that adversely affects the surrounding area.*

Chair Oram entertained a motion by Vice Chair Kopczynski, which was duly seconded by Ms. Welsh.

Vice Chair Kopczynski said there was no testimony from public or Staff stating any issues with the matters listed in the criteria.

On a vote of 4–0, application LB 22-05 was found to be in compliance with Criteria 2.

Criteria 3: *The use does not produce public safety or health concerns in connection with traffic, pedestrians, public infrastructure, and police or fire department actions.*
#3.

A motion by Vice Chair Kopczynski to find the application in compliance with Criteria 3 was duly seconded by Ms. Welsh.

Vice Chair Kopczynski said there was no testimony from the public or Staff that there were issues with any of these items.

On a vote of 4–0, application LB 22-05 was found to be in compliance with Criteria 3.

On the overall application, Vice Chair Kopczynski made the following motion, which was duly seconded by Mr. Savastano.

On a vote of 4-0, the Congregate Living and Social Services Licensing Board approved application LB 22-05.

V. New Business

This is a placeholder on the agenda for the Board members to bring any new issues forward for Staff attention before the next meeting.

Ms. Welsh requested that the Committee be allowed to see the inspection reports before the application is heard at the next meeting. Mr. Rogers said absolutely, and the Chief could speak to the fire aspect. Mr. Rogers continued that an insubstantial report is generated for health and code unless a violation is found, but Staff could do their best to get something.

Mr. Savastano wondered if the Board was on track with the anticipated schedule for the various months and categories of agencies. Ms. Marcou said they were attempting to stay on schedule and the next round is lodging houses. She admitted that it had been challenging reaching all of the houses in the area and she was unsure if all would be onboard for November. There is still the continued application for the Serenity Center. Mr. Savastano asked if lodging houses, for example, are not ready for November, if they just bleed into next months and are not pushed until next year. Ms. Marcou said yes. Mr. Rogers added that it is taking Staff and applicants more time and effort for this first time through; it is more time consuming than initially thought due to applicants needing more help, which he anticipates for lodging houses as well.

Ms. Welsh asked if approved plans are open to the public so other applicants can see examples. Ms. Marcou said yes, all agenda packets are posted on the Board's webpage with the applications therein. Mr. Rogers thought the Board would notice the difference between this evening's applications and earlier ones received. With all applications available to the public, he thought there would be a better template moving forward. He said they were moving in the right direction toward a more complete application process.

Chair Oram said that the SCS applications had a substantial amount of effort to keep the addresses unknown and asked whether the addresses should be redacted when posted, if they consider that a security issue. Mr. Rogers said at this time, it is a public record, and he understood the desire to keep it private. During the initial set-up of this Ordinance, he said Staff looked at this issue for a domestic violence shelter, which is not required to appear before this Board for this reason. Still, these are public records and they are not typically redacted in this way in a commercial setting. Mr. Rogers would talk with the City Attorney about whether it is possible.

VI. Non-Public Session (if required):

VII. Adjournment

There being no further business, Chair Oram adjourned the meeting at 6:57 PM.

Respectfully submitted by,
Katryna Kibler, Minute Taker
October 4, 2022

Reviewed and edited by,
Corinne Marcou, Board Clerk

Page intentionally left blank

City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. LB-22-06
Date Filled 9/2/22
Rec'd By CSM
Page 1 of 41

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

☐ Drug Treatment Center	☐ Group Home, Small	☐ Homeless Shelter
☐ Fraternity/Sorority	☐ Group Resource Center	☐ Lodginghouse
☑ Group Home, Large	☐ Residential Drug/Alcohol Treatment Facility	☐ Residential Care Facility

SECTION 2: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Monadnock Peer Support Agency	NAME/COMPANY: Monadnock Peer Support Agency
MAILING ADDRESS: 32-34 Washington Street, Keene, NH 03431	MAILING ADDRESS: 32-34 Washington Street, Keene, NH 03431
PHONE: 603-352-5093	PHONE: 603-352-5093
EMAIL: christine@monadnockpsa.org	EMAIL: christine@monadnockpsa.org
SIGNATURE: Christine Allen	SIGNATURE: Christine Allen
PRINTED NAME: Christine Allen	PRINTED NAME: Christine Allen

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☑ Same as owner
NAME/COMPANY:	NAME/COMPANY:
MAILING ADDRESS:	MAILING ADDRESS:
PHONE:	PHONE:
EMAIL:	EMAIL:
SIGNATURE:	SIGNATURE:
PRINTED NAME:	PRINTED NAME:

SECTION 3: PROPERTY INFORMATION

PROPERTY ADDRESS:	TAX MAP PARCEL NUMBER:
32-34 Washington Street, Keene, NH 03431	568-058-000-000-000
ZONING DISTRICT: Downtown Core	☑ **LOCATION MAP:** *Please attach*

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

MPS's programs are free and open to any New Hampshire resident (18 years or older) who is a recipient, former recipient, or is at risk becoming a recipient of mental health services. MPS has spent 26 years developing strong, connecting relationships where people feel valued, become empowered and move toward recovery. Our programs are grounded in the principles of personal responsibility, mutuality, reciprocity, and respecting others' thoughts and beliefs as valid and important. We encourage growth beyond stigma, shame, and limits placed upon us, creating and maintaining a strong, active voice and presence dedicated to social change.

MPS's offerings go far above and beyond the minimum requirements of our contract to provide the very best peer support to our community and beyond. We strive to have groups, activities, and training every hour of the day. We see open time on our schedule as opportunity to offer more; unused time is wasted time. We strive for continuous improvement in our offerings.

MPS is governed by a Board of Directors with a plan for governance that meets the requirements outlined in He-M 402.03 (b). MPS's peer support center is open 50 hours each week and follows all Department Life Safety requirements.

MPS programs use Intentional Peer Support (IPS), a recognized best practice founded by Shery Mead (Mead, S. (6/2011) In the 1990s, Intentional Peer Support provides a powerful framework for creating relationships where both people learn and grow. Peers come together around shared experiences and often a desire to change their lives. However, without a new framework to build upon, people frequently re-enact "help" based on what was done to them. IPS offers a foundation for doing something different. It derives from a history of grassroots alternatives that focus on building relationships that are mutual, exploitative, and conscious of power.

MPS programs also use Wellness Recovery Action Plan (WRAP), an evidence-based practice started by Mary Ellen Copeland, Ph D., recognized by the Substance Abuse and Mental Health Service Administration (SAMHSA).

MPS provides transportation for our members. MPS owns an appropriately registered/inspected and fully insured 12 passenger 2010 Ford Econoline e350 van VIN 1FBSS3BL9ADA93207 with which it provides transportation to members and participants. The van is black and bears MPS signage. We have two drivers on staff who are both appropriately-trained via the NSC Defensive Driving Course Online- 4 hour and background checked. Our on-boarding process ensures that this will always be the case.

The van leaves at 7 AM each morning to pick members up throughout our region and departs at 6:30 PM to bring folks home. Additionally, we ensure that our guests in Respite and Step-up Step-down programs have transportation to and from their start and completion of their stays and all required meetings and appointments in the interim.

We also utilize the van to pick up donations from the Keene Community Kitchen weekly and other donors on an as-needed basis. Guests are welcomed to participate in our weekly 'Shopping Trip', which is a time to do all sorts of errands from shopping and pharmacy to banking and post office visits, even short visits to receive medication at MFS. In addition, the van is used to transport members to our weekly bowling activity and monthly outings.

MPS's first and primary source of programming and group input is and always will be its members. We have a monthly community meeting with members; we listen to our members and strive to provide the services and groups they are asking for. We have an open-door policy allowing members/residents the opportunity to provide input throughout the month as well. Secondarily, we rely on our community partners to inform us and arm our staff with the knowledge they need to generate timely and appropriate program ideas, regardless of whether the topics are 'interesting' to our members. We recognize our responsibility to bring them the information and skills they need.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

The building is 12,640 square feet, and sits on .28 acres. We have 12 beautiful rooms for residents and staff and each equipped with queen or twin sized bed, plenty of linens, a personal refrigerator, and storage for clothing and personal belongings. There is a private living room space for the two separate living areas. We also have shared common areas such as an industrial kitchen, a dining area, a fully equipped gym, a group facilitation room, and a gaming room. We also have a parking area that is 2,400 square feet, currently only being used for parking.

During the day we serve anyone in the community with our day program offerings and we average about 40 people on site, per day.

Our public hours of operation are Monday through Friday 9am to 7pm. We have a staff member on-site, 24/7, so someone is always on-site with residents overnight.

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

We have three different categories of residents on-site.

1. Respite guests: Respite guests have an average stay of 6 nights and 7 days.

2. Step up / Step down (SUSD): SUSD guests have an average stay of 90 days

3. Washington Wellness (WW): WW guests have an average stay of 1 year.

SUBMITAL CHECKLIST

A complete application must include the following items and submitted by one of the options below:

- **Email:** communitydevelopment@keenenh.gov, with *"CLSS License Application"* in the subject line
- **Mail / Hand Deliver:** Community Development (4th Floor), Keene City Hall, 3 Washington St, Keene, NH 03431

The submittal requirements for a Congregate Living & Social Services License application are outlined further in **Chapter 46, Article X** of the City of Keene Code of Ordinances.

Note: Additional information may be requested to complete the review of the application.

✔ **PROPERTY OWNER:** *Name, phone number and address*	✔ **POINT OF 24 HOUR CONTACT:** *Name, phone number, and address of person acting as the operator, if not owner* ✔ **Same as owner**
✔ **REQUIRED DOCUMENTATION:** *Provide all required state or federal licenses, permits and certifications*	✔ **WRITTEN NARRATIVE:** *Provide necessary information to the submittal requirements*
✔ **PROPERTY INFORMATION:** *Description of the property location including street address and tax map parcel number*	✔ **APPLICABLE FEES:** $165.00 application $ 62.00 legal ad (*checks made payable to City of Keene*)
☐ **COMPLETED INSPECTION:** or *Inspection date:* _____	✔ **SCHEDULED INSPECTION:** *Inspection date:* 10/10/22

✔ **OPERATIONS AND MANAGEMENT PLAN:**

Plan based on the industry standard "*Best Management Practices*" to include:

- ◊ Security Plan
- ◊ Life Safety Plan
- ◊ Staff Training and Procedures Plan
- ◊ Health and Safety Plan
- ◊ Emergency Response Plan
- ◊ Neighborhood Relations Plan
- ◊ Building and Site Maintenance Procedures

In addition, Homeless Shelters will need to provide:

- ◊ Rules of Conduct, Registration System and Screening Procedures
- ◊ Access Policies and Procedures

Security Plan

Monadnock Peer Support

24 Vernon Street

Keene, NH 03431

603-352-5093/5094

Last Revised: August 2022

The safety and security of our employees and staff is the first consideration of Monadnock Peer Support. Our philosophy is to ensure the safety and wellbeing of all while at MPS. To achieve this, MPS maintains a comprehensive plan that is geared toward continuous improvement of workplace Safety.

A1. Program Goals

The goals we are working towards will continue to further our mission of being able to provide better peer support for our members and participants. In order to keep our building safe, we have put together the following goals:

- Hold meetings with all employees to discuss policy, roles, responsibilities, and avenues for communication.
- Develop and explain clear procedures for reporting incidents, injuries, illnesses, and close calls/near misses.
- Continuously revise checklist for hazards to look for.
- Conduct regular inspections using checklist.
- Discuss, reevaluate, and share emergency procedures.
- Discuss, reevaluate and share the security plan
- Ensure all employees are trained on how to identify and uphold our security.
- Review and update program as needed.

A2. Resources

Monadnock Peer Support will ensure that all employees will have access to phones, handheld two way radio, number of individuals in the building. Access to all cameras and footage.

- MPS has 12 live cameras in the building to ensure the safety and security of its members and staff.
- MPS has 3 exterior cameras to ensure the safety and wellbeing of members and staff.
- MPS is continuously working with Keene PD, Keene Fire and Keene Mutual aid to find areas of improvement. MPS does and will continue to install cameras that are suggested from these professionals.

A3. Expectations

Members will:

- Follow the rights and responsibilities of MPS and hand over all weapons upon entering the facility
- Members are not permitted to bring drugs or alcohol into the facility
- Members are not permitted to behave in an aggressive or inappropriate manner as outlined in our rights and responsibilities
- Members will not engage in sexual activities while at the center

- Members in our Residential unit are not permitted to enter another persons room

Executive Director will:

- Oversee program development and implementation
- Ensure adequate resources for anything needed
- Designate employees to carry out regular workplace inspections, incident reports, and follow up on corrective actions.
- Communicate policy to employees, members, and vendors
- Encourage employees to report safety and health concerns through an open door policy, as well as providing a suggestion box.
- Determine whether program goals are being met
- Lead review of the program to see if it needs improvement

Directors will:

- Set a good example by always following workplace practices
- Ensure that equipment and work areas under their direction are safe and well kept
- Ensure that procedures are being followed for safety and security
- Ensure employees are adequately trained in safety work procedures
- Participate with ED in regular safety and security procedures
- Respond promptly to reports of concerns
- Always be ready to dial 911

All other employees will:

- Follow procedures and policies for working safely and securely
- Report any injuries or illnesses to appropriate director
- Document any and all incidents
- Communicate with Keene PD regarding issues that need attention and support maintaining the trauma informed model and individual

B1. Employee Participation

People on the job often know the most about potential safety and security issues. Therefor, management will involve employees in all aspects of the plan.

B2. Encourage workers to report

- The Executive Director will instruct workers to report concerns directly to their manager
- The Director of Community Relations will provide a suggestion box if anyone wants to report anonymously any safety or security concerns

- The Executive Director will respond to any emergency, accident, or injury in person, or send another director.
- Information reported will be used to improve the safety and security efficiency of our operations and will never be used as a basis for retaliation or discrimination

B3. Encourage to access information

- Executive Director will communicate the results of safety/security inspections, incident investigations, and other safety/security-related issues to all
- To help employees understand hazards in the workplace, the Executive Director will ensure that employees have access to relevant safety information such as SDSs, equipment safety instructions, ect.

B4. Involve employees

- The Executive Director will involve employees in all aspects of the program, such as:
    - Developing and setting goals for health, safety and security
    - Finding and implementing solutions to safety, security health issues
    - Documenting safe and secure work practices
    - Conducting workplace inspections
    - Investigating any incidents
    - Reviewing and improving training programs

B5. Remove barriers to participation

- The Executive Director will ensure that employees will not face retaliation or discrimination or be discouraged from reporting any injuries, illnesses, or accidents
- The Executive Director will respond to any reports of illnesses, injuries, accidents, or health, safety and security concerns in person, or delegate an appropriate staff member to respond
- The executive Director will ensure that all training materials are understandable for all workers

C1. Collect information about security

- The Executive Director and Facilities Manager will review relevant information about potential health, safety and security:
    - Applicable security standards
    - Information about past incidents
    - Safety data sheets and security data sheets (SDSs)
    - Equipment safety information
    - Close calls/near misses
    - Input from all employees about possible areas for improvement

C2. Inspect the workplace

- The Executive Director or designated employee will develop, use, and regularly update a checklist for potential safety and security issues
- Using the checklist, the designated staff will conduct inspections in all areas of the facility weekly
    - Whenever an employee brings up a safety or security concern
    - Whenever we change processes, equipment, or materials
    - Review log notes every shift.
    - Daily Check In's
    - Regularly communicate with Fire Chief and Keene PD mental health officers
    - Check cameras and its batteries daily
    - Check outside lights to ensure they are working properly
    - Continuous scanning of the facility inside and out
    - Respite Staff to continuously count number of individuals in building and checking on members during night shift
    - Respite staff being available

- The Executive Director will assess emergency situations and non-routine tasks workers might encounter, such as fire, weather emergencies, violence, ect.
    - For hazards identified, the ED will prioritize the need for control by considering
        - Severity of hazard
        - Likelihood of recurrence
        - Number of people exposed
    - The ED will implement any readily available interim controls immediately

For Safety and Security issues that cannot be controlled immediately, MPS will:

- Select and provide controls to protect employees or members to prevent exposure to the incident
- Reevaluate controls as needed
- Document the incident and send to appropriate agencies including the Bureau of Mental Health

For safety/security issues that happen when the center is closed, MPS will:

- Develop plans and procedures to respond effectively and safely
- Obtain any equipment needed to control emergency-related hazards
- Incorporate relevant plans and procedures into trainings

D1. Follow up to confirm that controls are effective

Monadnock Peer Support will verify that control measures have been implemented according to schedule. The Executive Director or delegated staff will verify that the appropriate measures have been taken and that the measures do not interfere will other operations of the center. Weekly staff meetings are conducted to check in on the efficacy of controls being used, and regular inspections will be carried out by the facilities manager to ensure that 1) the safety of all staff and members is maintained and 2) check to make sure that nothing is being missed. Monadnock Peer Support will track any incidences

E1. Education and Training

Monadnock Peer Support will ensure that all staff receives training on the policies and procedures, how to report hazards, and how to handle hazards when the center is closed. The training will occur annually and for any new hires. The training will be conducted in an accessible way, and the organization will maintain records of all who have completed the training.

E2. Train workers on their roles and responsibilities

Monadnock Peer Support will provide training to ensure every worker knows how they can contribute to the health and safety of the center, especially the importance of reporting health and safety concerns in a timely manner to the appropriate staff.

E3. MPS offers weekly and monthly training to both staff and members. MPS is transparent with all members regarding cameras onsite and has signs at appropriate locations throughout the facility expressing that the environment has a camera.

E4. MPS is working with Lieutenant Shane Maxfield at Keene PD to do an Active Shooter Training course slated for September of 2022.

Active Shooter Procedure:

1. Run
2. Hide
3. Fight

F1. Program Evaluation and Improvement

Monadnock Peer Support will track the following measures to help with program effectiveness:

- Number of inspections conducted
- Number of safety/security and close calls/near misses reported
- Timeliness in completing corrective actions
- Number of injuries avoided compared to a similar timeframe in the previous year
- Feedback from managers and employees on program effectiveness

F2. Verify program implementation

Monadnock Peer Support will review our program twice a year to make sure it is being implemented as designed to meet our needs. The Executive Director will involve staff in the review process, if need be, and will communicate the results of the review to all staff.

F3. Correct program shortcomings

The Executive Director, with employees and members' input, will revise the policies and procedures as needed to correct any deficiencies and implement improvements. They will set the goals for the next year and assign responsibilities and provide resources as needed to address deficiencies or meet new goals.

Staff Training and Procedures Plan

Taken from the most updated Employee Manual:

3.9 Staff Orientation:

Upon being hired, the new employee will receive orientation from the Executive Director or designated staff on all aspects of the job, program regulations, personnel policies, pay, time sheets, benefits, etc.

3.10 Training and Career Development:

Employees are required to complete and maintain any certifications required under state rules, regulations, and contract requirements. MPS will provide details of such training and cover the costs associated. Trainings required by MPS will be compensated at the staff member's determined rate of pay.

MPS requires employees to participate in job training activities and career development programs when available. On a case-by-case basis, training on MPS time may be acceptable and encouraged. Approval of the Executive director is required. On a case-by-case basis, MPS may pay for training or workshops. Approval of the Executive Director is required.

Health and Safety Plan

Monadnock Peer Support

24 Vernon Street

Keene, NH 03431

603-352-5093/5094

Last Revised: August 2022

The safety and health of our employees is the first consideration of Monadnock Peer Support. Our philosophy is that all workplace injuries and illnesses can be prevented. To achieve this, MPS maintains a comprehensive plan that is geared toward continuous improvement of workplace safety and health.

A1. Program Goals

The goals we are working towards will continue to further our mission of being able to provide better peer support for our members and participants. In order to keep our building safe, we have put together the following goals:

- Hold meetings with all employees to discuss policy, roles, responsibilities, and avenues for communication.
- Develop and explain clear procedures for reporting incidents, injuries, illnesses, and close calls/near misses.
- Continuously revise checklist for hazards to look for.
- Conduct regular inspections using checklist.
- Discuss, reevaluate, and share emergency procedures.
- Ensure all employees are trained on how to identify and control hazards.
- Review and update program as needed.

A2. Resources

Monadnock Peer Support will ensure that all employees will have access to training, equipment, personal protective equipment, substitute chemicals or other products, and materials like Safety Data Sheets and other information about chemicals used at the center.

A3. Expectations

Executive Director will:

- Oversee program development and implementation
- Ensure adequate resources for anything needed
- Designate employees to carry out regular workplace inspections, incident reports, and follow up on corrective actions.
- Communicate policy to employees, members, and vendors
- Encourage employees to report safety and health concerns through an open door policy, as well as providing a suggestion box.
- Determine whether program goals are being met
- Lead review of the program to see if it needs improvement

Directors will:

- Set a good example by always following workplace practices
- Ensure that equipment and work areas under their direction are safe and well kept
- Ensure that procedures are being followed for safe use of hazardous substances
- Ensure employees are adequately trained in safe work procedures
- Participate with ED in regular safety and health inspections following incidents and identification of hazards
- Respond promptly to reports of concerns

All other employees will:

- Follow procedures and policies for working safely
- Report any injuries or illnesses to appropriate director

B1. Employee Participation

People on the job often know the most about potential safety and health hazards. Therefor, management will involve employees in all aspects of the plan.

B2. Encourage workers to report

- The Executive Director will instruct workers to report concerns directly to their manager or to them
- The Director of Community Relations will provide a suggestion box if anyone wants to report anonymously
- The Executive Director will respond to any emergency, accident, or injury in person, or send another director.
- Information reported will be used to improve the safety and efficiency of our operations and will never be used as a basis for retaliation or discrimination

B3. Encourage to access information

- Executive Director will communicate the results of safety inspections, incident investigations, and other safety-related issues to all
- To help employees understand hazards in the workplace, the Executive Director will ensure that employees have access to relevant safety information such as SDSs, equipment safety instructions, ect.

B4. Involve employees

- The Executive Director will involve employees in all aspects of the program, such as:
    - Developing and setting goals for health and safety
    - Finding and implementing solutions to safety and health issues
    - Documenting safe work practices
    - Conducting workplace inspections
    - Investigating any incidents

- Reviewing and improving training programs

B5. Remove barriers to participation

- The Executive Director will ensure that employees will not face retaliation or discrimination or be discouraged from reporting any injuries, illnesses, or accidents
- The Executive Director will respond to any reports of illnesses, injuries, accidents, or health and safety concerns in person, or delegate an appropriate staff member to respond
- The executive Director will ensure that all training materials are understandable for all workers

C1. Collect information about hazards

- The Executive Director and Facilities Manager will review relevant information about potential safety and health hazards, including:
  - Applicable OSHA standards
  - Information about pat incidents, injuries, and illnesses
  - Safety data sheets (SDSs) for hazardous chemicals
  - Equipment safety information
  - Close calls/near misses
  - Input from all employees about possible hazards

C2. Inspect the workplace

- The Executive Director or designated employee will develop, use, and regularly update a checklist for potential job hazards
- Using the checklist, the designated staff will conduct inspections in all areas of the facility monthly
  - Whenever an employee brings up a safety or health concern
  - Whenever we change processes, equipment, or materials
  - Every month

C3. Identify the hazards

- The Facilities manager or other designated staff member will identify any sources of health hazards in our workplace, such as:
  - Chemical hazards – by examining SDSs and product labels to identify chemicals in use
  - Physical health hazards – by considering exposures to noise or heat
  - Biological hazards – by considering exposures to bodily fluids, molds, or animal materials
  - Ergonomic hazards – by evaluating activities involving repetitive motions, heavy lifting, work above shoulder height, or vibration

C4. Conduct investigations

- The Executive Director or designated staff member will investigate injuries and illness to identify hazards and systematic failures that might have caused those injuries or illnesses. They will:
  - Train the people conducting investigations on incident investigation techniques, emphasizing the need to be openminded

    - Investigate the root causes of all incidents
    - Initiate investigations within 24 hours or any incident reported
    - Use corrective and preventive action processes following the investigation that includes:
        - Documenting findings and corrective actions
        - Describe how the recommendations will be implemented
        - Verify completion
        - Communicate findings to appropriate parties
        - Monitor the corrective and preventive actions to determine effectiveness
- The Executive Director will assess emergency situations and non-routine tasks workers might encounter, such as fire, weather emergencies, violence, ect.
    - For hazards identified, the ED will prioritize the need for control by considering
        - Severity of hazard
        - Likelihood of recurrence
        - Number of people exposed
    - The ED will implement any readily available interim controls immediately

D1. Hazard Prevention and Control

For hazards we identify or anticipate, the Executive Director or delegated staff will gather and evaluate information about appropriate actions to take through input from employees, members, anyone above the ED at the state level, and other consultations.

D2. Develop and update a hazard control plan

To develop, MPS will:

- Plan to control hazards
- Prioritize hazards for control based on the seriousness of injuries or illnesses that could result
- Quick fixes will be made as needed
- Update plan as it is implemented

For hazards that cannot be controlled immediately, MPS will:

- Select and provide controls to protect employees or members to prevent exposure to the hazard
- Reevaluate controls as needed
- Document the control measures and hazard control as needed
- Communicate any plan to control the hazard agency-wide

For hazards that happen when the center is closed, MPS will:

- Develop plans and procedures to respond effectively and safely
- Obtain any equipment needed to control emergency-related hazards
- Incorporate relevant plans and procedures into trainings

D3. Follow up to confirm that controls are effective

Monadnock Peer Support will verify that control measures have been implemented according to schedule. The Executive Director or delegated staff will verify that the appropriate measures have been taken and that the measures do not interfere will other operations of the center. Quarterly staff meetings will be scheduled to check in on the efficacy of controls being used, and regular inspections will be carried out by the facilities manager to ensure that 1) the safety of all staff and members is maintained and 2) check to make sure that nothing is being missed. Monadnock Peer Support will track any injuries or illnesses.

E1. Education and Training

Monadnock Peer Support will ensure that all staff receives training on the policies and procedures, how to report hazards, and how to handle hazards when the center is closed. The training will occur annually and for any new hires. The training will be conducted in an accessible way, and the organization will maintain records of all who have completed the training.

E2. Train workers on their roles and responsibilities

Monadnock Peer Support will provide training to ensure every worker knows how they can contribute to the health and safety of the center, especially the importance of reporting health and safety concerns in a timely manner to the appropriate staff.

F1. Program Evaluation and Improvement

Monadnock Peer Support will track the following measures to help with program effectiveness:

- Number of inspections conducted
- Number of hazards and close calls/near misses reported
- Timeliness in completing corrective actions
- Number of injuries and illnesses avoided compared to a similar timeframe in the previous year
- Feedback from managers and employees on program effectiveness

F2. Verify program implementation

Monadnock Peer Support will review our program twice a year to make sure it is being implemented as designed to meet our needs. The Exewcutive Director will involve staff in the review process if need be, and will communicate the results of the review to all staff.

F3. Correct program shortcomings

The Executive Director, with employees and members' input, will revise the policies and procedures as needed to correct any deficiencies and implement improvements. They will set the goals for the next year and assign responsibilities and provide resources as needed to address deficiencies or meet new goals.

Neighborhood Relations Plan

Monadnock Peer Support

24 Vernon Street

Keene, NH 03431

603-352-5093/5094

Last Revised: August 2022

It is of the utmost importance that Monadnock Peer Support has wonderful relationships with our fellow neighbors, municipalities local businesses and beyond. We are constantly making efforts to include, engage and promote community by engaging, inviting and educating.

Many of our members have significant trauma. We have found that having Keene Fire and Keene PD visit or facility regularly is incredibly beneficial to or members who have trauma and negative experiences with our local law enforcement and Fire Fighters. Both Keene PD and Keene Fire have a vested interest in being trauma informed and make every effort to collaborate with and engage our members in a non-confrontational, inviting and engaging way.

We use Intentional Peer Support (IPS) to talk and engage with our membership population. We have found that Keene PD and Keene Fire organically are picking up on this model and are using it in their own practices.

Our ED has regular communication with Chief Joseph Sangermano as we share a building, parking lot and areas outside of the building that can often host homelessness or possible dangerous encounters. We collaborate frequently to ensure that we are working together and protecting the citizens of Keene.

MPS, Keene Housing and Monadnock Family Services serve many of the same clientele and work very closely on a daily basis with the same goals in mind.

MPS is incredibly respectful to our fellow small businesses and landlords that surround us and have very good relations with all.

MPS has very strict rules around drugs, alcohol, smoking and aggressive behavior. We have a designated smoking policy in and effort to be respectful to our fellow neighbors and have a zero tolerance for anyone to smoke on premises outside of the designated smoking area. Additionally, we have a zero tolerance for drugs, alcohol or aggressive behavior. It is not tolerated and correct the behavior immediately and remove individuals when they are non-compliant.

The Executive Director is in constant communication with Keene's Fire Chief Don Farquhar. Our Fire Chief comes to the center on a regular basis to engage with our staff and members.

MPS is continuously hosting events inviting neighbors, city employees, the mayor, politicians, chamber members and beyond to learn about our agency and how serve our community.

Monadnock
PEER SUPPORT

AN INCLUSIVE AND JUDGEMENT-FREE COMMUNITY
TO SUPPORT YOUR MENTAL WELL-BEING.

EMERGENCY RESPONSE PLAN

MONADNOCK PEER SUPPORT
32 Washington Street/24 Vernon Street
PO Box 258
Keene, NH 03431
603-352-5093/5094
www.monadnockpsa.org

Date Revised: August 2022

Emergency Personnel Names and Phone #'s

When we are open:

DESIGNATED RESPONSIBLE INDIVIDUAL: Christine Allen; 603-803-1616

If Christine isn't here;

DESIGNATED RESPONSIBLE INDIVIDUAL: Matt Johnson

If Christine and Matt aren't here;

DESIGNATED RESPONSIBLE INDIVIDUAL:

Karen Richi; 603-762-7574

- **When we are closed:**

DESIGNATED RESPONSIBLE INDIVIDUAL: Respite Staff; see employee contact sheet

EVACUATION ROUTES

Evacuation route maps have been posted in each work area. The following information is marked on evacuation maps:

1. Emergency exits
2. Primary and secondary evacuation routes
3. Locations of fire extinguishers

Site personnel should know at least 2 evacuation routes.

Emergency Phone Numbers

In case of immediate emergency, please dial 911!

Fire Department:

Central Station: (603) 357-9861

Station 2: (603) 357-9886

Fire Prevention Bureau: (603) 757-1863

Fire Alarm Division: (603) 757-1864

Police Department:

Non-Emergency: 603-357-9813

Records: 603-357-9815

Poison Control:

Hotline: 1-800-222-1222

Administrative: 207-662-7222

Fax Number: 207-662-5941

Ambulance:

DiLuzio: (603) 357-0341

UTILITY COMPANY EMERGENCY CONTACTS

ELECTRIC:

Eversource Customer Service: 800-662-7764

TTY/TDD Hearing Impaired: 800-346-9994

WATER:

Main Office: 603-352-6550

Water Billing: 603-352-3239

After Hours Emergency: 603-357-9813

GAS:

Liberty Utilities Emergencies: 1-855-327-7758

Customer Care: 1-800-833-4200

OIL:

Dead River Telephone: 603-352-5240

Toll-Free: 800-442-5240

PHONE/INTERNET:

Consolidated Communications: 1-844-968-7224

EuropaIT Support Line: 802-275-4848

MEDICAL/CRIMINAL EMERGENCY

- Call medical emergency phone number (see page 4)
    - Fire
    - Police
    - Poison Control
    - Ambulance
- Provide the following information:
    - Nature of the medical emergency
    - Location of the emergency (address, room, ect.)
    - Your name and the number from which you are calling
- Do not move the person in distress unless absolutely necessary
- If personnel trained in First Aid and CPR aren't available, attempt to provide the following assistance:
    - Stop bleeding with firm pressure on wounds (please avoid contact with blood or other bodily fluids)
    - Clear the air passages using the Heimlich Maneuver in case of choking
- In case of rendering assistance to personnel exposed to hazardous materials, consult the Poison Control number or website. Please wear the appropriate protective equipment.

FIRE EMERGENCY

When fire is discovered:

- Notify the local fire department by calling 911 or (603) 357-9861
- If fire alarm is not available, notify site personnel and members/guests by the following means:
    - Face-to-face
    - Phone call

Fight the fire ONLY if:

- The fire department has been notified
- The fire is small and not spreading to other areas
- Escaping the area is possible by backing up to the nearest exist
- The fire extinguisher is in working condition and personnel are trained to use it

Upon being notified of the fire emergency, occupants must:

- Leave the building using the designated escape routes (please see attached Emergency Exit Procedure)
- Assemble in the designated area: sidewalk on the corner of Vernon Street and Elm Street
- Remain outside the building until the Designated Official announces that it is safe to enter

Designated Official/Supervisors must:

- Delegate responsibility of assisting any physically challenged individuals to another member/participant/guest
- Disconnect utilities and equipment unless doing so jeopardizes her safety
- Coordinate an orderly evacuation of personnel/guests/members
- Perform an accurate headcount of individuals gathered in designated area
- Provide the Fire Department personnel with necessary information about the facility
- Perform assessment and coordinate with other staff to determine emergency closing procedures and how to transport guests/members if need be

SEVERE WEATHER AND NATURAL DISASTERS

Tornado:

- When a warning is issued by sirens or other means, seek inside shelter. Consider the following:
    - Small interior rooms on the lowest floor and without windows,
    - Hallways on the lowest floor away from doors and windows, and
    - Rooms constructed with reinforced concrete, brick, or block with no windows.
- Stay away from outside walls and windows.
- Use arms to protect head and neck.
- Remain sheltered until the tornado threat is announced to be over.

Earthquake:

- Stay calm and await instructions from the Emergency Coordinator or the designated official.
- Keep away from overhead fixtures, windows, filing cabinets, and electrical power.
- Assist people with disabilities in finding a safe place.
- Evacuate as instructed by the Emergency Coordinator and/or the designated official.

Flood:

- If indoors:
    - Be ready to evacuate as directed by the Emergency Coordinator and/or the designated official.
    - Follow the recommended primary or secondary evacuation routes.
- If outdoors:
    - Climb to high ground and stay there.
    - Avoid walking or driving through flood water.
    - If car stalls, abandon it immediately and climb to a higher ground.

Blizzard:

- If indoors:

- Stay calm and await instructions from the Emergency Coordinator or the designated official.
- Stay indoors!
- If there is no heat:
  - Close off unneeded rooms or areas.
  - Stuff towels or rags in cracks under doors.
  - Cover windows at night.
- Eat and drink. Food provides the body with energy and heat. Fluids prevent dehydration.
- Wear layers of loose-fitting, light-weight, warm clothing, if available.

Monadnock
PEER SUPPORT

AN INCLUSIVE AND JUDGEMENT-FREE COMMUNITY
TO SUPPORT YOUR MENTAL WELL-BEING.

Life Safety Plan

Monadnock Peer Support

24 Vernon Street

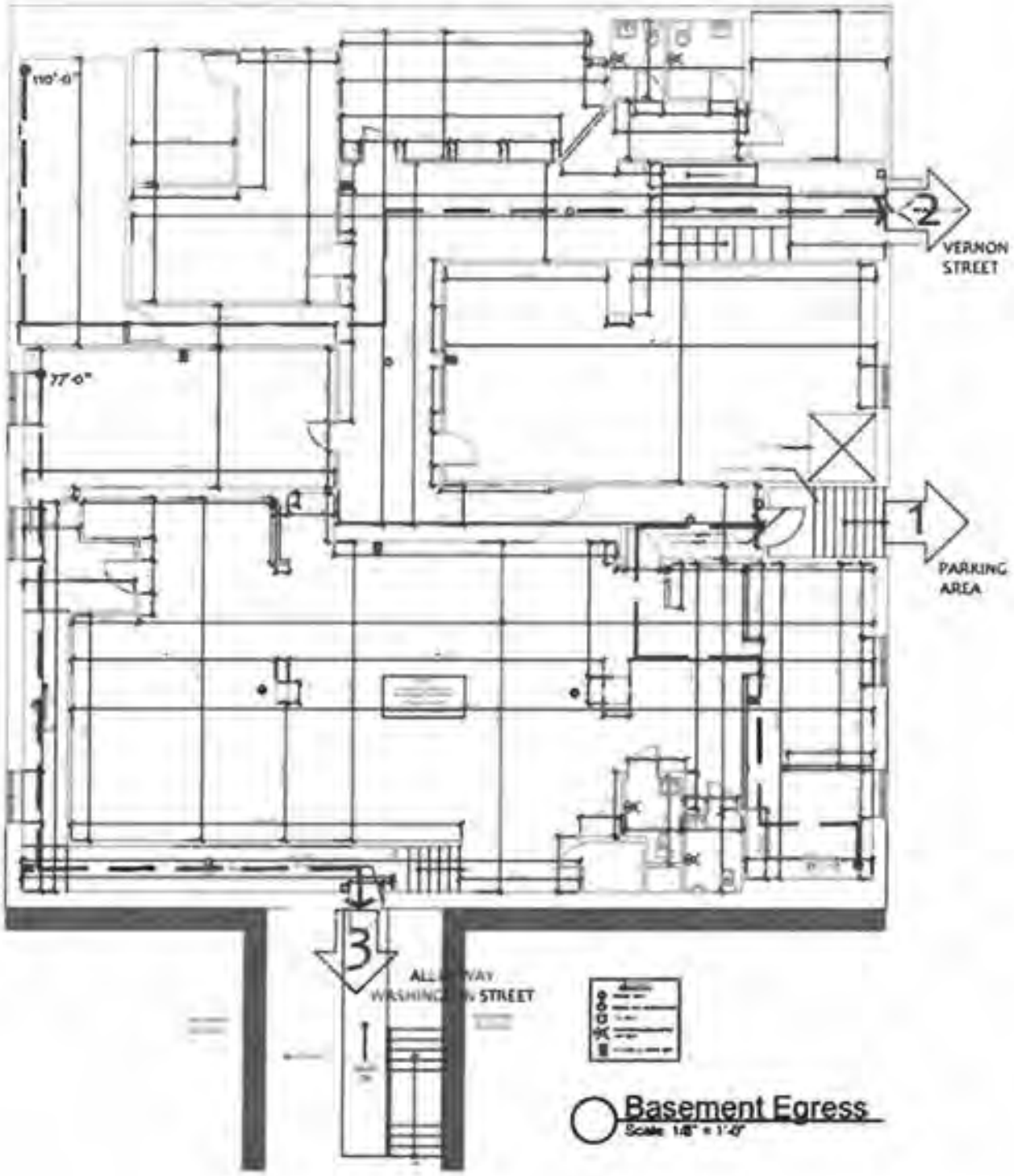
Keene, NH 03431

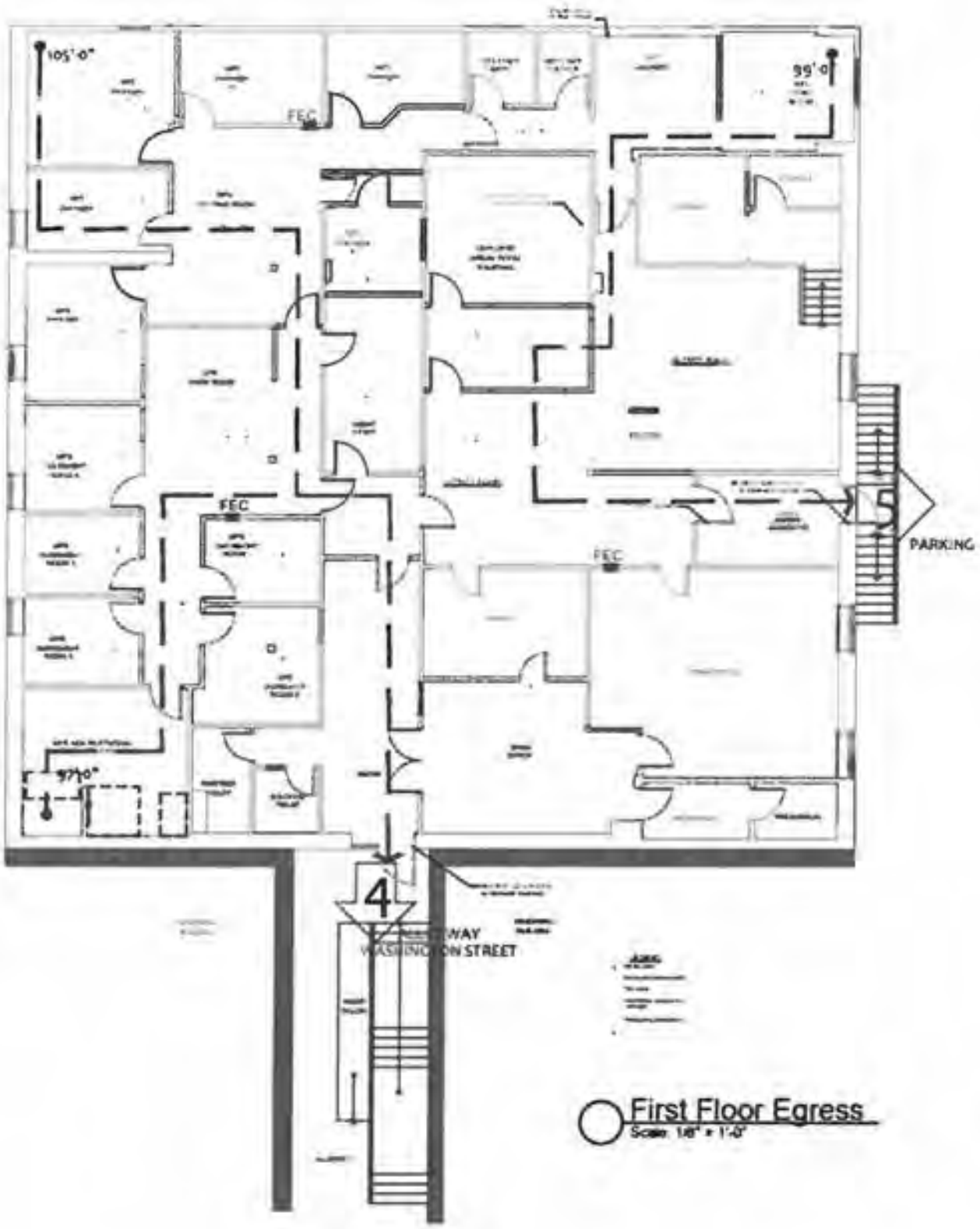
603-352-5093/5094

Last Revised: Aug 2022

A life safety plan is a plan in place for when an emergency situation occurs and an Egress route is needed in order to evacuate the building in a safe manner.

- Front of the building
- Top Entrance and Exit
    - Elevator for wheelchair or disabled individual
    - Bottom Entrance and Exit
        - Elevator for wheelchair or disabled individual
    - Back Entrances
        - One Entrance and Exit to top floor
        - Two Entrances and Exits for bottom floor
        - Second Bottom Entrance has wheelchair ramp
    - Exterior and Interior Emergency Lights
    - Exterior and Interior Exit Signs
    - Smoke/Carbon monoxide Detectors
    - Sprinkler System
    - Accessible Fire Extinguishers in every room


110'-0"
77'-0"
2
VERNON
STREET
1
PARKING
AREA
3
ALLEYWAY
STREET
Basement Egress



First Floor Egress

Monadnock
PEER SUPPORT

AN INCLUSIVE AND JUDGEMENT-FREE COMMUNITY
TO SUPPORT YOUR MENTAL WELL-BEING.

Building and Site Maintenance Procedures

Monadnock Peer Support

24 Vernon Street

Keene, NH 03431

603-352-5093/5094

Last Revised: Aug 2022

Building and Site Maintenance Procedures include cleaning common areas, removing trash regularly to maintain a clean space for all individuals. Repairing items that are broken or replacing items that cannot be fixed. Inspecting, Repairing, and maintaining electrical systems (heating, air conditioning systems, and utility services) are included in maintaining a safe environment for all individuals.

- Kitchen
  - Checking fridges for leaks
    - Electrical tears in wires
    - Cooling temps
      - Fridge cleanliness
  - Checking ice machine/microwave/coffee makers and maintaining cleanliness
    - Electrical tears in wires
    - Leaks
    - Mold and mildew
  - Faucets
    - Plumbing
    - Dishwasher leaks and electrical tears
    - Garbage Disposal
  - Oven
    - Electrical tears
    - Electrical power outlet
    - Cleanliness
    - All knobs/buttons in working order
  - Fire Alarms
    - Electrical tears
    - Batteries if needed
    - Test as needed
    - Fire extinguisher up to date and not used
  - Mold and mildew check in ceiling and floors
- Common Areas
  - Electrical Outlets
  - Fire Alarms are up to date along with fire extinguishers
  - Cleanliness
  - Air conditioning working properly
  - Heating working properly
  - Electrical Lights are working properly
  - Mold and mildew check in ceiling and floors
- Residential Areas
  - Electrical Outlets
  - Fire extinguishers and Fire alarms
  - Exit signs are working properly
  - Cleanliness

- Electrical Lights are working
- Air conditioning working properly
- Heating working properly
- Mold and mildew check in ceiling and floors

- Group Rooms
  - Electrical Outlets
  - Fire extinguishers and Fire alarms
  - Exit signs are working properly
  - Cleanliness
  - Electrical Lights are working
  - Air conditioning working properly
  - Heating working properly
  - Mold and mildew check in ceiling and floors
- Staff Meeting Rooms
  - Mold and mildew check in ceiling and floors
  - Electrical Outlets
  - Fire extinguishers and Fire alarms
  - Exit signs are working properly
  - Cleanliness
  - Electrical Lights are working
  - Air conditioning working properly
  - Heating working properly

Descriptive Narrative

Existing / Proposed Uses:
The building is classified as an Institutional Use (I4). There is no proposed change in use as part of this application.

Description of Size / Intensity of Use:
There is no proposed expansion to the size or intensity of use. This application seeks to develop a small part of the exterior space to be utilized as a common gathering area for existing client to have additional options for meeting space.

Description of Proposed Redevelopment:
This application proposes to redevelop one small exterior space that will be used to provide an exterior space that is screen from the public for clients to meet. This use is consistent with the use of the existing building.

Description of Site and Safety Procedures:
The proposed site is located in the downtown district. The building is consisting in size and scale with the surrounding neighbor. The building is multistory and the exterior is comprised of a mix of concrete block and vinyl siding. At this point in time there is no intention of changing the exterior of the building.

Description of Intake Areas:
There is no proposed changes to the existing intake areas.

Traffic Impact:
There will be no impact to traffic. The proposed exterior space is intended for existing clients.

Description of Parking Demand / Imapct:
There will be no impact to traffic. The proposed exterior space is intended for existing clients.

Location of access points:
Access to the building and site will remain unchanged. There is no plan for any exterior work to the building or site.

Other Descriptive Information:
This proposal is limited to the install of vinyl fencing to screen an existing parking area as well as provide an additional private area for clients to meet in an outside space.

Drainage & Stormwater Management:
There is no exterior work planned. There will be no change to existing drainage or stormwater management.

Sedimentation Control:
Sedimentation control will not be required. There is no site work being proposed as part of this proposal.

Snow Stroage and Removeal:
There is limited parking area and paved surfaces. Snow storage therefor is also limited. Snow will be removed from the site as required to maintain parking areas.

Landscaping:
There are no proposed planting or changes to any landscaping.

Screening:
This application proposes to install screen that will provide additional privacy for those who utilize the property. Screening will reduce the amount of the parking area that will be visible from the road as well as private a private area (approximately 16'x16') for clients to gather outside of the building. White vinyl fencing is being proposed.

Lighting:
There are no proposed exterior lights as part of this proposal.

Water & Sewer:
The building is tied to city water and sewer. There will be no change in use / intensity.

Traffic & Access Management:
There is no change to site access and traffic patterns as part of this proposal. Vinyl fencing is proposed for privacy screening only parking and traffic patterns will remain intact.

Filling & Excavation:
There is no excavation of filling of the site proposed as part of this proposal.

Surface Waters & Wetland:
There are no wetlands on the site. There is no change to surface water as part of this proposal.

Hazardous & Toxic Materials:
There are no hazardous or toxic materials involved with this proposal.

Noise:
Noise impact from the proposed project will be minimal. The proposed exterior gathering space is intended for quiet meetings and private conversations.

Architectural & Visual Appearance:
The architectural and visual appearance of the building is not being changed as part of this proposal. White vinyl privacy fencing is being proposed to screen an area to outside gathering

1

Monadnock PEER SUPPORT

TO:
City of Keene
Community Development Department
3 Washington Street
Keene, NH 03431

FROM:
Monadnock Area Peer Support Agency
Christine Allen, Executive Director
32 Washington St #REAR
Keene, NH 03431
Email: Christine@MonadnockPSA.org
(603) 352-5093

ORIGINAL TRANSMITTAL LETTER
Request for use of Parking Lot
24 Vernon Street, Keene, NH
8/25/2022

To whom it may concern,

Please accept this narrative as a description of our center and its usage in response to a complaint that was issued by Gary Kinyon from Bradley & Faulkner on Tuesday August 16, 2022. On behalf of Monadnock Area Peer Support Agency (MPS).

Please know that I, Christine Allen, am authorized to bind Monadnock Area Peer Support Agency to all statements. I will also serve as primary contact for all matters relevant to this is Congregate Living & Social Service Conditional Use Permit Application.

Sincerely,

Christine Allen, Executive Director, Monadnock Area Peer Support Agency

Monadnock Area Peer Support Agency, familiarly known as "MPS", is seeking permission to use the parking lot located at 24 Vernon Street. We are requesting the ability to have a designated smoking section for our members as well as the ability have an outside seating area. In addition to the cars in the parking lot we have made the most of our outdoor space until August 18, 2022 when I met with the city to talk about the next steps in the CUP process. It was during this meeting that I learned a complaint was made regarding the usage of our parking lot stating that we were in violation. Below is the Complaint from Gary Kinyon:

"I write to inform you that outside of the rear of this building, there are chairs and a picnic table set up and used frequently.

The minutes of the Planning Board Meeting of January 24, 2022 for the application for conditional use permit state, in addressing the standards for granting a permit:

B. The proposed use will be established, maintained, and operated so as not to endanger the public health, safety, or welfare.

The applicant did address this item in their narrative and did indicate all activities associated with the proposed use will occur inside the existing building.

D. The proposed use will be of a character that does not produce noise, odors, glare, and/or vibration that adversely affects the surrounding area.

PB Meeting Minutes ADOPTED

Ms. Brunner noted due to the fact that the proposed use will be located entirely inside the existing building, staff does not expect this to be an issue.

This outdoor use is a clear violation of the basis on which the permit was granted."

Upon learning that we were in violation, we immediately removed an 8-foot wooden picnic table located in the corner of the parking lot with a red umbrella. A 5-foot round picnic table in the opposite side of the parking lot for nonsmokers and 10 colorful Adirondack chairs as to ensure that we are no longer in violation. We are seeking approval to have use of our parking lot with a designated smoking section which would be 25 feet away from any door and the ability to have outdoor chairs for individuals to utilize while at the center. Within these documents, you will see why the usage of outdoor space for seating is so important to our members and guests and will further understand how we plan to address any issues that may arise. Tim Sampson from Sampson Architect has drafted some drawings which will show the fencing that we plan to put in place to prevent the seating areas from being visible to the public.

Through this application you will learn that MPS's programs are outstanding; our financials are strong; our policies and procedures are clean, compliant and undergo regular review; our culture and staff are well-loved; our community relationships are substantial; we have an outstanding relationship with Keene PD and Keene Fire and our facilities are top-notch and getting better by the day.

MPS's offering go far above and beyond the minimum requirements of our contract to provide the very best peer support to our community and beyond. We strive to have groups, activities, and training every hour of the day. We see open time on our schedule as opportunity to offer more; unused time is wasted time. We strive for continuous improvement in our offerings.

MPS is governed by a Board of Directors with a plan for governance that meets the requirements outlined in He-M 402.03 (b). MPS's peer support center is open 50 hours each week and follows all Department Life Safety requirements.

MPS programs use Intentional Peer Support (IPS), a recognized best practice founded by Shery Mead (Mead, S. (6/2011) in the 1990s. Intentional Peer Support provides a powerful framework for creating relationships where both people learn and grow. Peers come together around shared experiences and often a desire to change their lives. However, without a new framework to build upon, people frequently re-enact "help" based on what was done to them. IPS offers a foundation for doing something different. It derives from a history of grassroots alternatives that focus on building relationships that are mutual, explorative, and conscious of power.

MPS programs also use Wellness Recovery Action Plan (WRAP), an evidence-based practice started by Mary Ellen Copeland, Ph.D., recognized by the Substance Abuse and Mental Health Service Administration (SAMHSA).

MPS provides transportation for our members. MPS owns an appropriately registered/inspected and fully insured 12 passenger 2010 Ford Econoline e350 van VIN 1FBSS3BL9ADA93207 with which it provides transportation to members and participants. The van is black and bears MPS signage. We have two drivers on staff who are both appropriately-trained via the NSC Defensive Driving Course Online- 4 hour and background checked. Our on-boarding process ensures that this will always be the case.

The van leaves at 7 AM each morning to pick members up throughout our region and departs at 7 PM MWF and 5 PM TuTh to bring folks home. Additionally, we ensure that our guests in Respite and Step-up Step-down programs have transportation to and from their start and completion of their stays and all required meetings and appointments in the interim.

We also utilize the van to pick up donations from the Keene Community Kitchen weekly and other donors on an as-needed basis. Guests are welcomed to participate in our weekly 'Shopping Trip', which is a time to do all sorts of errands from shopping and pharmacy to banking and post office visits, even short visits to receive medication at MFS. In addition, the van is used to transport members to our weekly bowling activity and monthly outings.

MPS's first and primary source of programming and group input is and always will be its members. We have a monthly community meeting with members; we listen to our members and strive to provide the services and groups they are asking for. We have an open-door policy allowing members/residents the opportunity to provide input throughout the month as well. Secondarily, we rely on our community partners to inform us and arm our staff with the knowledge they need to generate timely and appropriate program ideas, regardless of whether the topics are 'interesting' to our members. We recognize our responsibility to bring them the information and skills they need.

Our staff members are regular attendees and active participants at coalition and workgroup meetings that address matters impacting our members. We find that by engaging with such groups, MPS remains in-tune and first-to-know about changes, needs and hot topics impacting our members and is able to quickly design or re-design programming and prepare resources appropriately. The following alphabetical list reflects the purpose and frequency of each group of which MPS staff are members:

- **Business Networking International (BNI)**- Goal: to introduce local business owners to MPS offerings and build a network of champions in the community. Thursdays 7:30 AM to 9 AM
- **Community Health Improvement Plan (CHIP) Behavioral Health Work Group**- Goal: bring together community partners to move forward on Dartmouth-Hitchcock's Community Health Improvement Plan goals to Improve Behavioral Health Outcomes/Prevent and Reduce Harm from Substance Use and Mental Illness. 4th Tuesday of the Month, 10 AM to 11 AM
- **Community Network Team (CNT)**- Goal: increase collaboration and referrals among social services agencies in the Keene area. 2nd Thursday of the Month, 12 PM to 1 PM
- **Greater Keene Homeless Coalition (GKHC)**- Addresses homelessness in the Monadnock Region 4th Thursday of the Month, 1:30 PM to 3:30 PM
- **Greater Monadnock Public Health Network (GMPHN) Risk & Protective Factors Workgroup.** Goal: Build, maintain and sustain a regional network of professionals and community members who are concerned about substance misuse in the region
- **Interagency Team**- Goal: Increase collaboration and referrals among social services agencies in the Keene area. 4th Monday of the Month, 9 AM to 11 AM
- **Keene New Hampshire Lions Club**- Goal: To empower volunteers to serve their communities, meet humanitarian needs, encourage peace and promote international understanding. Every Tuesday 12:15 PM to 2 PM
- **Monadnock Regional Council for Community Transportation (MRCC)**- Goal: a coalition of transportation providers, purchasers and users in Southwest New Hampshire working together to create an affordable community transportation system that provides all community members access to services and opportunities and improves the health and social cohesion of the Monadnock Region. 3rd Tuesday of the Month, 9 AM to 10:30 AM
- **Monadnock Region Partners Across the Continuum (MRPAC)**- Goal: bring together community partners from across the continuum; to exchange information, provide support and improve communication among regional organizations engaging in substance misuse and mental health related services. 3rd Wednesday of the Month, 1 PM to 2:30 PM
- **New Hampshire Mental Health Peer Alliance (NHMHPA)**- Goal: to educate and connect Peer Support Agency staff. 3rd Tuesday of the Month, 10 AM to 12 PM
- **NHMHPA Advocacy Workgroup**- Goal: discuss the various ways we can move NHMHPA's our

action plan and strategic communication plan forward: train peers as advocates, create a website and brochure. Every Tuesday, 1 PM to 2 PM

- **NHMHPA Legislative Workgroup**- Goal: Advocate for equal rights and a recovery-oriented mental health system to legislators, peers, government personnel and the general public. Every other Friday, 10:30 AM to 11:30 AM
- **Provider Network**- Goal: Increase collaboration and referrals among social services agencies in the Peterborough area. 4th Tuesday of the Month, Noon to 1:00 PM
- **YMCA Community Coalition on Substance Misuse**- Goal: Bring together stakeholders to work collaboratively to prevent substance misuse among youth and young adults in our community. 3rd Thursday of the Month, 4 PM to 5 PM

MPS's day programs are free and open to any New Hampshire resident (18 years or older) who is a recipient, former recipient, or is at risk becoming a recipient of mental health services. MPS has spent 26 years developing strong, connecting relationships where people feel valued, become empowered and move toward recovery. Our programs are grounded in the principles of personal responsibility, mutuality, reciprocity, and respecting others' thoughts and beliefs as valid and important. We encourage growth beyond stigma, shame, and limits placed upon us, creating and maintaining a strong, active voice and presence dedicated to social change.

Our site is separate from the local Community Mental Health Center (Monadnock Family Services--MFS) and has ample parking located near downtown Keene and is within walking distance to MFS, the Community Kitchen (food pantry and soup kitchen), Hundred Nights Shelter and Family Resource Center and cold weather/family shelters, Southwestern Community Services, ServiceLink, Monadnock Center for Violence Prevention, Alternative Sentencing Program and Mental Health Court, Monadnock Food Co-op, Keene State College, Keene Recreation Center, Keene Serenity Center, Keene Public Library, Keene Senior Center, City and County Government offices and resources.

We are fortunate to have both indoor and outdoor space where our members, participants, and guests can gather to engage in mutually beneficial connections. While we understand that the usage of our parking lot is not currently permitted it is our hope that by addressing this issue with the city we will once again be able to provide a designated smoking section for our participants along with the opportunity for non-smoking folks to have a place sit outside and enjoy the outdoors. Daytime visitors have access 5 bathrooms (one of which is fully accessible or handicapped usage), two showers, a complete kitchen and a kitchenette, community dining space, a large activity area, a laundry room, weight room, a crafting area, gaming area, computing area, and a private groups room. All are fully furnished and beautifully decorated.

As part of our programming, we offer our guests and community members the following services: 24 - hour onsite staff, lockers to hold individual items, access to internet with onsite computers and printers, streaming TV and music, a library of DVD's, a library of books about mental health and advocacy, laundry and showering facilities, and access to crafting supplies, games, and our gym. Guests are also welcomed to participate in our weekly 'Shopping Trip', which is a time to do all sorts of errands from shopping and pharmacy to banking and post office visits, even short visits to receive medication at MFS.

Guests have access to prepare and eat food items donated weekly by the Keene Community Kitchen, Peterborough Food Pantry, and Freihofer's Bakery, and can get water from water bubblers. As needed, they can find clothing and toiletries in Marla's Cabinet, which is an area that MPS maintains for donations that are received by the community. Around the holidays, MPS partners with a local the Keene Family YMCA, Partners In Health and a pawn shop to collect high-frequency items like socks, coats, sweats, hand warmers, and other items as requested via a Giving Tree campaign.

MPS offers all support groups and activities in its informal non-clinical setting. Our current discussion groups are Beyond Bipolar and Depression, Anxiety/Depression, Trauma, Isolation, LGBTQIA+, Hearing Voices, Eating Disorder Recovery/ Body Image, Self-Harm Care, Survivors of Suicide Attempts, Feelings of Anger, Navigating Relationships, Co-Parenting, Addiction Support/Recovery, Domestic Violence Survivors, and Survivors of Sexual Assault. There is also a daily check-in and check-out and weekly men's and women's groups.

We administer many groups to facilitate well-being. We have two employees that hold Personal Training and Group Exercise certifications. This allows us to fully integrate exercise into each members wellness plan. Currently, we offer a chair yoga class, strength training classes, a walking group and access to our fully equipped gym that even has a heavy bag and a speed bag. Monthly bowling trips keep our members moving as well. We supplement physical wellness offerings with weekly prompts for stretching, meditation, and journaling and some months we hold groups like Happy Things Hour and Meditation Manifestation. In quarter one, our Ted Talks group was very popular because it featured expert speakers on topics like ableism, self-advocacy, resilience, and vulnerability. In January we offered an Exploring Faith class and we offer rides to two local churches for members who choose to practice faith in their wellness journeys.

Our skill-building groups are very popular. In the last few months, we have held cooking classes, Life Skills, Tech Time with Mike (computer skills), Cookies and Coloring, and Creative Expressions (various arts and crafts projects). Our weekly IPS Skills group teaches participants about how to relate to others and practice the principals of Intentional Peer Support in their everyday lives. We hold a weekly community lunch, which is facilitated, but largely peer-lead. We also offer a weekly peer-lead movie night and gaming groups. Our Life Goals group addresses employment, independence, housing, obtaining and maintaining benefits, and financial skills. We intend to schedule member-facing groups on Charting the Life's Course and Person-Centered Planning in partnership with our local Bureau of Developmental Services Area Agency, Monadnock Developmental Services.

Once a month, MPS offers trips to destinations chosen by members at our monthly community meetings. Trips in 2022 have included Yankee Candle, Crescendo Acres Farm to learn about the maple sugaring process and visit Alpacas, the Cheshire Fair, Hampton Beach, On The Road to Wellness in Manchester, Magic Wings Butterfly Conservatory and many more. These trips generate friendship, trust, connection, and mutuality. The photos of memories we make on these trips are captured in our monthly

newsletter and are evidence to the community that MPS is an incredible place. Many of the photos are taken by our Director of Community relations, who is a professional photographer.

One of our goals at MPS is to reduce stigma around mental illness in the Monadnock Region and to reduce internalized stigma in the individual as a way of increasing social connectedness and engagement in the community. We do this through a monthly Community Meeting which serves as a gathering place for members, participants, and guests to bring up their concerns to the MPS community at large. Notes are recorded and posted for members who are not able to attend the meeting. Members often speak about the things that they want to see change or mention things that are not going well in the community and discuss how to address these issues in a way that engenders accountability and personal responsibility. In these meetings, members enjoy planning parties around significant holidays such as Halloween, Thanksgiving, Christmas (Holiday Party), Super Bowl, St Patrick's Day, Easter, and Valentine's Day.

MPS's peer respite program, Monadnock Peer Respite, is housed in its beautiful Downtown Keene facility, which offers all accommodations needed to allow guests 18 years and older experiencing crisis or who have mental illness to take a break from the stress in their life in a non-clinical, peer supportive environment for 7 days and 6 nights. The program is designed to be a diversion from hospitalization that provides individuals with a chance to overcome mental health crises in a healthy way and learn how to manage similar mental health events in the future.

MPS's Step-Up Step-Down program (SUSD) is a 90-day alternative to inpatient mental health care that is free and open to any New Hampshire resident (18 years or older) who is a recipient, former recipient, or is at risk of becoming a recipient of mental health services who requires additional support while experiencing mental health episodes serious enough to lead them to the hospital in the absence of other options, and by providing a place for re-integration into everyday life for people coming out of clinical and institutional settings such as New Hampshire Hospital (inpatient psychiatric services), Cheshire County Jail, Dartmouth-Hitchcock Keene Behavioral Health Unit, Rehabilitation, and hospitalization following self-harm. bookend psychiatric care, incarceration, and other institutional stays.

MPS's Washington Wellness program was established in 2021, MPS entered a partnership with Monadnock Family Services (MFS), Region V's Community Mental Health Center on 'Washington Wellness', a project that adds six bedrooms in the MPS facility for individuals who experience serious and persistent mental illness. This program as been going strong for several months and it has been a delight to see the clinical environment and the peer support environment work in such harmony.

MPS and Cheshire County have submitted a grant application for a $750,000 Community Development Block Grant, which will be awarded in January of 2023. The Cheshire County Commissioners have agreed to be our sponsoring applicant and Southwest Regional Planning Commission has agreed to offer grant writing technical assistance and act as our grant administrator. Our partners at the Community Development Finance Authority feel that our project is strong and fundable, and that odds are extremely high that the grant will be awarded to us. This is important information as it shows our commitment to be better, to do better and provide a state of the art facility to our community for years to come.

This new phase of construction is called the 'MPS Community Center' project. It proposes facility renovation to replace windows and roof; install a new HVAC system, a limited use limited application elevator, two wheelchair ramps, five handicapped accessible doors, and stairwell enclosure; install rooftop access, solar, garden, and fence; install on the lower-level a commercial kitchen, shower, laundry room, conference room and community rec room; and address findings from an energy audit and an accessibility audit.

With such projects completed and pending, we feel that there is no other entity more capable of offering the robust services required of this community and no other entity that can more effectively help bridge the gap in services created by the absence of acute inpatient psychiatric beds and absence of counseling and therapy services in this region.

It is our hope that this narrative will provide you with a better understanding of our programming and will aid in the decision-making process to offer a designated smoking section to our members. Please see some of the comments from our members and staff:

"Smoking for me is therapeutic. I'm not doing drugs, I'm not drinking. I come here because I need the support. The only substances I am putting in my body is nicotine and caffeine. I'm doing so well, why would anyone complain about this?"

"I don't feel safe walking the streets of Keene. I can feel safe a the picnic table and be with my friends."

"Conversations and connections happen at the picnic table that don't happen anywhere else."

"Sometimes my emotions run really high in groups because I am working on me. My trauma is pretty intense. Going outside to sit and regroup is so important. I can't imagine not being able go outside and breath after."

"So what, we go across the street and hang out on the sidewalk and piss off the neighbors across the street? I thought you wanted us to be respectful of our neighbors?"

"I am handicapped. I think it is unrealistic for you to take away my safe place."

"I live on site in the SUSD program. This is my home for the next two months and now I can't go outside to sit and read my book"

"Those chairs is what got me to come to the center. I have forever felt shut out from our community and afraid of people judging me as I am part of the LGBTQIA+ community. When I saw the rainbow of chairs I just had to come! I thought, oh my god, finally and agency that really gets it. I felt like the agency was sending me a sign. It felt incredible and when I came to the LGBTQIA + group I realized so quickly how I was not alone in this town that has been so judgmental toward me. I sat in a room in Keene, NH with 6 other members from the LGBTQIA community. Today, I am no longer alone."

"I finally built up the courage to leave my house. I have been inside my home for 18 months. I sat at the table outside one day and was able to feel like a human. I promised myself I would come once a week and sit and talk to whoever sat next to me, and now I can't."

City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No.
Date Filled
Rec'd By
Page ____ of ____

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

☐ Drug Treatment Center	☐ Group Home, Small	☐ Homeless Shelter
☐ Fraternity/Sorority	☐ Group Resource Center	☐ Lodginghouse
☑ Group Home, Large	☐ Residential Drug/Alcohol Treatment Facility	☐ Residential Care Facility

SECTION 2: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: Monadnock Peer Support Agency	**NAME/COMPANY:** Monadnock Peer Support Agency
MAILING ADDRESS: 32-34 Washington Street, Keene, NH 03431	**MAILING ADDRESS:** 32-34 Washington Street, Keene, NH 03431
PHONE: 603-352-5093	**PHONE:** 603-352-5093
EMAIL: christine@monadnockpsa.org	**EMAIL:** christine@monadnockpsa.org
SIGNATURE: Christine Allen	**SIGNATURE:** Christine Allen
PRINTED NAME: Christine Allen	**PRINTED NAME:** Christine Allen

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☑ Same as owner
NAME/COMPANY:	**NAME/COMPANY:**
MAILING ADDRESS:	**MAILING ADDRESS:**
PHONE:	**PHONE:**
EMAIL:	**EMAIL:**
SIGNATURE:	**SIGNATURE:**
PRINTED NAME:	**PRINTED NAME:**

SECTION 3: PROPERTY INFORMATION

PROPERTY ADDRESS:	TAX MAP PARCEL NUMBER:
ZONING DISTRICT: Zoning Districts	☐ **LOCATION MAP:** *Please attach*

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

Monadnock Peer Support's (MPS) programs are free and open to any New Hampshire resident (aged 18+) who is a recipient, former recipient, or becoming a recipient of mental health services. MPS has spent 26 years forming deep connections where people feel valued, become empowered and move toward recovery. Our programs are grounded in the principles of personal responsibility, mutuality, reciprocity, and respect for others' thoughts and beliefs. We encourage growth beyond stigma, shame and limits placed upon us. Our culture fosters and maintains strong, activated voices; and a shared mission of social change.

MPS programs use Intentional Peer Support (IPS), a recognized best practice founded by Shery Mead (Mead, S. (6/2011) in the 1990s. Intentional Peer Support provides a powerful framework for creating relationships where both people learn and grow. Peers come together around shared experiences and, often, a desire to change their lives. However, without a new framework to build upon, people frequently offer distorted versions of "help" based on their lived experience. IPS aims to confront and challenge these responses. MPS programs also use Wellness Recovery Action Plan (WRAP), an evidence-based practice started by Mary Ellen Copeland, Ph.D., recognized by the Substance Abuse and Mental Health Service Administration (SAMHSA).

Our programs are grounded in the principles of personal responsibility, mutuality, reciprocity, and respect for others' thoughts and beliefs. We have an open-door policy allowing members and residents the opportunity to provide input anytime. We rely on our community partners to inform us and arm our staff with the knowledge needed to generate timely and appropriate program ideas. We recognize our responsibility to bring them the information and skills they need. We provide over 45 support groups dealing with a variety of topics: From lived experience, to educational groups and other activities like trips, events and holiday parties.

MPS owns an appropriately registered/inspected, fully insured 12 passenger van with which we provide transportation for members and participants. We also utilize the van to pick up weekly donations from the Keene Community Kitchen. Guests are welcomed to participate in our weekly 'Shopping Trip', which is a time to run errands for personal care items, pharmacy trips, banking and post office visits; Even short visits to receive medication at MFS. We are also pleased to provide transportation to our weekly bowling activity and monthly outings.

Our peer respite program, Monadnock Peer Respite, is housed in our Downtown Keene facility. We accommodate the needs of our guests, populated by individuals experiencing crisis or who have mental illness. Peer Respite affords our guests a break from stressors in a non-clinical, supportive environment for 7 days and 6 nights. The program is designed to be a diversion from hospitalization that provides individuals with space to overcome mental health crises in a healthy way. Our goal is to assist guests in learning how to manage similar mental health events in the future.

MPS' s Step-Up Step-Down program (SUSD) is a 90-day alternative to inpatient mental health care. SUSD is free and open to any New Hampshire resident (aged 18+) who is a recipient, former recipient, or at risk of becoming a recipient of mental health services. These individuals require additional support while experiencing mental health episodes which put them at risk of hospitalization. SUSD provides a place for reintegration into everyday life for people coming out of clinical and institutional settings such as New Hampshire Hospital (inpatient psychiatric services), Cheshire County Jail, Dartmouth-Hitchcock Keene Behavioral Health Unit, Rehabilitation, and hospitalization following self-harm. It is designed to bookend psychiatric care, incarceration, and other institutional stays.

Our Washington Wellness program was established in 2021 after MPS entered a partnership with Monadnock Family Services (MFS), Region V's Community Mental Health Center. This project adds six bedrooms inside the MPS facility for individuals who experience serious and persistent mental illness.

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

The building is 12,640 square feet and sits on 0.28 acres. We have 12 beautiful rooms for residents and staff. Each room is furnished with a twin sized bed, spare linens, a personal refridgerator, and storage for clothing and personal belongings. Each resident is assigned their own room with an individual key code and is expected to participate in household chores and programming during their stay. There is a private living room space for the two seperate living areas. We also have shared common areas such as an industrial kitchen, a dining area, a fully equipped gym, a group facilitation room, anda gaming room. Additionally, we have a parking area that is 2,400 square feet, currently being used for only parking. Our public hours of operation are Monday through Friday 9 AM to 7 PM. We are staffed 24/7 to provide support and supervision to all residents and members. Our site sees roughly 40 people on site per day and that number is only growing.

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

We have three different categories of residents on site. 1. Respite guests have an average length of stay of of 7 days and 6 nights. Guests of this program do not stay past 6 nights. 2. Step Up/Step Down (SUSD) guests have an average stay of 80 days. Most residents will stay the maximum stay of 90 days, while few will leave earlier. 3. Washington Wellness guests have an average stay of 1 year, with a maximum stay of up to 18 months.

SUBMITAL CHECKLIST

A complete application must include the following items and submitted by one of the options below:

- **Email:** communitydevelopment@keenenh.gov, with *"CLSS License Application"* in the subject line
- **Mail / Hand Deliver:** Community Development (4th Floor), Keene City Hall, 3 Washington St, Keene, NH 03431

The submittal requirements for a Congregate Living & Social Services License application are outlined further in **Chapter 46, Article X** of the City of Keene Code of Ordinances.

Note: Additional information may be requested to complete the review of the application.

☑ **PROPERTY OWNER:** *Name, phone number and address*	☑ **POINT OF 24 HOUR CONTACT:** *Name, phone number, and address of person acting as the operator, if not owner* ☑ **Same as owner**
☑ **REQUIRED DOCUMENTATION:** *Provide all required state or federal licenses, permits and certifications*	☑ **WRITTEN NARRATIVE:** *Provide necessary information to the submittal requirements*
☑ **PROPERTY INFORMATION:** *Description of the property location including street address and tax map parcel number*	☑ **APPLICABLE FEES:** $165.00 application $ 62.00 legal ad (*checks made payable to City of Keene)*
☐ **COMPLETED INSPECTION:** **or** *Inspection date:* _____	☑ **SCHEDULED INSPECTION:** *Inspection date:* 10/10/22

☑ **OPERATIONS AND MANAGEMENT PLAN:**

Plan based on the industry standard "*Best Management Practices*" to include:

◊ Security Plan
◊ Life Safety Plan
◊ Staff Training and Procedures Plan
◊ Health and Safety Plan
◊ Emergency Response Plan
◊ Neighborhood Relations Plan
◊ Building and Site Maintenance Procedures

In addition, Homeless Shelters will need to provide:

◊ Rules of Conduct, Registration System and Screening Procedures
◊ Access Policies and Procedures

Page intentionally left blank

City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. LB 22-07
Date Filled 9/30/22
Rec'd By CM
Page 1 of 141

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

☐ Drug Treatment Center	☑ Group Home, Small	☐ Homeless Shelter
☐ Fraternity/Sorority	☐ Group Resource Center	☐ Lodginghouse
☐ Group Home, Large	☐ Residential Drug/Alcohol Treatment Facility	☐ Residential Care Facility

SECTION 2: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: William K. Schofield	NAME/COMPANY: The Home for Little Wanderers, Inc.
MAILING ADDRESS: 27 Dublin Rd, Jaffrey, NH 03452	MAILING ADDRESS: 10 Guest St, Boston, MA 02135
PHONE: 603-532-4616	PHONE: 603-352-1928
EMAIL: wschof8@gmail.com	EMAIL: lsuggs@thehome.org
SIGNATURE:	SIGNATURE:
PRINTED NAME: William K. Schofield	PRINTED NAME: Leslie Suggs, President and CEO

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY: BCM Environmental & Land Law, PLLC	NAME/COMPANY: The Home for Little Wanderers, Inc.
MAILING ADDRESS: 41 School St, Keene, NH 03431	MAILING ADDRESS: 10 Guest St, Boston, MA 02135
PHONE: 603-352-1928	PHONE: 857-208-094
EMAIL: hanna@nhlandlaw.com	EMAIL: mmccall@thehome.org
SIGNATURE: Thomas R. Hanna	SIGNATURE:
PRINTED NAME: Thomas R. Hanna	PRINTED NAME: Matthew McCall, Vice President of Community Programs

City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No. _____
Date Filed _____
Rec'd By _____
Page _____ of _____

SECTION 1: LICENSE TYPE

☐ Drug Treatment Center	☑ Group Home, Small	☐ Homeless Shelter
☐ Fraternity/Sorority	☐ Group Recovery Center	☐ Lodging House
☐ Group Home, Large	☐ Residential Drug/Alcohol Treatment Facility	☐ Residential Care Facility

SECTION 2: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this application is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, I have notification from the owner to pursue this request.

OWNER	APPLICANT
NAME/COMPANY: William K. Schofield	NAME/COMPANY: The Home for Little Wanderers, Inc.
MAILING ADDRESS: 27 Dublin Rd. Jaffrey, NH 03452	MAILING ADDRESS: 10 Guest St. Boston, MA 02135
PHONE: 603-532-4616	PHONE: 603-352-1928
EMAIL: wschof8@gmail.com	EMAIL: lsuggs@thehome.org
SIGNATURE: [signature]	SIGNATURE:
PRINTED NAME: William K. Schofield	PRINTED NAME: Leslie Suggs, President and CEO

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY: BCM Environmental & Land Law, PLLC	NAME/COMPANY: The Home for Little Wanderers, Inc.
MAILING ADDRESS: 41 School St. Keene, NH 03431	MAILING ADDRESS: 10 Guest St. Boston, MA 02135
PHONE: 603-352-1928	PHONE: 857-205-094[illegible]
EMAIL: hanna@nhlandlaw.com	EMAIL: mmccall@thehome.org
SIGNATURE: [signature]	SIGNATURE:
PRINTED NAME: Thomas R. Hanna	PRINTED NAME: Matthew McCall, Vice President of Community Programs

Page 1 of 2

City of Keene, NH

Congregate Living & Social Services License Application

For Office Use Only:
Case No.
Date Filed
Rec'd By
Page ____ of ____

If you have questions on how to complete this form, please call: (603) 352-5440 or email: communitydevelopment@keenenh.gov

SECTION 1: LICENSE TYPE

☐ Drug Treatment Center	☑ Group Home, Small	☐ Homeless Shelter
☐ Fraternity/Sorority	☐ Group Resource Center	☐ Lodginghouse
☐ Group Home, Large	☐ Residential Drug/Alcohol Treatment Facility	☐ Residential Care Facility

SECTION 2: CONTACT INFORMATION

I hereby certify that I am the owner, applicant, or the authorized agent of the owner of the property upon which this approval is sought and that all information provided by me is true under penalty of law. If applicant or authorized agent, a signed notification from the property owner is required.

OWNER	APPLICANT
NAME/COMPANY: William K. Schofield	NAME/COMPANY: The Home for Little Wanderers, Inc.
MAILING ADDRESS: 27 Dublin Rd, Jaffrey, NH 03452	MAILING ADDRESS: 10 Guest St, Boston, MA 02135
PHONE: 603-532-4616	PHONE: 603-352-1928
EMAIL: wschof8@gmail.com	EMAIL: lsuggs@thehome.org
SIGNATURE:	SIGNATURE:
PRINTED NAME: William K. Schofield	PRINTED NAME: Leslie Suggs, President and CEO

AUTHORIZED AGENT (if different than Owner/Applicant)	OPERATOR / MANAGER (Point of 24-hour contact, if different than Owner/Applicant) ☐ Same as owner
NAME/COMPANY: BCM Environmental & Land Law, PLLC	NAME/COMPANY: The Home for Little Wanderers, Inc.
MAILING ADDRESS: 41 School St, Keene, NH 03431	MAILING ADDRESS: 10 Guest St, Boston, MA 02135
PHONE: 603-352-1928	PHONE: 857-208-094
EMAIL: hanna@nhlandlaw.com	EMAIL: mmccall@thehome.org
SIGNATURE: Thomas R. Hanna	SIGNATURE:
PRINTED NAME: Thomas R. Hanna	PRINTED NAME: Matthew McCall, Vice President of Community Programs

SECTION 3: PROPERTY INFORMATION

PROPERTY ADDRESS:	TAX MAP PARCEL NUMBER:
39 Summer Street	568-037-000
ZONING DISTRICT: Downtown Transition	☑ **LOCATION MAP:** *Please attach*

SECTION 4: APPLICATION AND LICENSE RENEWAL REQUIREMENTS

Using additional sheets if needed, briefly describe your responses to each criteria:

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on or off site.

See attached

2. Description of the size and intensity of the facility, including information about; the number of occupants, including residents, clients staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operations, size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

See attached

3. For Congregate Living Uses, describe the average length of stay for residents/occupants of the facility.

See attached

SUBMITAL CHECKLIST

A complete application must include the following items and submitted by one of the options below:

- **Email:** communitydevelopment@keenenh.gov, with *"CLSS License Application"* in the subject line
- **Mail / Hand Deliver:** Community Development (4th Floor), Keene City Hall, 3 Washington St, Keene, NH 03431

The submittal requirements for a Congregate Living & Social Services License application are outlined further in **Chapter 46, Article X** of the City of Keene Code of Ordinances.

Note: Additional information may be requested to complete the review of the application.

☑ **PROPERTY OWNER:** *Name, phone number and address*	☑ **POINT OF 24 HOUR CONTACT:** *Name, phone number, and address of person acting as the operator, if not owner* ☐ **Same as owner**
☑ **REQUIRED DOCUMENTATION:** *Provide all required state or federal licenses, permits and certifications*	☑ **WRITTEN NARRATIVE:** *Provide necessary information to the submittal requirements*
☑ **PROPERTY INFORMATION:** *Description of the property location including street address and tax map parcel number*	☑ **APPLICABLE FEES:** $165.00 application $ 62.00 legal ad (*checks made payable to City of Keene*)
☐ **COMPLETED INSPECTION:** **or** *Inspection date:* _____	☐ **SCHEDULED INSPECTION:** *Inspection date:* _____

☑ **OPERATIONS AND MANAGEMENT PLAN:**

Plan based on the industry standard *"Best Management Practices"* to include:

- ◊ Security Plan
- ◊ Life Safety Plan
- ◊ Staff Training and Procedures Plan
- ◊ Health and Safety Plan
- ◊ Emergency Response Plan
- ◊ Neighborhood Relations Plan
- ◊ Building and Site Maintenance Procedures

In addition, Homeless Shelters will need to provide:

- ◊ Rules of Conduct, Registration System and Screening Procedures
- ◊ Access Policies and Procedures

Location Map - 39 Summer Street

Keene, NH

September 26, 2022

1 inch = 68 Feet

0 68 136 204

CAI Technologies

www.cai-tech.com

CONGREGATE LIVING & SOCIAL SERVICES LICENSE APPLICATION
THE HOME FOR LITTLE WANDERERS, INC.
39 Summer Street, Keene, NH
TMP# 568-037-000

September 30, 2020

Section 4: Application and License Renewal Requirements Narrative

1. Description of the client population to be served, including a description of the services provided to the clients or residents of the facility and of any support or personal care services provided on- or off-site.

The Home for Little Wanderers ("The Home") proposes a residential group home in the existing building for up to 8 youth, ages 14-18, who identify as members of the LGBTQ+ community. This group home, to be called "Unity House," will offer youth a safe and supportive living environment while they prepare for family reunification, independent living, secondary education paths, and future self-sufficiency. Unity House will operate as a partner program to The Home's Waltham House in Massachusetts, which was the third group home in the country specifically supporting LGBTQ+ youth. Unity House will build on the Waltham House's very successful model for delivering high quality residential care for LGBTQ+ youth for the past nearly 20 years. The Home has a contract from the New Hampshire Department of Youth and Family Services to provide this service.

Unity House will be the first residential group home in New Hampshire designed specifically for LGBTQ+ youth. For many years our Massachusetts based program has served clients from New Hampshire. The opening of this program will allow us to support New Hampshire kids in New Hampshire, keeping them closer to their community, their family, and the future surrounding of their adult lives. Our founding principles are that every child deserves to live in an environment in which they feel safe, respected, supported and cared for by those around them.

Our group home will provide a safe and supportive living environment with 24-hour staffing for up to 8 gay, lesbian, bisexual, and/or transgender youth ages 14–18. Many youth at Unity House will have experienced difficulty — at home or in placement — due to their gender expression or sexual identities. Their stay at Unity House prepares them for what is next in their plan, which may be reunification with their families, transitioning to a foster family or preparing for independent living.

In the large, Victorian-style home located in Keene, our LGBTQ+ residential program will offer an array of behavioral and mental health services to support youth and help them build the self-sufficiency they will need for their future. The Home helps to ensure healthy development of all children at risk, without regard to race, religion, gender identity/expression or sexual orientation.

PRIMARY GOALS OF UNITY HOUSE

- Provide LGBTQ+ adolescents a safe, conscientious and supportive environment in which to live and grow
- Offer families the support they need in order to become reunified with an LGBTQ+ youth
- Prepare LGBTQ+ youth for independent living by helping them to develop essential life skills
- Facilitate opportunities for LGBTQ+ youth to develop strong connections to LGBTQ+ and non-LGBTQ+ communities
- Connect LGBTQ+ youth to gender-affirming medical care providers in the community
- Help LGBTQ+ youth reach their full potential

OUR SERVICES

- Multidisciplinary team approach to treatment plan development and implementation
- Individualized and creative stabilization services and interventions
- Individual, group and family therapy and case management by mental health professionals, including licensed and Master's level clinicians
- Family outreach and permanency support services
- Life skills development and vocational training
- Opportunities to attend community-based activities, such as sports and after-school programs, including peer education programs and Gay/Straight Alliances, social/support groups and community service projects
- Integrative Treatment for Complex Trauma (ITCT)
- Cognitive Behavioral Therapy (CBT) and Motivational Interviewing
- Restorative Justice Practice

Prior to admission, each youth and family will be assigned a masters-level clinician. Clinicians provide intensive treatment and case management that is permanency-centered, strength-based and needs-driven. An initial treatment plan will be created upon admission with input from the youth, family/guardian, and referral source. The full treatment plan will be completed within 30 days of placement and updated subsequently every three months. Treatment plans are developed in collaboration with milieu staff, nurse, program psychiatrist, occupational therapist, individual clinician, youth, family, natural supports and outside collaterals. Each treatment plan is individually tailored to meet specific youth needs including social, emotional, behavioral, educational, and recreational goals.

All youth will be offered weekly individual therapy or more often if clinically indicated. Individual sessions will be designed to support the youth in meeting their identified goals, with an overall goal for them to function in a less-restrictive setting. Weekly Family therapy will be offered, either at the program or in the community, preferably in the youth's home when possible. Family therapy will focus on family communication and functioning so that if the goal of reunification can be met it can be sustained post-residential treatment. When reunification is not the current goal, therapy can be used to strengthen the bonds and communication of those in the youth's life so that these critical relationships can remain in place.

For both scenarios, treatment will focus on developing life-long connections and addressing permanency. Group therapy will be offered multiple times per week in a variety of settings and formats, and is led by a mixture of clinical, OT, and milieu staff who work together to provide consistency across all domains. Groups may be process-oriented or activity-based groups, and both types of groups are designed to provide therapeutic benefits. Examples of groups offered include: Behavioral Therapy; Anger Management; Gardening; Cooking; Substance Abuse Education; Sex Education; Vocation Skills. Social skills will be taught in formal social skills groups at the program, as well as during trips into the community with a few or more peers. It is key for youth to be able to practice skills in real life settings to reinforce the skills that they have been working on and to help build self-confidence regarding gains that they have made.

The Group home treatment model will promote positive youth development on a daily basis, with particular emphasis on opportunities to learn and practice healthy behaviors, empower youth to assume leadership roles, promote skills to support physical and emotional safety and connect with caring adults. Staff will model positive social interactions and healthy behaviors, and support youth in building educational and employment competence in both informal and formal ways (e.g., groups, job coaching, tutoring, and collaboration with schools). The program will provide youth with access to recreational and community activities that support their respective treatment goals. Care will be provided by ethnically and racially diverse staff, including those who have lived experience and reside in the communities that the program serves. They will be extensively trained in and provide treatment that includes on-site individual and family therapy, in-home therapy, educational support and advocacy; social skills and targeted therapeutic groups (based on the current population); peer and staff mentoring; therapeutic milieu services; psychopharmacology; nursing services; crisis management in the home or community; vocational assistance and coaching; community activities; assessments; treatment and discharge planning; and behavioral support.

Permanency will be at the core of all the work which stems from a belief that "with family" is always the preferred setting if they are to proceed on a healthy developmental trajectory. This work includes proactively working with families to create or strengthen sustainable, lifelong supports for themselves as well as participating in advocacy efforts to keep young people at home and reinvest in communities so that families can focus on healing and growing together. Therefore, our treatment programs engage in intensive permanency focused work. While the clinical framework recognizes that out of home treatment is sometimes necessary to build important skills and to maintain safety in the context of trauma, the core belief is that out of

home treatment can cause harm if strong connection to family is not maintained. Even more problematic is when youth lose all hope of being able to return to family because relational ruptures have been so significant and the pathway to family feels uncertain. Permanency work in this way becomes a critical component of treatment. Unity House in Keene will implement the three best practices of permanency into our work: 1. Family Search and Engagement 2. Youth Guided 3. Family Driven Teaming.

Staff will practice an approach to treatment that de-emphasizes the use of external control, where youth are given opportunities to make appropriate choices for themselves, rather than staff or other adults making their choices. Youth who live in environments where professional staff have assumed much of the ownership for their safety often need support to take greater responsibility for their own health and well-being. Youth need to build skills required to better manage emotions and may need support in making safe choices. In addition, youth benefit from real opportunities to practice skills and decision-making in the community and with family when appropriate.

The program will benefit from our Performance Quality Improvement (PQI) team, which is a standing advisory and multidisciplinary committee that is responsible for ongoing review of quality and safety related matters concerning programs and initiatives and for making recommendations for improvement. The PQI committee has broad representation from program and department staff. The Home's Clinical Quality & Outcomes department, including Evaluation & Research and Workplace Learning & Development ("WLD") staff, work directly with program staff to support any training or outcomes measurement needs related to program-level Quality Management projects and quality improvement cycles. Program leadership meets monthly with Vice Presidents and Program Operations bringing emerging best practices and challenges to the attention of senior leadership as well as problem solving around how to address challenges in programs and bringing client and program needs to the attention of agency departments; and reviewing PQI-related findings.

The Home measures core outcomes across our programs that are tied to the agency's mission and theory of change. Core Outcome Domain measured are:

- change in mental health functioning
- progress towards permanency
- incident trends
- discharge disposition
- youth, parent/caregiver, and caseworker feedback
- post discharge outcomes.

Specifically, The Home uses the Child and Adolescent Functional Assessment Scale (CAFAS) to assess youth's functioning at intake to inform treatment planning and to reassess youth's functioning during service to evaluate progress on treatment goals. The CAFAS measures functioning in eight domains:

- School
- Home
- Community
- Behavior Towards Others
- Moods & Emotions
- Self-Harm
- Thinking
- Substance Use.

Demographic, clinical information, and treatment/intervention session dates are recorded in our electronic health record (Evolv NX). Program level data collection is currently conducted for other areas such as school and work attendance and hospitalization. Dates of pre-admission meetings are also tracked at the program level. Any additional data collection needs related to Intensive Community Services quality measures will be incorporated into the Evolv NX system.

Post-discharge outcomes are assessed through an agency-wide follow-up initiative. Evaluation and research staff members call parents/caregivers/caseworkers of discharged children (birth through 17) and transition-age youth directly to complete a structured phone interview up to a year after exit. The interview includes inquiries about functioning at school, home, and in the community, which provides needed information about the extent to which clients were able to maintain successes post-discharge. This information helps program staff determine whether to continue, enhance, or replace treatment interventions and components, and inform the development of new services. Our Evaluation and Research staff have sought ways to incorporate equitable evaluation principles into our work, including looking at client outcomes by racial, ethnic, and gender identity to assess the extent to which our practice is having equitable impact across our entire client/family population.

For 17 years, we have administered agency-wide satisfaction surveys to youth, parents/caregivers, and caseworks, that assess the stakeholders' perception about whether services have been delivered in a strength-based, permanency-focused, youth and family-driven, and culturally responsive manner. The survey also assesses youth's perception of the impact on services on their functioning in a variety of domains, including at school, with peers, and in the preparation for the transition to adulthood. Information gathered from surveys is used to inform quality improvement projects as indicated by responses, and to celebrate and share successes. The survey is translated into nine languages to ensure that we are receiving feedback from as diverse of a group of stakeholders as possible and implemented a variety of efforts to promote a strong commitment of program staff to administer surveys, including both individual level incentives (e.g., coffee gift cards) and program level incentives (e.g., trophies and pizza parties).

Ongoing evaluation is an essential part of our permanency practice. A youth's permanency status is assessed on a 1 to 5 scale at intake and throughout treatment. Program staff also report which

components of the permanency practice model they have used and how often they have used them. A recent analysis found that there was statistically significant difference between initial permanency status and permanency status at reassessment for youth in out of home care; this indicates that youth were closer to permanency upon reassessment. For youth still receiving services, there were several interventions associated with progress, including individual conversations with potential permanency connections, joint conversations, and youth-guided, family-driven teaming. This information has allowed us to support and train staff on the permanency practices that result in the greatest improvement for youth.

2. Description of the size and intensity of the facility, including information about: the number of occupants, including residents, clients, staff, visitors, etc.; maximum number of beds or persons that may be served by the facility; hours of operation; size and scale of buildings or structures on the site; and size of outdoor areas associated with the use.

Unity House will house 8 residents in its group home. There will be a total of 14.53 FTE's of staff at the program, accounting for program administrators, licensed mental health clinicians, nursing, maintenance, and direct care staff. On a typical day there will be between 3-5 staff on site during the day, 2 to 3 staff on site in the evenings, and 2 staff on site on the overnights. Typically, we see between 2-4 visitors a week at our group home programs. The program will operate 24 hours a day, 365 days a year.

The building sits on a 0.4-acre parcel and has a single 6,694 square foot building. There is a large wrap around porch on the front of the building and a small back yard with a seating area. There is also a large parking area in the back and another small parking area on the side of the building.

3. For congregate living uses, the average length of stay for residents/occupants of the facility.

Our average length of stay for group home residents at our Waltham House program is 12-18 months.

Operations and Management Plan Narrative

An operations and management plan, which shall be based on industry standard "best management practices" and, at a minimum, shall address the following.

a) **A security plan that includes provisions for onsite security including lighting, security cameras, and/or other measures appropriate to provide for adequate health and safety of clients and management.**

The building will have 24/7 awake staffing to provide the majority of security for the building. In addition, The Home will be installing additional exterior lighting around the house at all entrances, exits, and areas where people can congregate, such as the picnic area and parking lot in the back of the house. Video cameras will be placed at all entrances and exits to help monitor people coming and going from the building.

b) **A life safety plan that demonstrates compliance with the state minimum building code and fire codes.**

See attachment 8.b.1 – Facilities Services Maintenance and Operations Procedures Manual

c) **Staff training and procedures plan.**

WL&D provides a comprehensive new employee orientation and training designed to ensure that new employees not only receive an introduction to our history, mission, programs and services, but also feel welcomed and valued beginning their first day. Orientation includes the agency's philosophy, goals and organization; overview of the advantages of being part of The Home; benefits and technology; onboarding overview, and completion of new employee forms. Staff ID's will also be issued. We also request professional license and any other certifications to add to their personnel file. New employees will receive immediate training in a number of areas, outlined in Attachment 8.c.1, Course and Training overview and are facilitated by seasoned employees with extensive experience in their perspective topic areas. Class sizes are limited, and a mix of live and online training is used to create a richer and more engaging experience for staff. Staff have up to 3 months to complete required trainings.

The foundational course for all our residential and group home programs is Therapeutic Crisis Intervention (TCI). The Cornell University, Family Life Development Center curriculum is incorporated in a 5-day, 30-hour TCI training for new employees, that provides staff with the skills and knowledge to become the catalyst through which the child changes old habits, destructive behaviors and maladaptive behavior patterns and provides an understanding on the effects of trauma and how to intervene with children who have experienced trauma. The goal is to train staff to help children develop new responses to their environment that will enable them to achieve a higher level of social and emotional functioning. It also teaches therapeutic restraints, holds and releases. The TCI system provides a crisis prevention and intervention model for residential child care

organizations that will assist in preventing crises from occurring, de-escalating potential crises, effectively managing acute crises, reducing potential and actual injury to children and staff, learning constructive ways to handle stressful situations and developing a learning circle within the organization. The training is offered 1-2 times a month. All trainers are certified by Cornell University and trainings are co-facilitated with a program trainer and The Home's Agency Trainer, who is professionally certified by Cornell. Refresher trainings are held routinely and staff must complete annually 12 hours of refresher training and pass written and physical exams.

Training opportunities are available to all staff who are encouraged to not only learn about aspects pertinent to their current role, but to look at opportunities for their future growth and development. The Home hosts regular trainings in a variety of topics related to the clinical and milieu models of care led by local, national, and international experts in the child welfare, behavioral, and mental health fields.

Furthermore, we are committed to providing regular, high-quality supervision. Employees receive a weekly one-hour individual supervision with a trained supervisor who has a minimum of two years of prior experience in the field. We recently incorporated elements of reflective supervision into the training we offer to all program level supervisory staff, after a cohort of supervisors and members of WL&D participated in the Reflective Supervision training series offered through the CBH Knowledge Center. All supervisors engage in a bi-annual competency-based performance review process that begins with the employee completing their own self-evaluation. This supports open and structured dialogue around strengths and areas for growth are occurring in addition to other job performance content that might also be discussed during individual meetings. Within the reflective supervision framework, our supervision model brings forward some of the skills reviewed in our EQ2 training. EQ2 embraces the parallel process concepts that are so much a part of reflective supervision by recognizing that we must support an employee's ability to self-regulate if they are going to be effective in using co-regulation with youth during moments of crisis. Similarly, given the critical focus our organization places on permanency, tasks that are needed to support ongoing permanency needs for each case are regularly reviewed in supervision.

Our programs conduct monthly all-staff meetings and regular, discipline specific team meetings to discuss particular areas of focus. Each program also reviews every client via a multi-disciplinary treatment team model on a monthly basis and helps support and guide the work of all team members who work directly with that youth and family.

The Home engages in a number of practices to ensure that staff are competent and maintain fidelity to the treatment model. Through extensive recruitment practices the Home hires highly qualified and diverse employees, representative of a variety of racial and ethnical backgrounds, gender identities, sexual orientations, and other identities and cultural experiences. Job descriptions have been developed for all positions, and criminal background, driving record, and educational and relevant licensing credentials are verified at the time of hire.

Group Home staff receive extensive internal and external training through WLD, including new employee orientation and training, a professional development opportunity calendar, program-specific training and consultation, and on-the-job training. Upon hire, employees participate in a comprehensive training program (up to 80 hours) that includes: healthy growth and development; mental health; behavior support; health and wellness; engaging families; boundaries; mandated reporting of suspected abuse and neglect; cultural responsiveness; the effects of out-of-home placements; domestic violence; working with Gay, Lesbian, Bisexual, Transgender and Questioning youth; safety; youth-guided and family driven care; strengths based treatment and care; care integration; risk management; medication/side effects; trauma informed care, cognitive behavioral therapy and trauma focused cognitive behavioral therapy; Therapeutic Crisis Intervention (restraint prevention); positive youth growth and development; and CPR and First Aid.

Staff in specialty programs receive additional training upon hire. Staff who work in our LGBTQ+ group home undergo trainings that have been developed to teach best practices for working with LGBTQ+ children and adolescents in a group home setting and follows the American Psychological Association's Guidelines for working with transgender and gender non-conforming individuals in treatment. Clinical staff utilize Transgender Affirmative Cognitive Behavioral Therapy (TA-CBT) to support youth with their unique needs and the challenges they face. TA-CBT is a version of CBT that has been adapted to affirm all gender identities and expressions and to ensure the delivery of CBT content within an affirming and trauma-informed framework. Clinical staff are also well-versed The World Professional Association for Transgender Health's (WPATH) standards of care. Professional development is offered to all staff via on and off-site trainings, conferences, educational opportunities (e.g., Boston University Certificate Program in Non-Profit Management, writing courses), and a rich array of offerings centered on clinical practice (e.g., TCI, CBT, TF-CBT, Motivational Interviewing, Trauma-Informed Care and Preparing Adolescent for Young Adulthood). Each program also develops an internal training and an annual staff development agenda, with regular trainings on core competencies and program specific skills and techniques. These trainings focus on tailored topics designed to meet the needs of specific programs. Program-specific trainings include Best Practices for Working with LGBTQ Children and Youth, Traumatic Stress Disorders in Children and Adolescents, Cultural Competence and Sensitivity in the LGBTQ Community, and Addressing Suicide in Adolescents and Transition Age Youth.

Fidelity to the Treatment Model: The Home has many checks and balances that promote fidelity to the treatment model. Weekly individual supervision is provided to support learning and professional growth and development. Youth-specific "mini-team" meetings are regularly scheduled to ensure that all staff levels have a shared understanding of treatment issues and agreed upon interventions. All cases are reviewed on a quarterly basis by a centralized UR team, comprised of senior clinicians from different programs and Program Operations. The team examines the appropriateness of treatment goals, if the clinician(s) are utilizing evidence-based practices and to what extent, record completeness, including consent forms, degree of collaboration with external resources,

and compliance with the Group Home treatment model. Additionally, the entire treatment team, (youth, family, program staff, DCYF workers, as well as outside providers and other natural supports) participate in quarterly treatment planning meetings.

Multi-Disciplinary Team (MDT) meetings are held weekly to review cases. For Group Homes, MDT comprises of senior clinician, clinician, the Program Director (and/or Assistant Program Director), milieu staff, nurse, psychiatrist or OT when appropriate. Staff throughout the agency and external resources can be added to provide a fresh perspective, consultation and expertise. For example, Occupational Therapist have been collaborating with all our group homes for the last 4 years on reducing a client's need for sleep medication through OT interventions. This collaboration led to a dramatic reduction in the need for sleep medication, reductions in night-terror, increased sleep per night and a general improvement in the quality of sleep.

d) Health and safety plan.

See attachment 8.d.1 - Health Services Manual

e) An emergency response plan that establishes procedures for addressing emergency situations and for coordinating with local emergency service providers.

See attachment 8.e.1 - Preparing for an Emergency

f) A neighborhood relations plan that includes provisions for communicating with adjacent property owners and the City of Keene, including the Keene Police Department.

Unity House will provide for multiple opportunities and methods of communication with the neighbors and abutters of the program. Firstly, all abutters and neighbors will have access to the program's phone number. This will allow 24 hour a day access to an employee of the program should an immediate concern arise. They will also have access to the on-call system to be able to contact a program administrator or executive leadership member if there are additional concerns. Email addresses for key personnel will also be provided. A post-card will be sent to all immediate neighbors and the Keene Police Department with this information for ease of access for the neighborhood.

Unity House will hold 4 neighborhood meetings a year at the property. These meetings will be an opportunity for Unity House to communicate any program announcements, concerns, or updates to the neighbors, and allow neighbors to speak directly with program and agency leadership.

g) Building and site maintenance procedures.

See attachment 8.b.1 - Facilities Services Maintenance and Operations Procedures Manual

HFLW Facility Services Maintenance and Operations Procedures Manual

The Home for Little Wanderers
John Davis, Director of Facilities and Planning

Facility Services Maintenance Operations Procedures Manual

Table of Contents

Mission Statement

The Facility Services Department is committed to providing quality service to students, faculty, staff, and visitors of the Home. Maintenance is responsible for maintaining each individual house, office and campus in a manner that contributes to the attractiveness and function of the educational environment. Maintaining the physical facilities is essential to enhancing the overall educational environment along with ensuring safe and secure campuses.

Facility Services employees are committed to support the goals and vision of the Home. Employees are dedicated to the concept of improving productivity and effectiveness through more efficient use of time and materials, implementation of new technology and equipment, and improving skills through training and seminars. It is recognized that the major strengths of Facility Services are the employees and available resources used in the performance of its work. The support and commitment of the administration and board of trustees to providing well-maintained developed properties strengthen this. By this commitment, we are able to provide support to the academic excellence and educational programs of the Home.

The Facility Services Department's management team is committed to treating employees with dignity and respect; fostering positive attitudes and acceptable behavior; recognizing satisfactory employee performance; administering policies fairly; and, communicating the plans and directions of the department to all employees.

General Information Facility Services Operations

Facility Services Operations is a service organization responsible for the planning, construction, renovation, repair, and maintenance of all buildings and facilities. The department also provides and administers utilities, and grounds care, custodial services and shipping and receiving. Our goal is to provide these services in a manner consistent with the mission.

Services provided by Facility Services include but are not limited to the following:

1. General maintenance and custodial work in all academic buildings, and recreational facilities including the services of carpenters, electricians, plumbers, and HVAC mechanics to ensure a safe and adequate educational environment for academic and administrative functions.
2. Maintenance of classrooms and public spaces including furnishings.
3. Maintenance of walks, grounds, and maintenance of athletic facilities.
4. Operation and maintenance of utilities

5. Custodial services.
6. Preventive maintenance for building systems.
7. Energy conservation through education and including installation of equipment to conserve energy.
8. Moving and set-up responsibilities for campus functions.
9. Management of building and renovation projects.
10. General Contractor consultation for small-scale projects.

Any questions concerning the operation and services provided should be directed to the department at 517-585-7506

Organization

Facility Services employs a force of professional, skilled, and semi-skilled, employees. Department employee duties can include: General Maintenance, Electrical, HVAC, Preventative Maintenance, Plumbing, Locksmith, Painter, Carpenter, Custodians, Groundskeepers, Receiving, and Administrative Staff. Our employees can respond to urgent and specialized needs and provide continuity of basic maintenance and repair programs. Also, they can offer timely and efficient response on minor renovation projects.

Project Scope of Work

At times Facility Services is called upon to render services for many alteration and renovation projects by various departments. While Facility Services is a repair and maintenance organization, at times it is cost effective to take on renovation projects of a limited scope. The general rule is not to take on projects that would take any longer than 7 workdays to complete. Also, projects that require specialized equipment or are scientific or technological in scope are usually contracted out to local contractors based on the experience of the firm. Facility Services administers all contracts and provides planning and consultation services for these projects. The Administration and Facility Services determine the best means to complete each project.

Maintenance Requests

Maintenance Requests should be submitted using our Computerized Maintenance Management System (CMMS) Dude. The individuals that we have determined need access to this system are dictated by each programs individual needs.
If you are not one of these individuals submit your maintenance request to one of the above individuals.

New Service Request

A. Click on ***Campus/Facility***. Select a Campus/Facility.
B. ***Location/Room Number***. Type in the *Location or Room* where the work is required.

C. Requestor's Name. Type the Requestor's Name.
D. Click on *Select **Problem Type***. Select a Problem Type category.
E. Click on ***Select Priority***. Select a Priority category.
F. *Problem Description.* The requestor must fully describe the services desired and should identify any constraints such as time periods or special conditions on the service requested. All requests should be addressed to Facility Services Department.
G. Provide Schedule Information such as *Date work is needed by.* (Should correspond with priority). Facility Services reserves the right to change the date the work is needed if there is a scheduling conflict, does not cause a hardship, parts or materials are needed, or cause an event to be canceled.

Maintenance Requests are required, for all routine, major and minor repair work and set-ups for special events.

For emergency priority service work please utilize the Emergency Contact list for your individual site and call order.

Work orders should be submitted at least two weeks prior to the work request date. Event work orders should be submitted at least 10 working days before an event. Work orders are received by the Maintenance Supervisor and reviewed prior to assignment to the appropriate technician. Questionable work orders are reviewed prior to approval.

Work is assigned to the appropriate technician and orders are placed for materials if they are not in stock. The work will generally be performed or evaluated by the due date. The technicians and the Maintenance Manager are responsible for conveying information to the requestor regarding scheduling delays.

Priority of Work

Generally, requests for basic services take priority over other requests, exceptemergencies. When the time factor is critical, Maintenance may use outside contractors to complete all or part of the work. The Maintenance Supervisor prioritizes each request for services received. Priorities have been developed to ensure that Maintenance responds appropriately to a request. Therefore; the assistance of a department in detailing the nature or seriousness of the problem is important. Some conditions may override othersin case of emergency or disaster.

The priority system is as follows:

Emergency/Safety

1. Emergency conditions that affect the safety or health of persons or property, for example, broken glass, ruptured pipes, inoperable exterior locks, interior locks on sensitive space, blocked or malfunctioning toilets if no others are available.
2. Conditions that immediately affect the continued performance of academic or administrative services, the same-day non-resolution of which would

impact use or performance in the space, for example, blown circuit breakers, an outlet without power (where only one is available), inoperabledoors, or hot or cold offices or classrooms.

3. Conditions that if not immediately attended to could damage facilities or further damage the item in question, for example, ceiling drips, leaking toilets, unfastened windows.
4. Work that should be completed within eight (8) hours.
5. Conditions that must be attended to during the day (or night) they are reported.
6. Work that requires overtime or night shift, if not completed during normal work hours.

High

1. Conditions which represent a potential safety or health hazard - danger, damage, or breakage that is not an immediate hazard but could become one with more use or stress. For example, a loose handrail, loose doorknob, damaged stair tread, or cracked door glass.
2. Nuisance conditions that do not require extensive work, but which, if not remedied, failure of which to remedy would reflect poorly on the Home, for example, paint, offensive graffiti, follow-up of one trade's work by another trade.
3. Valid, dated requests by customers, which must be completed by a certain date.
4. Debris or garbage accumulations.
5. Work that should be completed within three (3) work days or less.
6. Work that can be worked into existing schedules.

Medium

1. Work that should be completed within five (5) to ten (10) workdays.
2. Work that may be scheduled in advance.
3. Work that represents most routine maintenance.
4. Resolution of "temporary fixes."
5. Work identified by building surveys, tours, or area coordinators, other than long-range or major improvements.

Low

1. Work that should be completed within one (1) month.
2. Work that can be scheduled in advance.
3. Work that represents improvements or additions to facilities such as building shelves or installing air-conditioning units work covered by most service requests.
4. Work that requires outside vendors, contractors, or procurement of materials (not off-shelf items).
5. Work that requires a coordinated and planned schedule between a requestor and a technician.

Scheduled

1. Work that can be programmed for the next season.

2. Work that can be scheduled for periods between school breaks.
3. Work that has been identified in advance but cannot be done at the time of identification because facilities are in use.
4. Jobs requiring several technicians and long-range planning.

Department Chargeback For Services

At times Facility Services receives requests for services rendered to departments and activities for which Facility Services does not receive a budget allocation. When this occurs, the requesting department must provide a budget source for funding. Facility Services charges (materials) to the Department include actual cost charges only. No profit or overhead charges are billed to departments.

Examples of Department Charged Services include:

1. Alterations to buildings or structures requested by and assigned to departments and activities.
2. Requests for materials.
3. Painting of offices and departmental spaces, or of public spaces to change colors, or painting not warranted by the condition (fading or flaking) of existing paint.
4. Alteration, repair, or refinishing of office not warranted by condition
5. Building of wooden cabinets and computer workstations.
6. Removal of unauthorized construction or materials (i.e. rooms in corridors) by a department that violates building codes.
7. Removal of wiring or equipment installed by a department that violates building codes or safety regulations.
8. Removal of plumbing or equipment installed by a department that violates building codes or safety regulations.
9. Special events that cannot be covered by assigned custodians or maintenance personnel during normal working hours (7:00 am - 4:00 pm) Monday-Friday for events.
10. Requests for manpower beyond normal working hours for events.

Technician Billing Rates

	Normal Hours	Overtime
Grounds Worker	$20.00/hr.	$30.00/hr.
Custodian	$20.00/hr.	$30.00/hr.
Maintenance Technician	$20.00/hr.	$30.00/hr.
The overtime rate applies to school activities andexternally sponsored events after normal hours.		

Limitations of Services

Labor, materials, and/or equipment cannot be used for private or personal benefit either on or off campus.

Materials and equipment cannot be loaned to departments, employees, students for on campus use without a written request and written approval from Facility Services Director.

Moving and Setups

Grounds, custodial and building personnel are responsible for limited moving of furniture and offices. Due to the scope of responsibilities of the staff, moving of furnishings outside the capabilities of each campus' custodial and building occupants is scheduled 10 days in advance.

Requestors are responsible for packing all belongings. Campus custodians and other Facility Services employees are not responsible for packing belongings. It is imperative that the requestor or a representative be present while the moving of belongings is taking place to ensure that materials are delivered to the correct place. A limited supply of boxes can be obtained; however, if additional boxes are needed, they can be purchased from a supplier at program cost.

Requestors are responsible for emptying all desks, horizontal or lateral filing cabinets (vertical file cabinets need not be emptied), and bookcases prior to the commencement of the moving operation.

Facility Services processes all set-up requests for special events outside the scope of the campus custodians. The party requesting the setup is responsible for all costs (rental of tables, chairs, and decorations). Set-up requests must be submitted to Facility Services at least five (5) working days prior to the event.

Storage

The Facility Services Department storage facility is **very limited**. Storage of materials and furnishings is the responsibility of each campus/department.

Funding

Facility Services Department allocates a certain amount of funding to make corrective repairs to facilities. In some cases the requesting department may be asked to provide funding if requests do not follow the criteria for normal repairs and maintenance. Please contact the Director of Facilities and Planning to verify funding.

Routine Failures

Defective or burned-out light bulbs or fluorescent tubes, broken window panes, broken classroom furniture, heating or air conditioning malfunctions, and leaking or non- working plumbing should be regarded as routine failures and reported promptly to Facility Services utilizing Dude.

Facilities Improvement Program (FIP)

Major capital projects and department requests for alterations and renovations are handled through the Facilities Improvement Program (FIP). FIP requests are reviewed and referred to the Board of Trustees for approval and funding. Requests for FIP and FMP work for the next fiscal year are distributed to the campuses the 1st week of January and due back to the Director of Facilities and Planning by the 1st week of February. Facility Services personnel are available to provide limitedestimating services for all departments for inclusion on FIP requests.

Facilities Master Plan

The Facilities Master Plan has planned improvements in three phases. Phase I include major renovations and repairs to existing campus facilities. Phase I will improve the conditions of facilities and classrooms and enhance the aesthetic qualities of each campus. Phase II will include additional renovations and repairs to grounds and existing structures and Phase III will be the beginning of new buildings and facilities.

Facilities Deferred Facility Services Program (FDMP)

Funding for repairs and maintenance to all facilities is provided through the annual Facilities Deferred Maintenance Plan (FDMP). The FDMP covers costs incurred for the repairs required from normal "wear" and "tear" on the facilities such as HVAC replacement, painting, lighting, and building code upgrades.

Preventive Maintenance

Preventive Maintenance is the scheduled attention to the physical needs of a system that results in the reduction of the possibility of breakdown and the lengthening of the life of a system. Maintenance schedules routine preventive maintenance checks on building, HVAC, electrical, plumbing, and mechanical systems. Floor drains and building areaways, and roofs are periodically cleaned and inspected.

Furnishings

Facility Services can purchase desks, chairs, shelving, bookcases, special equipment,and other office furnishings. Each individual department is responsible for purchasing room furnishings funding. Facility Services has been designated as the primary point of contact to assist you when purchasing furnishings. Please contact Facility Services prior to making any furnishing purchases. This is done to ensure quality and consistency throughout the district. Some used office and classroom furnishings are available in the Facility Services storage area. Facility Services budgets funds for the repair and maintenance of classroom and common area furnishings only.

Bulletin Boards and Sign Holders

Bulletin boards, whiteboards, tack boards, and hanging strips for offices are the responsibility of the requesting department. These items will be installed when requested. Please contact Facility Services prior to making any purchases.

Special Equipment and Instrumentation

Individual departments are responsible for procuring and maintaining special equipment such as computers, printers, and all diagnostic and other equipment used for teaching purposes. Departments are required to contact Facility Services prior to purchasing special equipment.

Facility Services will determine the space needs, availability and capability of correct electrical service or HVAC equipment. Any alterations, electrical power needs, or HVAC modifications that may be required may be the responsibility of the requesting department. Facility Services will make all arrangements to perform the work. Campuses/Departments will be charged for actual incurred costs or will be responsiblefor procuring adequate funding for requested work.

Building Maintenance personnel must be consulted and prior approval obtained from them for the source of power, equipment phasing, voltage, and amperage of special equipment.

When purchasing office or laboratory equipment, the following principles of electrical characteristics should be observed.

1. All must be 60 Hz and have the Underwriter's Lab (UL) seal of

acceptance.

2. No equipment or group of equipment rated at 120 volts requiring 10 amps (1250 watts) or more of power should be purchased without prior approval of Facility Services.
3. No equipment requiring, by the manufacturer, a special or dedicated circuit should be purchased without prior approval of Building Maintenance.
4. Prior approval must be obtained for any equipment rated 208, 240, or 480 volts single or three phase.
5. Use and purchase of EPA certified energy star equipment is strongly recommended by Building Maintenance.

Contractors

Facility Services Department maintains an active list of contractors that show an interest in performing work. This list is reviewed periodically and always when a project requiring services is anticipated, planned, or approved to proceed. Contractors must be pre-qualified and evaluated for each project before they are invited to bid or provide proposals for projects.

Grounds

The Home takes a great deal of pride in the appearance of its building and grounds. Facility Services employs a grounds crew/contractor that is responsible for care of shrubs, plantings, trees, and turf maintenance; road and walk cleaning and maintenance; and snow and ice control. Hundreds of students utilize the campuses daily. It takes conscious efforts on everyone's part to help keep the campus grounds and buildings as free of litter, graffiti, and abuse as possible. Please help keep your campus clean.

Refuse Removal

Trash/recycling contractors (private contractor) provides refuse removal and disposal on a scheduled basis throughout the year. Questions regarding pick-up should be directed to your Maintenance Operations.

As a basic operational service, Maintenance Operations provides pickup of normal refuse on sites. Special pickups and disposal of extraordinary amounts of trash or building items may be arranged by submitting a work request in Dude.

Refuse Disposal (Hazardous, Infectious and Special Waste)

The disposition of hazardous waste is coordinated by Maintenance Operations. Any hazardous waste will not be placed in receptacles provided for normal, day to day refuse.

A regulated hazardous waste includes:

- Flammable Liquids (flash point less than 140 deg. F)
- Corrosives (pH less than 2.0 or above 12.5)
- Reactive (Unstable compounds)
- EP Toxic (certain heavy metals and pesticides)
- Off Specification Chemical Products (acute or toxic hazardous waste)
- Hazardous Waste from Nonspecific Sources (primarily toxic solvents)

A special waste may include a non-hazardous solid waste from a nonresidential source. Examples of special waste include waste oil, waste paint, non-hazardous chemical products, incinerator ash and asbestos. Contact Maintenance Operations to arrange for proper disposal.

Shredding Confidential Documents

The Home maintains a paper shredder/service for use by departments for shredding confidential documents and tests. Due to the confidentiality requirements, the shredding of documents is the responsibility of the requesting department. Custodians and other Facility Services personnel are not responsible for shredding documents.

Asbestos Containing Materials

From the turn of the century until the 1970s, asbestos was widely used in various building materials. It is commonly present in insulation materials found on pipes, ducts, and boilers, in acoustical insulation, and in fireproofing materials. Vandalism and abuse, as well as routine maintenance, repairs, or replacements of items that contain asbestos, may release airborne asbestos fibers that are health risks. Those areas that pose a health risk or have been evaluated, when necessary, are cleaned up. In conjunction with this cleanup, a comprehensive survey of asbestos material locations is made, along with the condition of the installations. Removal is scheduled and undertaken when necessary. Meanwhile, the Director of Facilities and Planning carefully monitors known and suspected sites and works with Facility Services personnel for the removal or repair of materials as needed and required.

Custodial Services

Facility Services provides custodial services to each campus and administrative office on a routine basis. Classrooms, offices, hallways, and stairways are cleaned on a scheduled basis. Restrooms are cleaned and serviced daily. Windows, carpets, and floors are maintained periodically depending on academic schedule. The staff controls snow and ice on entranceways and walks leading into buildings.

Pets on Campus

Because of extensive use of campus buildings and sanitation issues, bringing pets into buildings is prohibited with the exception of Service Animals.

Signage

Production and installation of room and office signage is the responsibility of Maintenance. Requests for signage can be submitted using a Maintenance Service request. The standard format for all office signage includes the room number and name ofthe office. Due to limitations and our effort to standardize room signs throughout the School District, signs will meet certain size requirements.

Inspections

Maintenance routinely inspects facilities for wear and tear and makes corrections based on these inspections utilizing a Facilities Condition Report. However, we depend on the various users to notify Maintenance Operations of problems when they are identified.

Heating, Ventilation, and Air Conditioning

Living in an area where it can be 0 degrees in March and be 80 degrees in November, it is always a challenge to determine when the weather will change. However, due to our unpredictability of the weather, Maintenance monitors conditions and will adjust systems to suit the predicted conditions.

Thermostats are calibrated on a routine basis by our Maintenance staff. During the air conditioning season, thermostats are set at 72 degrees F. with a fluctuation expected at 3 degrees F. In the event of extremely hot weather, most systems will provide a 15-degree F. differential inside. During the heating season, thermostats are set at 70 degrees F. with an expected variation of 3 degrees F.

Building Codes

Fire and building codes are adhered to in all work performed by Maintenance. If there are specific questions about code requirements,contact the Director of Facilities and Planning .

Consultation

Members of our Maintenance staff are available and welcome the opportunity for discussion and consultation with faculty and staff members. Call or e-mail the Director of Facilities and Planning for an appointment or referral to the appropriate person for a particular problem or question.

Keys and Locks

This procedure will apply to all keys, including door keys, desk keys, filecabinet keys and storage keys:

1. The department head or his/her designee will submit a key request in Dude listing all keys needed.
2. Maintenance will deliver the keys to the Department Head. Each campus or department must maintain an inventory of all keys for their facility.
3. A key control log should be maintained by listing all key holders and the keys they have been issued on the log.
4. The employee will sign the *Key Control Log* and pick up keys from the Department Head.
5. All master keys and building keys require approval from the appropriate Department Head.
6. All keys must be returned to the Department Head upon termination of a position, change or designation, or any movement, which requires different keys, or no keys.
7. Keys turned in by employees to Department Head will be returned to the campus key inventory.
8. Keys are issued to authorized employees and **should not** be duplicated by users.
9. Maintenance, upon request by the department head can provide duplicate keys.
10. Maintenance is the only department allowed to cut and issue keys. Duplication of keys by an outside locksmith is strictly prohibited.
11. Maintenance requests for a lock and key changes or repair should be directed to Maintenance Operations. Maintenance Operations will determine if any associated costs will be charged to the department/office making the request.
12. Requests for master keys to a building must be submitted to and approved by the Department Head of the requesting department before processing by Maintenance.
13. Loss of keys must be reported immediately to Maintenance. In the event rekeying is necessary, the requesting campus or employee will be charged for all new keys and locks.

14. Expenses incurred for lost keys $25.00 or failure to have keys returned by departing employees is the responsibility of the department and handled through Human Resources and Maintenance. Core changes are $100 per lock and are performed by the Locksmith/Key Control Manager. The number of doors that have to be changed will determine the expense incurred for the loss of a Master key. Payment must be made to the finance department and a copy of the receipt turned into Maintenance Operations before a duplicate key is made or issued.

Equipment Lockout Procedures

Purpose

This procedure establishes the minimum requirements for lockout of energy sources that could cause injury to personnel. All employees shall comply with the procedure.

Responsibility

The responsibility for ensuring that this procedure is followed is required by all employees. The Maintenance Supervisor shall instruct all employees in the safety significance of the lockout procedure. Each new or transferred affected employee will be instructed by the Maintenance Supervisor in the purpose and use of the lockout procedure.

Preparation for Lockout

Employees authorized to perform lockout shall be certain as to which switch, valve, or other energy isolating devices applies to the equipment being locked out. More than one energy source (electrical, mechanical, or others) may be involved. *The employees shall clear any questionable identification of sources with their supervisor.*

Sequence of Lockout Procedure

a. Notify all affected site personnel that a lockout is required and the reason therefore.
b. If the equipment is operating; shut it down by the normal stopping procedure (such as: depress stop button, open toggle switch).
c. Operate the switch, valve, or other energy isolating devices so that the energy source(s) (electrical, mechanical, hydraulic, etc.) is disconnected or isolated from the equipment.
d. Stored energy, such as that in capacitors, springs, elevated machine members, rotating flywheels, hydraulic systems, and air, gas, steam or water pressure, must also be dissipated or restrained by methods such as grounding, repositioning, blocking, bleeding down.
e. Lockout energy isolating devices with an assigned individual lock.
f. After ensuring that no personnel are exposed and as a check on having disconnected the energy sources, operate the push button or other normal operating controls to make certain the equipment will not operate. *CAUTION: Return operating controls toneutral position after the test.*
g. The equipment is now locked out.

Restoring Equipment to Service

a. When the job is complete and equipment is ready for testing or normal service, check

the equipment area to see that no one is exposed.

b. When equipment is clear, remove all locks. The energy isolating devices may be operated to restore energy to equipment.

Procedure Involving More Than One Person

In the preceding steps, if more than one individual is required to lock out equipment, each shall place his/her own personal lock on the energy isolating device(s). One designated individual of a work crew or a supervisor, with the knowledge of the crew, may lock out equipment for the whole crew. In such cases, it may be the responsibility of the individual to carry out all steps of the lockout procedure and inform the crew when it is safe to work on the equipment. Additionally, the designated individual shall not remove acrew lock until it has been verified that all individuals are clear.

Rules for Using Lockout Procedure

All equipment shall be locked out to protect against accidental or inadvertent operation when such operation could cause injury to personnel. Do not attempt to operate any switch, valve, or other energy-isolating device bearing a lock.

Roofs

No one is permitted on the roof of any building without prior authorization from Facility Services. This is necessary because of bonds or guarantees present with many of our roofs, the potential damage to the building and its contents from roof damage leaks, and because of the great initial expense of roofing and repairs that might be necessary if uncontrolled roof traffic is permitted.

Cameras, television cameras, television antennas, or other equipmentsupported by tripods or stands may not be placed on any roof without prior coordination with Facility Services.

Alterations and/or additions to roofs are not permitted without prior approval of Maintenance.

Building Plans and Maps

Facility Services maintains a file for all building plans. The objective is to convert these plans and maps to a digital library.

Restrictions for Use of Property (Land)

No one is permitted to use or gain access to any property without propet authorization from Facilities Dept.

Facility Use/Room Reservations

Facility Use Requests should be submitted using our Computerized Facility Scheduling System Dude for each site as needed.

Tobacco

Tobacco use and e-cigarettes use is prohibited in/on buildings, vehicles, and grounds.

Storage of Materials

No equipment or materials of any sort may be stored in stairways or public corridors or placed to block fire exits. These conditions constitute Fire Department and Occupational Safety and Health Administration (OSHA) violations. Equipment and materials stored or placed in violation of Fire Department and OSHA regulations will be removed and discarded and the owning department charged for all removal costs.

Equipment and materials may not be stored in mechanical equipment rooms or electrical closets.

Telephone Installation

Facility Services provides installation of telephones and other phone services in coordination with IT Dept.

Architectural/Engineering Service

Facility Services is responsible for all architectural and engineering functions at the Home, including engineering services, plant development, and mechanical and electrical systems overview.

Facility Services provides consultation to various departments on the maintenance and operations aspects of proposed capital improvement projects. It represents the Home during the design and construction phases for capital improvement projects, which are implemented by outside architects and engineers. Facility Services also prepares plans and specifications for capital improvement projects when the development of the design for such a project is the responsibility of Maintenance.

In addition, Facility Services is responsible for feasibility studies that determine the direction campus planning systems should go. It is also responsible for general surveillance of the Homes energy conservation program, developing new programs and plans for conservation, keeping Facility Services advised on program areas,costs, and the like, and advising other departments in the field of energy conservation.

Emergencies

In the event of an emergency between the hours of 7:00 AM and 4:30 PM, all calls for service should be made per the Emergency Contact list for each specific site.

In the event of an emergency between the hours of 4:30 PM and 7:00 AM, all calls for services should be made to the individual listed on the Emergency Contact List, and they will contact the appropriate Facility Services personnel.

Summary of Trades and Services

General Maintenance

The General Maintenance performs general maintenance repairs and provides assistance with the repair of building structures and their mechanical, electrical, and sanitary systems throughout the sites. Including repairing woodwork; replacing electrical switches, fixtures, and motors; painting, repairing, and replacing plumbing fixtures and drainage systems, flooring ceiling grid; and replacing broken glass. This shop also inspects and repairs the building exterior and interior, playground equipment, and grounds (fencing and gates).

Custodial Services

Custodial Services is responsible for routine cleaning, paper waste removal, and pre-scheduled work such as window washing, floor care, and rug shampooing, and pest control.

Preventative Maintenance

The preventative maintenance staff provides maintenance that is regularly performed on a scheduled basis on an equipment to lessen the likelihood of it failing. Examples are changing HVAC filters on a scheduled basis, lubricating equipment, changing equipment belts as well as cleaning downspouts and roof gutters. Performing scheduled preventative maintenance helps extend the life of mechanical and building systems.

Grounds Maintenance

This unit is responsible for the care and maintenance of campus grounds, including mowing, seeding, fertilizing, and watering lawns, maintaining established shrubbery and trees on the campus, snow removal, and maintenance of athletic facilities.

Paint Shop

The paint shop provides services related to painting needs, and sheetrock repair throughout the sites

Attachment 8.c.1

THE HOME FOR LITTLE WANDERERS

BETTER BEGINNINGS FOR BOYS

The Home Courses and Trainings

- Agency Directives
- Harassment (Employee Rights & Responsibilities)
- Employee Development
- Trauma 101
- Professionalism in the Workplace
- Workplace Safety
- Cultural Humility
- Therapeutic Boundaries
- HIPAA for Behavioral Health
- Blood-borne Pathogens
- Mass Privacy Law
- Nutrition & Physical Activity Basics I
- Cultural Competence
- Workplace Harassment
- Discrimination in the Workplace (supervisors only)

For all employees in Residentials, Group Homes and TASP

- Therapeutic Crisis Intervention
- Adult & Child CPR/AED/First Aid
- Nutrition & Physical Activity Basics II
- Defensive Driving: The Basics
- Trauma Informed Care
- EvolvNX (client information system)
- CBT Trauma-Focused (residential staff; master level only)
- CAFAS (Clinical Staff Only)
- CANS (Clinical Staff Only)

THE HOME FOR LITTLE WANDERERS

BETTER, BRIGHTER FUTURES FOR KIDS

Health Services Manual
Unity House

Version 1.0 2022

Revised September 29, 2022

The Home for Little Wanders
Unity House Health Care Manual of Policies and Procedures
Statement of Review

I have reviewed this manual for the school year 2022-2023.

The information contained in the Health Care Manual has been approved for accuracy with current laws and regulations and HLW policies and procedures. It is understood, that any new changes or additions shall be approved by Program Director, The Home for Little Wanderers Program Operations Team and the Unity House Program Nurse.

Signature:
Title:
Date:

The Health Care Manual serves as a resource and is available in the administrative main office and Health Services for all state agencies and school personnel to utilize in supporting the Health Services at Unity House. The Health Care Manual is reviewed annually and updated as needed with approval.

Table of Contents

I. Introduction

A. The Purpose of the Health Services Manual

This manual is a resource book providing basic information and recommended best-practices related to health services and wellness initiatives at The Home for Little Wanderers (HLW). It reflects the importance of general health to constructive functioning. It also reflects the growing emphasis on wellness and health promotion and the partnership of agency, school, and family in promoting health and client's self-efficacy in health matters.

This manual seeks to:

- ✓ Increase caretaker's awareness of health issues affecting the client in HLW's care.
- ✓ Provide guidelines for practice on issues relating to health.
- ✓ Reflect the responsibility of all staff to promote wellness.
- ✓ Serve as a tool for orienting personnel to health-related issues and guidelines.

The Health Services department reflects the mission of HLW. It is based on the belief that specific health promoting interventions lead to desired outcomes and contribute to the health and Well-being of client, families and communities. It incorporates the theories of self-efficacy and social support, the concepts of resilience (the potential for healing) and vulnerability (the potential for injury) innate in the human condition.

We believe that the family, caregivers and/or client natural network, know the client best and are in the best position to hold potentially powerful solutions to the presenting problems requiring referral. These individuals are encouraged to be involved extensively in the care of the client. Client benefit from involved families/caregivers, whether they live at home or in residential care. At HLW, all individuals and families are welcomed, empowered, and respected throughout the therapeutic process as they are essential to success in the care planning. We assist the client and families/caregivers in exploration of their existing relationships and in developing an understanding of how they interact with one another and facilitate the strengthening of these connections. We acknowledge that the community in which the family or natural network lives offers accessible and appropriate recourses for care and that "it takes a village to raise a client."

B. Organization of Health Resources and Provision of Services

The health and safety of client at The Home for Little Wanderers is the responsibility of all staff. All direct care staff and nurses are trained in Standard Precautions, CPR, First Aid, and epinephrine auto-injector administration.

Selected staff are also trained and certified in the administration of medications in accordance with state regulations.

In collaboration with the client's parent/guardian and clinician, the nursing staff at the program coordinates the client's health care and are available to client for their health education needs.

With the agency's Wellness Initiative, which began in 2004, the shift is moving toward seeing and treating the clients' health needs in a prevention model. The support of each program's Wellness Committee aids in the shift and implementation of improved and sustained health awareness and practices.

Each client has an identified Primary Care Provider, and is seen for annual physicals, postural screening, eye exams, routine lab work, updating of immunizations, dental exams, and other health appointments as needed. All client are admitted to a program with health insurance, and if for some reason they do not have it, the case manager assists the family or guardian in obtaining health insurance.

The client/parent handbook serves as a resource for important health-related information for client, families, and caregivers. The handbook is provided upon admission and available through Health Services upon request.

PHYSICIAN CONSULTATION

Each New Hampshire program within The Home for Little Wanderers that is licensed under DHHS has a local physician who is available for consultation. The school physician will consult on matters such as direct service, clinical consultation, policy consultation, health education, public relations, advocacy, system development, and act as a liaison to community physicians.

The Program Physician will be appointed by the Medical Director of The Home.

Pediatrician Consult
TBD

NURSE STAFFING

HLW employs a nurse in each program who is:

- A graduate of an approved school for professional nursing;
- Currently licensed as a Registered Nurse

Unity House employs a part-time program nurse working 20 hours a week at the program. The nursing hours listed above are sufficient for the needs of the populations served at Unity House. The Director of Nursing is on call 24 hours per day, 7 days per week and supervises all program nurses.

Program nurses onsite during school hours are responsible for the following:

- Direct nursing services (triage, injuries/illnesses, providing first aid & emergency response, conducting screenings & preventative assessments)
- Collaboration with outside medical personnel, medical facilities, and guardians
- Health education and staff training regarding medical needs of the population
- Community health
- Emergency planning
- Oversight of delegation of medication administration following New Hampshire Department of Public Health regulations (for approved program)
- Address health issues impacting learning
- Maintain health records: immunization, vision, hearing, postural, height & weight, physical exams, medical history

The priority is always the health and safety of each client.

Director of Nursing
Peggy Andreas, RN, DON
617-615-9024
pandreas@thehome.org

Unity House Program Nurse:
TBD

All program nurses' New Hampshire License numbers are on file with The Home for Little Wanderers' Human Resources Department. Available upon request.

C. Notice of Privacy Practices

The Home for Little Wanderers
10 Guest Street
Boston, MA 02135

Tel. 617-267-3700
TTY 617-927-0699
www.thehome.org

The Home for Little Wanderers takes your privacy seriously. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully.***

INTRODUCTION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your health information.

"Protected health information" means health information (including identifying information about you) we have collected from you or received from your health care providers, health plan, your employer or a health care clearinghouse. It may include information about your past, present or future physical or mental health or condition, the provision of your health care, and payment for your health care services.
We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are also required to comply with the terms of our current Notice of Privacy Practices.

HOW WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION

We will use and disclose your health information as described in each category listed below. For each category, we will explain what we mean in general, but not describe all specific uses or disclosures of health information.

Uses and Disclosures That May Be Made For Treatment, Payment and Operations

For Treatment. We will use and disclose your health information without your authorization to provide your health care and any related services. Your health information is routinely shared among the clinicians and direct care staff involved in your care to ensure they all understand your treatment needs. We will also use and disclose your health information to coordinate and manage your health care and related services. For example, we may need to disclose information to a clinician who is responsible for coordinating your care. In addition, with your permission, we will disclose your health information to other health care providers (e.g., your primary care physician, a laboratory, the pharmacist) working outside of The Home.

For Payment. We may use or disclose your health information without your authorization so that the treatment and services you receive are billed to, and payment is collected from, your health plan or other third-party payer. We may need to disclose your health information to permit your health plan to take certain actions before they approve or pay for your services. These actions may include:

- making a determination of eligibility or coverage for health insurance;
- reviewing your services to determine if they were medically necessary according to your health plan's rules;
- reviewing your services to determine if they were appropriately authorized or certified in advance of your care;
- reviewing your services for purposes of utilization review, to ensure the appropriateness of your care, or to justify the charges for your care.

For example, your health plan may ask us to share your health information in order to determine if the plan will approve additional visits to your health care provider.

For Health Care Operations. We may use and disclose health information about you without your authorization for our health care operations. These uses and disclosures are necessary to run our organization and make sure that our consumers receive quality care. These activities may include, by way of example, quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training clients in clinical activities, licensing, accreditation, business planning and development, and general administrative activities.

We may combine health information of many of our consumers to decide what additional services we should offer, what services are no longer needed, and whether certain new services are effective. We may also combine our health information with health information from other providers to compare how we are doing and see where we can make improvements in our services. When we combine our health information with information of other providers, we will remove identifying information so others may use it to study health care or health care delivery without identifying specific client.

We may also use and disclose your health information to contact you to remind you of an appointment.

Uses and Disclosures That May be Made Without Your Authorization, But for Which You Will Have an Opportunity to Object

Persons Involved in Your Care. We may provide health information about you to someone who helps pay for your care. We may use or disclose your health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may also use or disclose your health information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures for this purpose to family or other individuals involved in your health care.

In limited circumstances, we may disclose health information about you to a friend or family member who is involved in your care. If you are physically present and have the capacity to make health care decisions, your health information may only be disclosed with your agreement to people you designate to be involved in your care.

But, if you are in an emergency situation, we may need to disclose your health information to other individuals such as a relative, significant other, or close friend, so that such person may assist in your care. In such situations, we will determine whether the disclosure is in your best interest and, if so, only disclose information that is directly relevant to participation in your care. And, if you are not in an emergency situation but are unable to make health care decisions, we will disclose your health information to:

- if applicable, the state agency responsible for consenting to your care, or
- your guardian or medication monitor if one has been appointed by a court.

Uses and Disclosures That May be Made Without Your Authorization or Opportunity to Object

Emergencies. We may use and disclose your health information without your authorization in an emergency treatment situation. For example, we may provide your health information to a paramedic who is transporting you in an ambulance. If a clinician is required by law to treat you and staff have attempted to obtain your authorization but have been unable to do so, staff may nevertheless use or disclose your health information to ensure you get necessary treatment.

Research. We may disclose your health information to researchers when their research has been approved by an Institutional Review Board or a similar privacy board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

As Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious and imminent threat to your health or safety, or to the health or safety of the public or another person. Under these circumstances, we will only disclose health information to someone who is able to help prevent or lessen the threat.

Organ and Tissue Donation. If you are an organ donor, we may release your health information to an organ procurement organization or to an entity that conducts organ, eye or tissue transplantation, or serves as an organ donation bank, as necessary to facilitate organ, eye or tissue donation and transplantation.

Public Health Activities. We may disclose health information about you as necessary for public health activities including disclosures to:

- report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
- report vital events such as birth or death;
- conduct public health surveillance or investigations;
- report child abuse or neglect;
- report certain events to the Food and Drug Administration (FDA) by a person subject to the jurisdiction of the FDA including information about defective products or problems with medications;
- notify consumers about FDA-initiated product recalls;
- notify a person who may have been exposed to a communicable disease or who is at risk of contracting or spreading a disease or condition;
- notify the appropriate government agency if we believe an adult has been a victim of abuse, neglect or domestic violence. We will only notify an agency if we obtain your agreement or if we are required or authorized by law to report such abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose health information about you to a health oversight agency for activities authorized by law. Oversight agencies include government agencies such as the New Hampshire Department of Public Health that oversee the health care system, government benefit programs such as Medicaid, other government programs regulating health care, and civil rights laws.

Disclosures in Legal Proceedings. We may disclose health information about you to a court when a judge orders us to do so. We also may disclose health information about you in legal proceedings without your permission or a judge's order when:

- you are a party to a legal proceeding and we receive a subpoena for your health information. Normally, we will not provide this information in response to a subpoena without your authorization if the request is for substance abuse records or for information relating to AIDS or HIV status or genetic testing;
- your health information involves communications made during a court-ordered psychiatric examination;
- you introduce your mental or emotional condition in evidence in support of your claim or defense in any proceeding and the judge approves our disclosure of your health information;

- you sue any of our clinicians or staff for malpractice or initiate a complaint with a licensing board against any of our clinicians;
- the legal proceeding involves custody, adoption or dispensing with consent to adoption and the judge approves our disclosure of your health information;
- one of our staff brings a proceeding, or is asked to testify in a proceeding, involving foster care of a client or commitment of a client to the custody of the New Hampshire Department of Social Services.

Law Enforcement Activities. We may disclose health information to a law enforcement official for law enforcement purposes when:

- you agree to the disclosure; or
- when the information is provided in response to an order of a court; or
- we determine that the law enforcement purpose is to respond to a threat of an imminently dangerous activity by you against yourself or another person; or
- the disclosure is otherwise required by law.

We may also disclose health information about a client who is a victim of a crime without a court order or without being required to do so by law. However, we will do so only if the disclosure has been requested by a law enforcement official and the victim agrees to the disclosure or, in the case of the victim's incapacity, the following occurs:

- the law enforcement official represents to us that: 1) the victim is not the subject of the investigation, and 2) an immediate law enforcement activity necessary to address a serious danger to the victim or others depends upon the disclosure; and
- we determine that the disclosure is in the victim's best interest.

Medical Examiners or Funeral Directors. We may provide health information about our consumers to a medical examiner. Medical examiners are appointed by law to assist in identifying deceased persons and to determine the cause of death in certain circumstances. We may also disclose health information about our consumers to funeral directors as necessary to carry out their duties.

National Security and Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or so they may conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official.

Uses and Disclosures of Your Health Information with Your Permission

Uses and disclosures not previously described in this Notice of Privacy Practices will, in general, only be made with your written permission called an "authorization." You have the right to revoke an authorization at any time. If you revoke your authorization we will not make any further uses or disclosures of your health information under that

authorization, unless we have already taken an action relying upon the uses or disclosures you have previously authorized.

Your Rights Regarding Your Health Information

Right to Inspect and Copy. You have the right to request an opportunity to inspect or copy health information used to make decisions about your care, regardless of whether they are decisions about your treatment or payment of your care. Generally, this would include clinical and billing records, but not psychotherapy notes.

You must submit your request in writing either directly to The Home's program from which you are currently receiving services, or to Medical Records Coordinator, 780 American Legion Highway, Roslindale, MA 02131. If you request a copy of the information, we may charge a fee for the cost of copying, mailing and supplies associated with your request.

We may deny your request to inspect or copy your health information in certain limited circumstances. In some cases, you will have the right to have the denial reviewed by a licensed health care professional not directly involved in the original decision to deny access. We will inform you in writing if the denial of your request may be reviewed. Once the review is completed, we will honor the decision made by the licensed health care professional reviewer.

Right to Amend. For as long as we keep records about you, you have the right to request us to amend any health information used to make decisions about your care – whether they are decisions about your treatment or payment of your care. Generally, this would include clinical and billing records, but not psychotherapy notes.

To request an amendment, you must submit a written document to The Home's program from which you are currently receiving services, or to the Medical Records Coordinator, 780 American Legion Highway, Roslindale, MA 02131 and tell us why you believe the information is incorrect or inaccurate.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend health information that:

- was not created by us, unless the person or entity that created the health information is no longer available to make the amendment;
- is not part of the health information we maintain to make decisions about your care;
- is not part of the health information that you would be permitted to inspect or copy; or
- is accurate and complete.

If we deny your request to amend, we will send you a written notice of the denial stating the basis for the denial and offering you the opportunity to provide a written statement disagreeing with the denial. If you do not wish to prepare a written statement of disagreement, you may ask that the requested amendment and our denial be attached to all future disclosures of the health information that is the subject of your request.

If you choose to submit a written statement of disagreement, we have the right to prepare a written rebuttal to your statement of disagreement. In this case, we will attach the written request and the rebuttal (as well as the original request and denial) to all future disclosures of the health information that are the subject of your request.

Right to an Accounting of Disclosures. You have the right to request that we provide you with an accounting (i.e. a list) of disclosures we have made of your health information. However, this list will not include routine disclosures we have made for purposes of treatment, payment, and health care operations. To request an accounting of disclosures, you must submit your request in writing to The Home's program from which you are currently receiving services, or to the Medical Records Coordinator, 780 American Legion Highway, Roslindale, MA 02131. For your convenience, you may submit your request on a form called a "Request For Accounting," which you may obtain from your program, or from our Privacy Officer. The request should state the time period for which you wish to receive an accounting. This time period should not be longer than six years and not include dates before April 14, 2003.

The first accounting you request within a twelve-month period will be free. For additional requests during the same 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the amount we will charge and you may choose to withdraw or modify your request before we incur any costs.

Right to Request Restrictions. You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. You may also ask that any part (or all) of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes, as previously described in this Notice.

You must request the restriction in writing and addressed to the Privacy Officer at 10 Guest Street, Boston, MA 02135. The Privacy Officer will ask you to fill out a Request for Restriction Form, which you should complete and return to the Privacy Officer. We are not required to agree to a restriction that you may request. If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. For example, you may request that we contact you only at work or by e-mail. To request such a confidential communication, you must make your request in writing to The Home's program from which you are currently receiving services. We will accommodate all reasonable requests. You do not need to give us a reason for the request, but your request must specify how and where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice of Privacy Practices electronically, you may still obtain a paper copy. To obtain a paper copy, ask The Home's program from which you are currently receiving services, or contact the Privacy Officer at 617-267-3700.

Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We will post a copy of the current Notice of Privacy Practices at our main office and at each site where we provide care. You may also obtain a copy of the current Notice of Privacy Practices by calling us at 617- 585-7502 and requesting that a copy be sent to you in the mail or by asking for one any time you are at one of our offices or programs.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact our Privacy Officer. All complaints must be submitted in writing.

The Home's Privacy Officer can be contacted at 10 Guest Street, Boston, MA 02135, by telephone at 617-267-3700, or by email at HIPAA@thehome.org, and will assist you with writing your complaint if you request such assistance. We will not retaliate against you for filing a complaint.

D. Procedure for Informed Consent for Treatment

Informed Consent for Treatment		No. 1-11
Scope: All programs of The Home for Little Wanderers providing treatment to registered Client		
Effective Date: May 8, 2001	Revised:	Last Review: January 16, 2016

TABLE OF CONTENTS

8.0 How to Proceed When Consent for the Treatment is Denied

9.0 Procedures for Which Informed Consent is Not Needed
Emergency Treatment

10.0 Withdrawal of Consent

11.0 The Responsibility of the Administration of The Home
Information to be Provided Upon Admission
Posting Consent for Psychotropic Medication
Posting Information Regarding Informed Consent
Information Regarding Medications
Implementation and Annual Review of the Policy

12.0 Situations in Which Clinical and Legal Counsel May be Sought

In the Policy on Informed Consent for Treatment and herein, these definitions apply:

"Routine, general, and preventative treatment" shall mean standard medical examinations, clinical tests, standard immunizations, treatment for minor illnesses and injuries, and the standard treatment modalities of the Home's programs, e.g., individual, group, family, occupational, and milieu therapies.

"Emergency treatment" shall mean a treatment provided as necessary on an emergency basis by a physician licensed to practice medicine or other employees or emergency personnel trained in emergency care.

"Non-routine treatment" shall mean psychopharmacological treatment or treatment that is rarely used, highly intrusive or high risk, e.g. forced tube feedings or ECT.

"Clinician" shall mean the person providing therapeutic and case management services to the client and family. Clinicians include Licensed Mental Health Counselors (LMHC), Licensed Independent Clinical Social Worker (LICSW), Licensed Clinical Social Worker (LCSW), masters level mental health counselors and social workers, interns currently enrolled in an accredited masters level program in mental health counseling, social work or marriage and family therapy.

1.0 **Consent to Treatment**

1.1 ***Consent to Routine, General, and Preventative Treatment.*** Informed consent is to be obtained and documented for routine, general and preventative treatment.

Informed consent is the knowing consent, given in a manner that is free of coercion, by a client and/or their parent/legal guardian who can weigh the indications, risks, and benefits of the particular treatment being proposed by the health care provider. Persons who have given consent are at any time free to withdraw their consent. In some cases, the withdrawal of consent can

have serious consequences for the client's treatment. The HLW Informed Consent Policy and Procedures shall comply with the requirements of New Hampshire law and the standards of all licensing agencies responsible for regulating the services provided by the HLW. At the outset of routine, general and preventative treatment or upon admission to a Program of the HLW, the client and/or parent/legal guardian shall be informed of the indications, risks, and benefits of the routine, general and preventative treatment that is ordinarily performed at, or arranged by, the program or facility. The informed consent of the client and/or parent/legal guardian will be documented on a *Consent for Routine, General, and Preventative Treatment* form (see Appendix).

Medication will not be administered to a client without written authorization from a parent/guardian. Such authorization shall be renewed annually.

A. The health care provider will obtain informed consent from the parent/legal guardian. Informed consent would include the purpose of the medication, potential benefits, and potential side effects and adverse effects.
B. The health care provider will complete an informed consent form, with copies filed in both the client's medical record and clinical record.
C. The health care provider will inform the client of the purpose, potential benefits, potential side effects and adverse effects of the medication and will encourage the engagement of the client in monitoring the effectiveness and side effects of the medication.
D. The HLW or outside health care provider will provide the transcribing nurse client-specific information about the indication, side effects, and adverse effects. The program nurse will communicate this information to appropriate staff and provide the information in written form in an accessible place for staff reference.
E. The program nurse will obtain information about all medications prescribed for each client and the date of the next scheduled visit with the prescribing physician for review of the medication.
F. The program nurse and clinical supervisor will ensure that an *Authorization for Medication Administration* form (see Appendix) signed by the parent/legal guardian is in the client's record before any medication is administered to the client in the program. A copy of the form will be kept in or in proximity of the *Medication Log* for reference. If a client's medication regime includes an antipsychotic medication and if a minor is the under the guardianship of DCF, the nurse or clinical supervisor will ensure that a current court order and treatment plan are on file in the client's record (Rogers order). If the court order is not on file or is outdated, the medication will not be administered, and the nurse will contact the program director and program psychiatrist immediately.
G. The program shall create and maintain a "tickler" system, which keeps track of the expiration dates of medication prescriptions, and

court issued medication orders, so that timely action can be taken to insure extension of administration of medication without interruption.

1.2 ***Consent to Non-Routine Treatment.*** For non-routine treatment, more specific informed consent must be obtained and documented. This higher level of informed consent must be obtained and documented in the following situations:

1.2.1 Psychotropic Medication. When treatment with a psychotropic medication is to be initiated, informed consent must be documented on The HLW's *Consent Form for Psychotropic Medications* (see Appendix). If psychotropic medication is to be administered, a signed copy of the *Consent Form for Psychotropic Medication* shall serve as the primary documentation unless a Rogers order has been issued by a court of competent jurisdiction, in which case it shall replace the *Consent form for Psychotropic Medication* as the principal document. The court review date of the Rogers order shall be prominently recorded in a tickler system designed to ensure adequate time to prepare documents and evidence for the Rogers review hearing. The client and/or parent/legal guardian shall be provided with a signed copy of the consent form. The informed consent process and the use of the *Consent Form for Psychotropic Medication* shall also be recorded in the health care provider's progress note. Documentation of ongoing informed consent discussions concerning questions about and/or changes in the client's status shall be included in the progress notes of the health care provider as they occur. When treatment with a psychotropic medication is to be initiated, informed consent must be documented in the health care provider's progress note. If non-routine prescription medications are to be administered, informed consent should also be documented in the health care provider's progress note. Where indicated, the note should contain a statement as to the capacity of the client and/or parent/legal guardian to give informed consent.

1.2.2 Other High-Risk, Rare Medication. When a rarely used, unusual, highly intrusive, or high-risk intervention is to be implemented, informed consent must be documented on a written consent statement specifically created for that treatment. For other treatments that exceed the scope of routine treatment, the health care provider must conduct discussions with the client and/or parent/legal guardian as delineated in Paragraph 1.2 above, and document such discussions in detail in the progress notes.

1.2.3 Treatment Protocol. When any research treatment protocol is to be implemented, informed consent must be documented on a *Consent for Participation in Research* form.

1.2.4 HIV Antibody Testing. When HIV antibody testing is to be conducted, informed consent must be documented on an HIV antibody testing consent form (M.G.L. Chapter 111,§70F). If HIV testing is to be conducted, documentation of consent for HIV antibody testing from the client's health care provider will be included in the client's record.

2.0 Knowledge Required/Given for Informed Consent

2.1 ***Clinician or Clinical Supervisor's Responsibility.*** Ensuring the provision of information necessary for informed consent is primarily the responsibility of the clinician or the clinical supervisor. If necessary, this information shall be provided in the language of the client and/or parent/legal guardian, and the information shall be provided in terms that they can understand.

2.2 ***Discussion of Options and Risks.*** Because the knowing exercise of the right to accept or forego treatment requires knowledge of the available, appropriate treatment options and the indications, risks and benefits attendant on each, the clinician and/or clinical supervisor must fulfill their duty to inform by discussing the indications, risks and benefits of all appropriate treatment options to the client and or parent/legal guardian.

3.0 Information Given by Health Care Provider for Non-Routine Treatment

3.1 ***Discussion Topics.*** For all treatment exceeding the scope of routine, general, and preventative treatment, the health care provider shall discuss with the client and parent/legal guardian the following:

(a) the condition(s) for which treatment is being recommended;
(b) the recommended medication(s) and/or treatment(s);
(c) the dosage range of medication(s), and how it will be administered (i.e., by mouth or injection, etc.);
(d) the anticipated duration of treatment;
(e) the indications (i.e., the reasons that this medication is appropriate for the client's condition(s);
(f) the benefits and the desired outcomes of the proposed medication(s) and/or treatment(s), including prognosis with treatment;
(g) the risks, including significant, common, and possibly serious or life-threatening side effects of the recommended medication(s) and/or treatment(s);
(h) the dangers of abruptly discontinuing the medication(s) and the methods of safely discontinuing the medication(s) and/or treatment(s);
(i) appropriate alternative treatments, including a discussion of the indications, benefits, risks and probable effectiveness of each reasonable alternative treatment;
(j) possible outcomes if no treatment is received (prognosis without treatment);

(k) the rights of the client and/or parent/legal guardian to ask questions about the recommended treatment, before or during or after treatment;
(l) the rights of the client and/or parent/legal guardian to refuse treatment; and,
(m) the rights of the client and/or parent/legal guardian to revoke consent at any time and its consequences.

3.2. ***Written Information***. Written information about the proposed medication(s) and/or treatment(s) shall be made available, when requested.

3.3 ***Informing Minor Client***. While informed consent for the HLW clients who are under the age of eighteen (18) is, in most cases, legally obtained from the client's parent/legal guardian, it is the HLW policy to inform minors of the indications, risks, and benefits of the recommended treatment and treatment options, in a manner consistent with the client's age and capacity to understand.

4.0 Assessment of the Competence of Client and/or Parent/Legal Guardian

Based on his/ her discussions with the client and/or parent/legal guardian, and other information available, the health care provider shall make and document an assessment of the ability of the client and/or parent/legal guardian to understand the information presented and to give competent informed consent. For psychotropic medication treatment, competency assessment shall be documented on the *Consent Form for Psychotropic Medications*. If the health care provider determines that the client or parent/legal guardian is not competent, and the client or parent/legal guardian takes the opposite position, then a formal competency evaluation shall be conducted.

5.0 Informed Consent: An Ongoing Process

Providing information to a client and/or parent/legal guardian is an ongoing responsibility of the health care provider and is necessary to allow the client or parent/legal guardian to determine whether to continue to consent, or to withdraw their consent.

5.1 ***Substantial Changes Require New Consent***. Whenever substantial changes in the client's treatment are indicated, or in the event that the client's mental and/or physical status changes in such a manner as to substantially change the indications, risks, benefits, or appropriate options for his or her treatment, informed consent for changes in medication(s) and or treatment(s) shall be obtained and shall be documented on a new *Consent Form for Psychotropic Medications*.

5.2 ***Ongoing Consent Discussions***. Discussions about informed consent, regarding psychotropic medications, do not stop with the initial consent, but continue through the course of treatment as the client experiences the medication, its benefits and side effects, or when the client's care is transferred to a new health care provider.

5.3 ***Periodic Reviews and Renewed Consent.*** Even if there are no changes indicated in a client's medication and/or treatment, periodic review, discussion, and documentation of informed consent shall occur in periodic reviews and/or in progress notes at minimal intervals:

(a) For psychologically stable client being served on an outpatient basis, annual review is sufficient.

(b) For client in residential settings, documentation of informed consent discussions shall be included in the periodic review process, minimally at three (3), six (6), and twelve (12) months after admission, and annually thereafter. This review may be covered in a brief statement or check box on a periodic review form, though any significant new information should be covered in a progress note or a new consent form.

c) For client returning to program from an admission to a hospital or outside facility, for any length of time, should be reviewed by team upon return within 72 business hours.

6.0 Documentation of Informed Consent in the Client's Record

The client's clinician shall be responsible for collaborating with Health Services to ensure documentation of informed consent is received and updated, with all necessary signatures from the authorized prescribing clinician, including but not limited to the following:

6.1 ***Consent Documentation.*** Documentation indicating that the client and/or parent/legal guardian has been provided information in accordance with the policy, including information about the indications, risks, and benefits of recommended treatments, appropriate treatment options, and indicating whether the client and/or parent/legal guardian has assented to or refused treatment.

6.2 ***Documentation of Capacity to Give Consent.*** An assessment of the capacity of the client and/or parent/legal guardian to give informed consent should be noted on the *Consent Form for Psychotropic Medications* or noted in a progress note for non-routine treatment. The assessment should include discussion of the ability of the client and/or parent/legal guardian to process the information given to them by the health care provider, to understand the nature of the illness/problem to be treated, and to evaluate treatment options presented. The assessment should note important questions and comments offered by the client and/or parent/legal guardian.

7.0 Those Who May Give Informed Consent

7.1 ***Legal Adults.*** Legal adults, i.e., individuals over the age of 18, are presumed to be competent to give informed consent, unless a court has decided otherwise. A legal adult's informed consent is necessary, and is sufficient, to comply with this policy. Given the HLW goal of supporting

optimal family health and functioning, we generally advise, when a competent adult client gives his or her permission, that the client's family is contacted so that important treatment decisions can be made in conjunction with informed family involvement, unless to do so would not be in the best interest of the client or would violate client confidentiality or privilege.

7.2 ***Minors and Incompetent Adults***. For those client incapable of making an informed decision to accept or forego certain forms of treatment, including, with certain legal exceptions, minors (those under the age of 18), New Hampshire law provides alternate means to protect their interests.

7.2.1 Guardianship of Incompetent Adults. If a legal adult is adjudicated by the Court as incompetent to give informed consent, the Court will appoint a guardian from whom informed consent shall be obtained. Note: a Court-appointed guardian must be specifically granted the "authority to admit" in the mittimus (Order of Guardianship). If authority to admit is not included in the mittimus, a separate Order must be obtained from the court before the client may be admitted (M.G.L Chapter 201 §6B).

7.22 Parents or Guardians of a Minor. Informed consent to the treatment of a minor shall be obtained from the parent/legal guardian. The parent/legal guardian is presumed to be competent to give informed consent unless otherwise determined by a court. The informed consent of a minor's parent/legal guardian is required and is sufficient to comply with the policy unless the parent no longer has legal custody of their child.

7.2.3 Exceptions to a Guardian's Right to Consent. However, a court-appointed guardian, such as the DCF guardian, may not give consent for certain highly intrusive or high-risk interventions, including, but not limited to psychotropic or antipsychotic medications, ECT, psychosurgery, sterilization, or abortion. A separate court order is required for these treatments, and consultation with The Home's legal counsel, via the Operations staff, should be sought in cases requiring such permission.

7.2.4 Informing Minors. While informed consent to the treatment of a minor is legally obtained from the parent/legal guardian, it is the policy of The Home to inform the minor, in a manner consistent with their capacity to understand about the indications, risks, and benefits of the recommended treatment and treatment options.

7.3 ***Questions as to Authority to Give Consent***. Sometimes questions will arise as to who has the authority to give informed consent to a client's treatment. If there is a question as to whom has legal guardianship of the client, or as to the scope of guardianship, the court mittimus, or order of guardianship, should be reviewed, and the H.W's legal counsel should be consulted. If a client has two guardians with appropriate authority to give consent whom

The HLW believes to be in conflict over consent (for example, parents involved in a custody dispute), the HLW's policy is to obtain consent from both parties. The clinical director and the HLW's legal counsel should be consulted if the clinician and prescribing physician determine that it would be in the client's best interest to obtain consent from only one of the client's parents/legal guardians in such a conflict. If the HLW's clinician or prescribing physician believe that a parent/legal guardian is, or has become, incompetent, it may be that Court intervention is necessary to seek appointment of a new guardian. Consultation with the HLW's legal counsel, via the Program Director and HLW Senior Administration, should be sought to assist with seeking the appointment of a new guardian.

7.4 ***Client in the Custody of DCF.***

7.4.1 Client in the Physical Custody of DCF. In cases in which DCF has been awarded only physical custody of a minor, the client's parent/legal guardian retains the right to consent to medical treatment. In such cases, consent to the use of psychotropic medications and all other medical treatments must be obtained from the client's parent/legal guardian.

7.4.2 Client in the Full Custody of DCF. In cases in which DCF has been awarded both physical and legal custody of a client, informed consent to medical treatment must be obtained from the client's DCF guardian, except for psychotropic medications (see 7.4.3 below).

7.4.3 Consent to Administration of Antipsychotic Medications. New Hampshire law requires that consent to treatment with psychotropic medication, even for those minors in the full custody of DCF, may only be obtained through a Rogers order issued by the Court. (DCF 110 CMR 11.14(4)).

7.5 ***Minors Authorized to Consent to Treatment.***

7.5.1 Emancipated Minors. If the client is an Emancipated Minor (a client under the age of 18 who is married, widowed or divorced; the parent of a child; pregnant or believes herself to be pregnant; a member of the Armed Forces; or living separate and apart from their parent/legal guardian and managing their own financial affairs) the client may give consent for medical or dental care, including psychiatric care, in the same manner as a legal adult (defined above in 7.1) provided, however, that no consent under this paragraph may be accepted for abortion or sterilization.

7.5.2 Drug Dependent Minors. If the client is a minor 12 years of age or older who is found to be drug dependent by two or more physicians, they may give consent to treatment related to the diagnosis or treatment of such drug dependency.

7.5.3 Contagious Diseases. A minor may consent to care if the minor reasonably believes that they suffer from or have come in contact with any disease defined as dangerous to the public health under Chapter 111, Sec.6 of New Hampshire law; provided, however, that such minor may only consent to care which relates to the diagnosis or treatment of such disease. If a facility or program determines, pursuant to applicable New Hampshire law, that a minor is an Emancipated or Drug Dependent Minor (as defined in Sections 7.5.1 and 7.5.2), and is therefore able to provide consent to treatment, the program may decide, in certain circumstances, not to notify the minor's parent/legal guardian. Such a determination must be made in consultation, via the Program Director, with the HLW's legal counsel.

7.5.4 Documentation. Documentation of informed consent obtained from minors should also be done in consultation with legal counsel.

7.6 ***Changes in Custody of the Client During Treatment.***
If, after consent for a particular treatment has been given by a parent/legal guardian, and there is a subsequent change in a client's legal/physical custody and/or guardianship, the informed consent of the new guardian must be obtained and documented in order to continue that treatment. If the treatment involves the use of psychotropic medications, changes in guardianship may require that a Rogers order be obtained from the Court.

8.0 How to Proceed When Consent for the Treatment is Denied

Refer to The HLW's policy on *Refusal of Treatment.*

9.0 Procedures for Which Informed Consent is Not Needed

9.1 ***Emergency Treatment.*** Under New Hampshire law, the HLW's medical personnel cannot be held liable for failing to obtain the informed consent of a client and/or parent/legal guardian to emergency examination and treatment, including blood transfusions, when delay in treatment would endanger the life, limb, or mental well-being of the client. Nonetheless, the client's parent/legal guardian should be informed of the HLW's authority to provide emergency treatment to the client as part of a review of routine and preventative treatment at the outset of treatment. Similarly, if such emergency treatment is rendered to a client, the parent/legal guardian should be informed as soon as possible, in keeping with the HLW's practice of fully informing the parent/legal guardian about the treatment of the client.

10.0 Withdrawal of Consent

Persons who have given consent are at any time free to withdraw their consent by giving written notice to their, or their client's clinician or prescribing physician, or

other appropriate HLW personnel. A withdrawal of consent shall become effective immediately upon receipt by the clinician or prescribing physician, whether received directly from the client or through other appropriate HLW personnel. Consequences of withdrawing consent are discussed in the HLW's policy on *Refusal of Treatment*.

11.0 The Responsibility of the Administration of the HLW

11.1 ***Information to be Provided Upon Admission.*** As soon as possible after admission to the Home (preferably within 72 hours of admission for inpatient and 24-hour residential programs the client and parent/legal guardian shall be informed of the client's rights, including informed consent, and the right to accept treatment, refuse treatment, or request alternatives to recommended treatment. At the HLW's in-patient and 24-hour residential programs, this information shall be provided by a human rights officer or clinical supervisor and by providing the client and parent/legal guardian with a copy of the written handbook on client's rights information (the "Handbook"). The Handbook is intended to supplement, and not replace, discussion with the client and/or parent/legal guardian.

11.2 ***Posting Consent Form for Psychotropic Medication.*** A blank copy of the *Consent Form for Psychotropic Medication* shall be posted in client areas. Similarly, copies of written material on psychotropic medications will be made available, translated into the appropriate language, whenever possible.

11.3 ***Posting Information Regarding Informed Consent.*** A separate document on *Informed Consent Rights* shall be posted in client areas. This posting shall reflect the values and principles embodied in this policy and shall convey that client and their parent/legal guardian have the right to consent to or refuse recommended treatment (without coercion, retaliation, or punishment), unless a court has ordered the treatment, or unless treatment is administered in an emergency situation.

11.4 ***Information Regarding Medications.*** Programs and facilities of the HLW that prescribe or administer medications shall have methods appropriate to clients' needs to provide, ongoing information and education about medication including, but not limited to, medication groups.

11.5 ***Implementation and Annual Review of the Policy.*** All health care providers who provide services at the HLW's programs and facilities shall review the requirements of informed consent annually. All staff involved in the delivery and dispensing of medication as well as human rights officers, will also review this annually. Implementation of this policy and its annual review is the responsibility of the Program Director of each of the HLW's facilities or programs.

12.0 Situations in Which Clinical and Legal Counsel May be Sought

Whenever questions arise as to the specific rights of a client and/or parent/legal guardian, appropriate supervisors and management personnel should be contacted for clarification and supportive second opinions. Staff should not hesitate to request consent to contact the HLW's legal counsel for advice on such questions. The HLW Counsel may, where necessary, contact the appropriate DMH/DCF legal offices.

E. Protection of Cultural and Religious Rights of Consumers

Purpose: To ensure that client in residential treatment have access to and are allowed to practice their sincere religious and cultural beliefs.

The Home respects diversity and the inherent right of client and families to practice religious beliefs. Each program shall allow for and take reasonable steps to arrange for the client to exercise their right to practice their religious beliefs. However, if the safety of the client or of other client is jeopardized, the agency reserves the right to cancel or restrict participation.

At the time of intake, parents/guardians shall be asked if the client will be attending religious services.

A client may elect to attend religious services at any time during their stay in the program.

If a client is restricted from religious observance for clinical reasons, those must be documented in the client's record and the client's parent/guardian must be informed.

If approved by the parent/guardian, a member of the clergy may visit the client in the program with proper notice. This does not mean the religious activity will occur in the program.

In accordance with M.G.L.c76 (15) a parent/legal guardian may object in writing to the administration of medical treatment to the client on the grounds that such treatment conflicts with their sincere religious beliefs. In such an instance, HLW will not require a client to receive medical treatment except in the case of an emergency or epidemic of disease declared by the DPH.

F. Policy on Refusal of Treatment

Purpose: To preserve the general rights of client of The Home for Little Wanderers ("The Home") and their parent/legal guardian to make informed decisions about treatment, including the right to refuse treatment.

Statement of Policy: Client of The Home and their parent/legal guardian have the right to refuse any services, treatment, or medication unless law or court order has limited such rights of refusal. In each instance, The Home informs a client and their parent/legal guardian of the consequences, if any, of such refusal. The Home reserves the right not to provide services or to terminate services if, in The Home's clinical judgment, such service refusal substantially interferes with the client's best interest, The Home's ability to treat the client, or otherwise prejudices The Home's ability to run the program.

Non-compliance with medication is a common issue in all areas of psychiatric and medical care. In the context of behavioral health care for children and adolescents, medication non-compliance may reflect a host of issues and concerns. The clinical team providing care to the client and family will consider the implications of medication non-compliance in their clinical formulation.

In the context of a therapeutic residential school program, medication non-compliance generally implies that the client has refused the medication that is offered. Client in residential programs frequently refuse prescribed medications. The current practice guideline provides a framework to guide the clinical response to such events.

1. The Development of the Initial Treatment Plan

   After admission and the signing of the Placement Agreement, the assigned clinician develops an initial treatment plan with the family. The assigned clinician provides a full explanation of the risks and benefits and requests informed consent (hereafter "consent") to the treatment. If medication is part of the treatment plan, the prescribing physician obtains consent for medication. When consent or a court order of substituted judgment is given, staff may proceed with treatment. Observations of treatment modalities are to be documented and placed in case records.

2. When a Parent/Legal Guardian Refuses to Accept the Treatment Plan

   If consent is refused by the parent/legal guardian, the assigned clinician/prescribing physician attempts to negotiate acceptable changes to the treatment plan with the parent/legal guardian. If such a modified plan is developed, the assigned clinician/prescribing physician provides a full explanation of risks and benefits and requests consent.

   If the parent/legal guardian continues to refuse consent to treatment even of the modified plan, the assigned clinician and Clinical Director convenes a meeting of the treatment team to determine whether the treatment that is being refused is an essential component of the treatment without which the program cannot meet the client's treatment needs, or if the presence of the untreated client in the program prejudices The Home's ability to operate the program in the interest of other children in the program.

If the treatment team determines that the needs of the client can be met without the proposed treatment, or with an alternative treatment approach, and that the program is not prejudiced thereby, such approach is proposed to the parent/legal guardian.

a. If accepted, treatment proceeds.
b. If not accepted by the parent/legal guardian, the assigned clinician and Clinical Director shall consult the Program Director, the Vice President for Placement Services, and the consulting physician, depending on the nature of the treatment refused, regarding whether the treatment refused is an essential component of the treatment plan for the client.

If these people at The Home agree with the assessment of the treatment team that effective treatment cannot be provided without the refused treatment component, or that there is unacceptable prejudice to the program, the Vice President for Placement Services will document this assessment and recommend options, in writing, to the Program Director. Options include, but are not limited to, termination of services, seeking a court order for treatment, and/or filing a 51(a) report of neglect. The Program Director will then instruct the Clinical Director, or designee, to implement the decision. If the decision is to terminate services, the treatment team will develop and implement a termination plan.

3. When a Minor Refuses Treatment

When a minor refuses to accept treatment, services, or medication consented to by their parent/legal guardian, staff shall respectfully listen to the client's wishes and concerns regarding treatment. If a client refuses to take a prescribed medication, the nurse, clinician or milieu staff will discuss the issue with the client. Staff should offer the medication/treatment three times, 15-20 minutes apart before considering it a refusal. The client should be given an opportunity to voice their concerns about the medication. The importance of consistent medication treatment and planned medication changes should be emphasized in a positive light. The client should be given time to review and possibly reconsider their decision. Client should NEVER be coerced into taking medication against their wishes. Refusals should be reported to Health Services and as directed, the client's health care provider according to orders (if not otherwise specified, the health care provider should be notified immediately). There should be a determination of whether the client is placed at a significantly heightened risk of an immediate medical event or complication because of medication non-compliance. Refusal of medications prescribed in conjunction with 1) a Rogers order, issued by a court of competent jurisdiction or 2) medications ordered pursuant to a substituted judgment decree on other than Rogers matters can constitute a medical emergency, and the health care provider shall be immediately informed. Non-emergency refusals are discussed in treatment team meetings and an effort is made to incorporate the client's thinking into adjusting and further developing the treatment plan.

If the treatment team determines that the proposed treatment component is essential to effective treatment, and the client continues to refuse the treatment, a behavior plan may be developed in collaboration with parent/legal guardian to encourage the client's participation. Parent/legal guardian must also consent to this behavior plan.

During this interim period, the client is not forced to receive treatment except authorized restraint (to which parent/legal guardian must have given consent), court ordered treatment, or emergency treatment ordered by a physician.

4. When a Client Refuses Medication

Medication refusal is NEVER an indication for a client to lose privileges within a program. However, medication refusal may occur in the context of a clinical presentation that may indicate the appropriate reduction in privileges. In such an instance, the clinical indications for the reduction in privileges (apart from the act of medication refusal) need be documented.

Medication refusal may place a client at heightened risk for a medical complication. This scenario may indicate a reduction in privileges to assure the health and safety of the client. The determination for a reduction in privileges to assure health and safety in this context must be established by a licensed health professional. Staff must document in the client record the process of determination, including the identity of the health professional consulted.

5. When Refusal of Treatment Leads to a Client's Termination from the Program

In a case where the refused treatment component is considered by the treatment team to be essential to treatment (or essential to assure that the untreated client does not materially prejudice the program), and inadequate progress is made in the collaborative effort among the program and the client and/or parent/legal guardian, The Home retains the right to terminate the client's treatment, such termination to be effectuated in an expeditious manner that also considers the client's needs for an orderly and clinically appropriate transition.

6. Procedure for Treating on an Involuntary Basis

Staff or parent/legal guardian may initiate a request for court approval to administer treatment involuntarily. Documentation of the order from a court of authorized jurisdiction is to be placed in the client's record.

7. Grievances

Client and parent/legal guardian may pursue grievances about treatment plans and processes, and management of The Home will monitor such grievances according to the *Client Grievances, Incident Reporting,* and *Critical Incident Investigations* policies and/or procedures of The Home.

II. Intake

A. Intake

Purpose: To meet the agency's commitment for quality, comprehensive and timely health care for client, the following intake components are required.

Unity House receives referral packets from sending school districts or other agencies (DCF or DMH). Prior to any consideration of acceptance to Unity House, an admissions application must be completed by the referring school district or referring agency and parent or guardian. Below is the needed information and attached is the *Admissions Application* form.

- *Admissions Application* form (which includes current diagnosis and medications list)
- Signed copy of the *Request for Residential Treatment*
- Current signed IEP
- Current DCF or DMH Service Plan
- Paperwork confirming Educational Surrogate Parent

The admissions team (comprised of clinical, education and health services personnel) meets as necessary to screen all referrals who have completed the admissions application process to ensure that each client meets eligibility requirements. If a client is found to meet requirements, an interview is scheduled with the prospective client.

An interview and tour onsite with the client and parent/legal guardian is preferred, but Unity House can send a representative to the client's current location if they are unable to tour in person. During the tour, a designee from health services will be available to meet with the client and/or parent/guardian to discuss any relevant health concerns.

After the interview, the admissions team convenes to further review the information obtained and to decide on acceptance or rejection of the referred client. Decisions are based on the compatibility of needs and services. If a client is deemed appropriate and their parent/legal guardian chooses the program, further paperwork is requested to complete the intake requirements.

Health Documentation Required:

- Copy of health insurance card
- Copy of birth certificate
- *Health History Form* (see Appendix)
- Results of the most recent physical, dental and vision appointment conducted not more than 12 months prior to the potential admission date
- Immunization information and TB test
    - 5 doses of DTaP/DPT
    - 4 doses of Polio
    - 3 doses of Hepatitis B
    - 2 doses of MMR
    - 2 doses of Varicella or record of chicken pox disease with written verification by the client's physician

- 1 dose of Meningococcal or waiver
- Rogers order signed by the court for administration of antipsychotic medication for a client in DCF Custody (Seroquel, Abilify, Zyprexa, Risperidal, Geodon, Clozaril)
- Rogers guardian information
- Updated *Medical Passport*, if available

Health Services will review serious or potentially serious health concerns related to the admissions information prior to intake into the program. With parent/guardian written consent, contact may be made with the client's primary care physician for additional information.

At or prior to intake, the clinician will ensure that the following informed consent documents are on file to ensure quality and legally sanctioned delivery of health services (see Appendix):

- ☐ *Admission Criteria Requirements*
- ☐ *Consent for Medication Administration*
- ☐ *Documentation Requirement Notification*
- ☐ *Authorization and Consent for Routine Health Care*
- ☐ *Consent for Emergency Medical Treatment*
- ☐ *Consent for Psychotropic Medication Administration*
- ☐ *Consent for Administration of Over-the-Counter PRN Medication*
- ☐ *Pelham Community Pharmacy Consent* (For residential client only)
- ☐ *MassHealth Authorized Representative Designation Form*
- ☐ *Signed Physician Medication Orders*
- ☐ *Consent to Request Records & Approval for Communication with Physicians*

B. Nurse Intake

At the time of intake, the parent/guardian will bring signed physician orders for current medications or treatment and the name, dose and time of the last medications(s) given. The parent/guardian will bring a 14-day supply of medications with them to the intake. The nurse will facilitate completion of the *Home for Little Wanderers Admission Health Assessment* with all available information within 72 hours of admission (see Appendix).

Prior to or at intake, Health Services will:

- ☐ Inform parent/guardian of all health-related services provided at the program.
- ☐ Review with guardian medication administration requirements regarding over-the-counter medications, delivery of medications to campus, and regular scheduled medications.
- ☐ The prescribing physician/psychiatrist will obtain written informed consent for each medication to be administered to the client while in The Home's care. See *Informed Consent for Treatment* practice guideline.
- ☐ Start the *Medication Administration Plan* for each prescribed medication with the guardian (see Appendix).
- ☐ Create *Individual Health Care Plan* (IHP) to become part of the medical record for each client with a chronic medical condition diagnosed by a physician. The IHP describes the chronic condition, symptoms, prescribed medication, potential medication side effects, and potential consequences to health while the client is in care (see Appendix).
- ☐ Inform staff of health-related information pertinent to care. If a nurse in not available that day, the intake will be rescheduled.
- ☐ Check all medications delivered by the pharmacy and received from home against the prescriber's orders.
- ☐ Ensure safe storage of all medications, including controlled substances.
- ☐ Enter countable substances in the *Countable Substances Log* to be signed by nurse and parent/guardian

C. Integrated Health Care

The nurse is a key member of an integrated team of direct staff working to promote the health and safety of client. The nurse coordinates and oversees each client's health care in coordination with the client, physician, clinician, state agencies, and parent/legal guardian.

Within one month of intake, the nurse will work with the client, parent/guardian, and staff to address the following:

- ☐ Promoting wellness: health goals, health education, growth and development, nutrition, BMI, exercise and other health habits
- ☐ Prevention: screenings, immunizations, routine health care, education
- ☐ Chronic health concerns including allergies and asthma
- ☐ *Emergency Action Plans*, as needed
- ☐ *Medication Administration Plan* for each prescribed medication
- ☐ *Traveling Medical Binder*

The nurse will schedule and ensure that vision, hearing, postural and other screenings are conducted according to M.G.L. regulations. When screenings are not conducted on program site they are included in the yearly physical exams through the client's primary care physician's office or clinic. All findings are documented in the client's record.

The nurse or clinician will prepare an *Emergency Fact Sheet* for each client. This sheet will be kept in a page protector in the front of each client's section of the medication administration book and travel binder and will include:

- ☐ Client's name and date of birth
- ☐ MA Health or other insurance info
- ☐ List of known allergies
- ☐ Photo
- ☐ Parent/guardian contact info
- ☐ Emergency back-up contact info
- ☐ Chronic medical conditions of the client
- ☐ Medication List
- ☐ GAL info
- ☐ Health care providers' contact information

The nurse will participate in the multidisciplinary team meetings; part-time nurses will participate as possible. The nurse will report on health status to include (but not limited to) current medications, medication changes, medication compliance, observed tolerance and effectiveness of medications, new allergies and conditions, nutritional status, hygiene, and exercise.

The Program Director in coordination with Director of Workforce Learning and Development and the nurse will ensure that direct care staff is up-to-date for health-related training requirements, e.g., CPR, first aid, standard precautions/blood borne pathogens, and medication administration.

The Director of Educational Services in coordination with Director of Workforce Learning and Development and the Principal will ensure that all HLW school staff receives mandated annual 766 health-related training.

The Director of Human Resources will ensure that records are maintained of all required trainings.

D. Return to Unity House after Admission to Outside Facility

While at Unity House, it may be necessary for a client to require outside assistance for either a physical ailment or psychiatric crisis. If a client is admitted to an outside facility for either medical or psychiatric needs, the Clinical Department and Health Services will work closely together to ensure a thoughtful transition back to Unity House. Prior to returning the Unity House, a meeting at the outside facility is recommended to ensure that all aspects of the transition are discussed (medications, discharge paperwork, transportation after discharge, etc.).

Prior to returning to Unity House, the discharging facility must fax or send electronically any new HCP orders for review along with medical clearance for school return specifying activity limitation along with the date of the next follow-up appointment to Health Services.

When the client returns to Unity House, the client will have a re-entry meeting with Health Services, the Clinical Department, and the school (if necessary). The Clinical Department will complete a risk assessment within 8 hours of returning to Unity House. If necessary, an email will be sent to all Unity House personnel with any additional plans or interventions.

III. Health Services

The ultimate goal of Health Services is to create a healthier, more teachable client population & healthier community.

A. Health Services Office Procedure and Guidelines

The nurse will schedule and ensure that vision, hearing, postural and other mandated screenings are conducted in a timely manner according to 105 CMR 200.100 (B) (1). Per MA 105 CMR 200.000, the purpose of mandated screenings is to identify and take appropriate actions with respect to disabilities and medical conditions of school children in public schools as soon as possible so as to enable all children to obtain the fullest benefit of their educational opportunities. The screenings are a tool used for referral and further follow-up and are not considered diagnostic. When screenings are not conducted on the program site they are included in the yearly physical exams through the client's primary care physician's office or clinic. All findings are documented in the client's record. A dated copy of request is kept in medical record until copies are obtained. If guardian requires help obtaining any screenings, the nurse can assist in this process.

HLW staff (direct care staff, clinicians, nursing staff) are often called upon to accompany client to medical and dental appointments. Only staff trained in TCI may accompany client to appointments. It is important that only staff members who know the client are assigned to this task. It is essential that staff accompanying client to appointments take the Traveling Medical Folder to the appointment and to ensure that client are returned to the program with clear written guidelines for care and follow-up. The written guidelines for care and follow-up must be given directly to the nurse or shift supervisor.

Traveling Medical Folder
The Traveling Medical Folder contains all the information needed for a client to be treated by a health care provider outside of Health Services. The folder will include:

1. Client's name, date of birth, known allergies, current medications, dates of immunizations, chronic health problems
2. Copies of recent *Health Encounter* forms
3. A copy of parent/guardian *Authorization for Treatment* forms
4. A blank *Health Care Report* form
5. A blank *Health Encounter* form
6. The MA Health or other insurance card

Health Service Visit / Office Guidelines
When clients request to be seen by the school nurse, teachers should call first to schedule a visit whenever possible. In the case of an emergency, nursing staff will be available by walkie during school hours.

Activity Restriction

The nurse must be informed of any activity restriction. A physician's note, detailing restriction, end date and physician follow-up date is required for any prolonged activity restriction when a client would miss more than one week of physical education. A screening by the school nurse is conducted for a client to return with a cast, sling, ace-wrap, or crutches. This screening, aids in assessing anticipated needs and resources. Physician's notes clearing clients to return to "restricted activity" is required in cases of concussions, other acute conditions/injuries, and continued follow-up, where there is no activity restriction end date specified.

B. General Management of Common Illnesses and Health Conditions

Staff will employ the Emergency Guidelines for all life-threatening or potentially life-threatening illness. In other situations, the following guidelines apply.

Assessment:

1. Staff will contact the nurse to assess the client following concerns of illness, injury, change in behavior, and/or complaint of pain/discomfort. The Nurse will assess the client, determine if a physician consult is required, then document the findings and actions. Following assessment, the nurse or physician will provide guidelines to staff for treatment and monitoring.

2. If the nurse is not on duty, staff reports symptoms to the shift supervisor. The staff refers to guidelines for the general management of certain common illnesses and health conditions outlined in this manual to help determine the seriousness of the situation and for minor illness interventions. If the situation warrants, the shift supervisor will call the on-call administrator to request that the health care provider be contacted. The shift supervisor and attending staff follow the treatment advice of the physician. To ensure follow-up, staff notifies the nurse ASAP of the illness and the steps that were taken to address the situation.

3. If you are unable to have a nurse or prescriber evaluate the client or consult with you by phone in a timely manner, call 911 and transport to nearest emergency room for assessment and treatment

1. Fever

The symptom of fever in client is extremely common. The degree of fever does not always correspond to the severity of the illness; neither does the absence of fever indicate absence of infection.

Normal ranges in body temperature are between 97.8 degrees F and 99.6 degrees orally. Normal ranges in body temperature can vary as much as 1.5 degrees, depending on amount of activity, emotional stress, type of clothing worn and temperature of the environment, and the time of day. Body temperatures in older client and adults fluctuate, the lowest peak occurring between 2 and 6 AM and the highest peak between 4 and 7 PM.

Most fevers are the result of an infectious process. A slight elevation in temperature may indicate dehydration.

Consult the nurse or physician if:

- ✓ Fever is greater than 100 degrees and/or persists for longer than two days.
- ✓ The client has symptoms of other illness, e.g. headache, stiff neck, irritability, light sensitivity, lethargy, loss of appetite, vomiting, and/or symptoms relating to ears, throat, lungs and abdomen.
- ✓ Do not hesitate to consult the nurse or physician if you have concerns in addition to those listed above.

General Management of Fever

- ✓ Increase oral fluid intake to prevent dehydration as tolerated.
- ✓ Ensure that the room temperature is comfortable, and that air can circulate.
- ✓ Monitor fevers at least every 2-4 hours when awake. Observe and monitor the sleeping client every 2 hours. Do not hesitate to awaken to check temperature if you have any concerns about the condition of the client.
- ✓ The nurse or physician may recommend that the client be given PRN medication for fever of 101 degrees or above (check the client's individual PRN Order sheet). Do not give a fever PRN medication without consulting the nurse. Never give aspirin with a fever.

Upper Respiratory Infection

- ✓ Control of fever (see fever instructions).
- ✓ Rest.
- ✓ Instructions in frequent hand washing.
- ✓ Increase fluid intake, especially water and fruit juice. Caffeine in soda may present problems; milk can often cause thickening of mucus in the throat.
- ✓ Cool mist humidifier may be used to relieve stuffy nose or troublesome cough. Check with the nurse for appropriate use.
- ✓ Check the medication book for standing orders for lozenges, cough syrup, decongestant and Tylenol. Follow the PRN order medication guidelines for the client. Consult the nurse prior to giving PRN medications.

2. The Common Cold

Colds are the most common infectious disease in client. Susceptibility to colds is universal. The average client has from three to eight colds per year. Colds are caused by a variety of viruses and antibiotics will not have an effect on the virus. The most frequent symptom of a cold in school age and older client:

- ✓ Temperature between 99-101 degrees that lasts from a few hours to a few days.
- ✓ Stuffy and runny nose.
- ✓ Sneezing.
- ✓ Sore throat.
- ✓ Decreased appetite.
- ✓ Irritability.
- ✓ Sometimes achy muscles and joint pains (flu-like symptoms).

A cold usually lasts three to ten days with a low-grade fever (less than 101 degrees) on the second or third day, after which symptoms gradually disappear.

When a client has symptoms of a cold and any of the following consult the nurse or physician. Do not hesitate to consult the nurse or physician if in doubt about the client's condition.

- ✓ Fever on 100 degrees or higher.
- ✓ Symptoms are not improving by the fourth day.
- ✓ Client is having difficult or rapid breathing, or chest pain cough is producing yellow, green or gray sputum.

3. Sore Throat

Viruses most often cause sore throats, although 30-50 percent of the acute Pharyngitis in school age client is caused by streptococcal infection. The only accurate way to distinguish between a strep infection and a viral sore throat is by throat culture. It is better to err on the side of caution and refer to a physician for a throat culture if:

- ✓ The client's sole or predominant complaint is sore throat
- ✓ Client has associated elevated temperature
- ✓ Client has other complaints such as abdominal pain, headache, vomiting, malaise
- ✓ Client has been in close contact with someone with diagnosed strep infection.

4. Vomiting and Diarrhea

Vomiting and Diarrhea are common in client. They can be caused by many illnesses such as ear infections, colds, stomach viruses, allergies and urinary tract infections. **Client tend to lose body fluids rapidly when they are ill, so they must be watched carefully.** Signs of dehydration are dry mouth and lack of urination for 7-8 hours. If the following signs are present, it is important to contact the client's primary care provider, and the nurse:

- ✓ Signs of dehydration (dry mouth, lack of urination)
- ✓ Severe abdominal pain
- ✓ Any blood in stool
- ✓ No improvements with 48 hours
- ✓ Persistent fever for more than 12 hours

General Management of Vomiting and Diarrhea:
Dietary modifications are the major treatment. It is important to replace fluids, not calories, and to give foods and fluids that be easily digested.

- ✓ Do not offer the client anything to eat for 2 hours after vomiting and begin with only sips of clear fluid after 1 hour. If the client is asking for something to eat or drink, avoid carbonated beverages, e.g. soda.
- ✓ Begin sips of clear fluid gradually every 15-30 minutes; large amount of fluid may cause the client to vomit again. Avoid all milk and dairy products; they are hard to digest. Examples of clear fluids are ice chips, water, popsicles, jello, ginger ale, clear chicken or beef broth with fat removed.
- ✓ Continue to give clear fluids for 12-14 hours.
- ✓ If there has been no further vomiting and the client wishes to eat, begin with a soft solid diet (see following for soft solid diet).
- ✓ If diarrhea is the only problem (no fever, no vomiting, no abdominal pain) a bland diet can be generally be given. Five clear fluids if other symptoms are present.
- ✓ If client manages a bland diet for 24 hours without difficulty, return to regular diet, adding raw fruits, vegetables, dairy products and fried foods last.

Other complaints:
Consult the nurse or the client's health care provider immediately or call 911 for complaints of severe abdominal pain, chest pain, headache, or sudden sensory/motor disturbance.

Dietary Recommendations
Clear Liquid Diet: Clear liquid diets are recommended for client who are experiencing vomiting and diarrhea. Clear liquid is any liquid you can see through. There should be no particles. Examples of clear liquids are:

- ✓ Ginger Ale
- ✓ Clear chicken or beef broth
- ✓ Water of ice chips, cubes
- ✓ Jello

✓ Popsicles (DO NOT USE juice bars)
✓ **No** milk or dairy products

Bland Diet: Bland diets are often recommended for one to several days after a client's vomiting has stopped and the client is beginning to feel better. Spices are eliminated in a bland diet. For breakfast, cooked cereals and toast are good choices. Foods to avoid are: juice, bacon, sausage, seasoned eggs, granola, bran and high fiber cereals. At lunch and dinner, rice, mashed potatoes, vegetables, baked meat or fish, as well as soups, sherbet, jello, crackers, skim milk, applesauce, and bananas. Fried foods, salads, and raw fruit should be avoided.

Extra Fluids: Extra fluids (more than 6-8 glasses per day) are often recommended for those on medications, with current illness or infection, and during times of hot weather and exercise. Offer and encourage increased fluid intake during these times. Fluids should be decaffeinated to prevent dehydration.

Increased Fiber Diet: Increased fiber diets may be recommended for constipation and to promote regular emptying of the bowel. Fiber is the part of the food not digested by the human body. High fiber foods include raw fruits: apples or pears with the skin on, whole oranges, dried fruits such as prunes, apricots, raisins, cooked or raw vegetables including broccoli, carrots, green beans, cauliflower, corn, baked potatoes, spinach, sweet potatoes, whole grain breads and cereals (for example, oat bran, whole wheat, granola and raisin bran).
*Extra fluids taken with high fiber foods aid in bowel cleansing. *

5. Allergies

Unity House is committed to providing a safe and nuturing environment . Recognizing the increasing prevalence of life-threatening allergies in the population, Unity House will work in cooperation with parents, guardians, client and physicians to minimize risks and to provide a safe educational environment for all client. The focus of allergy management will be prevention, education, awareness, communication and emergency response. All HLW schools and residential programs are peanut and tree nut free. Unity House will make efforts to utilize latex free products.

Responsibilities of the School Nurse

- The nurse will obtain allergy information from referral materials and from parents/guardians during the intake health assessment.
- The nurse will meet with the client and parent/guardian to identify ways the program and the client will contribute to the management of the allergy.
- The nurse will obtain written recommendations for allergy management from the diagnosing or primary care physician.
- The nurse will develop an individual allergy action plan based on physician recommendations and discussion with the client and guardian and review this with program staff. The plan will include specific information about the client's allergy, past reactions, associated symptoms, measures to reduce exposure to client-specific allergens, and client-specific directions for responding to an allergic episode. A copy of the plan will be placed in the client's record.
- The nurse records allergy information onto the Medication Administration Log, the Physician's Order Sheet and the Health Service Treatment Plan. A brightly colored allergy alert sticker will be adhered to the cover of the client's record.
- The nurse supplies and regularly updates a list of current client with known allergies to the program director and site supervisors, along with measures to reduce exposure to allergen.

Responsibilities of Staff

- Staff will familiarize themselves with the allergy action plan of each client.
- Staff will know signs and symptoms of severe allergic reactions as provided in client's emergency action plan.
- Staff will participate in in-service training about client with life-threatening allergies.

6. Asthma

Asthma is a disease that affects the lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medication and avoiding triggers which aggravate asthma. Removing triggers from the environment which make asthma worse can help to improve it.

Triggers for asthma include dust mites, tobacco smoke, outdoor air pollution, cockroach allergen, pets, mold, smoke from burning wood or grass, infection, strong emotions that lead to hyperventilation, and exercise. Limiting or avoiding when possible exposure to asthma triggers helps decrease incidence of asthma exacerbations.

Goals of asthma treatment focus on:

- ☐ Reducing impairment: The frequency and intensity of symptoms and functional limitations currently experienced by a client
- ☐ Reducing risk: The likelihood of future asthma attacks, progressive decline in lung function, or medication side effects.

The goals of asthma management are for the client to enjoy an active life, to participate in normal activities, to sleep uninterrupted through the nights, and to minimize side effects from asthma medication.

At Intake:

The nurse will meet with the parent of guardian at or prior to admission to obtain a comprehensive health history. If the client is currently being treated for asthma or has a history of asthma, the nurse will:

- ✓ Obtain from the parent/guardian information specific to the client about the conditions that are likely to trigger an asthmatic episode, the frequency and severity of the asthmatic attacks, and the steps to be taken should attack occur.
- ✓ The nurse will request the parent/guardian to obtain the asthma action plan from the diagnosing or prescribing physician to guide management while the client is in the program. If the client is not currently being followed by a physician for the condition, a referral is scheduled.
  - ☐ If the prescribing physician order includes instructions that the client carries the inhaler, the school nurse will assess the youth's ability to self-administer inhaler and the plan will be discussed in multidisciplinary team meetings (MTD).
  - ☐ The nurse will ensure that the inhalers are labeled with a pharmacy label including the client's name, name of medication, dose, frequency of administration, route of administration, any specific directions for administration (e.g., every four hours as needed for wheezing) and the name of the prescribing physician.
- ✓ Obtain a written prescription order from the prescribing physician for any inhaler medication administered to the client in the program.

- ✓ Obtain written order for the use of a peak flow meter, if included in the physician's guidelines.
- ✓ Obtain a written order for a spacer, if recommended by the prescribing physician.
- ✓ Inform all staff who will be working with the client of the asthma condition, the specific triggers, symptoms of episodes, guidelines for management, location of inhaler and specific instructions for emergencies.

The nurse will enter the asthma medication order on the *Medication Administration Record*.

Integrated Care:

The nurse will develop an asthma episode prevention, monitoring and management plan as part of the client's *Asthma Action Plan*. This plan will be a part of the client's *Individual Health Services Plan*.

This list will include:

- ✓ A list of medications, dose, time and route of administering and any other pertinent medication information
- ✓ Plans for daily management
- ✓ Environmental safeguards
- ✓ A specific plan of action of staff in case of an acute episode
- ✓ Location of inhalers
- ✓ List of staff instructed in the specific use of the inhalers for the client
- ✓ A clearly defined emergency plan, including instructions for transportation
- ✓ Field trip guidelines
- ✓ A specific plan for staff members to educate, counsel, and support the client toward self-management of asthma, in collaboration with the parent/guardian

Asthma Action Plans:

An asthma action plan is specific to the client and used as a guideline to monitor and control a client's asthma symptoms and improve overall function and well-being. An asthma action plan includes daily treatment, such as what kinds of medications to take and when to take them. The asthma action plan includes instructions on how to recognize early signs, symptoms, and includes peak flow meter parameters individual to the client which aid in identifying worsening asthma. It describes how to control asthma long-term and how to handle worsening asthma, asthma attacks, and when to call the doctor or go to the emergency room. It also describes how to give the client medications and remove or withdraw from them environmental factors which may trigger an asthma exacerbation. The asthma action plan should be developed with the client's health care provider, in partnership with the client and/or client's guardian to help control their asthma. All of the people who care for the client should know about the client's asthma action plan, so that they can help the client follow his or her action plan. Specific instructions of whom and when to call should be included in the asthma treatment plan. The client plays a central role in the management of their asthma by learning

to identify the early warning symptoms, knowing who to notify and the locations of inhalers.

Link to Asthma Action Plan:
http://www.lung.org/assets/documents/asthma/asthma-action-plan-for-home.pdf

Management of Acute Asthma Exacerbations:

- ✓ It is essential to teach client how to monitor signs and symptoms of worsening asthma, and to take appropriate action. This shall be done by the nurse in conjunction with the health care provider responsible for overseeing management of the client's asthma.
- ✓ Staff working with the client shall be trained by the nurse which includes an overview of the condition, education on goals of asthma treatment, asthma triggers, implementing asthma action plans, and proper inhaler administration, management of acute asthma exacerbations, and emergency asthma situation instructions, if an approved DPH program. The purpose of this training is to enable staff to pro-actively recognize the onset of acute and chronic asthmatic symptoms for referral to the school nurse to further assess. A copy of this training and information should be available at every program site for reference. Direct care staff is trained in the General Protocol for Management of an Acute Asthma Exacerbation, so they are prepared to assist a client experiencing an exacerbation in an emergency situation when a client's asthma action plan is not readily available for reference and the school nurse is not readily available.
- ✓ The client's *Asthma Action Plan* shall be utilized by program staff in the management of an acute asthma exacerbation when possible.
- ✓ Symptoms of a serious acute asthma exacerbation include, but are not limited to:
    - Marked breathlessness
    - Inability to speak short phrases
    - Drowsiness
    - Increased breathing effort

General Protocol for Management of an Acute Asthma Exacerbation:

- ✓ Initial treatment: Give asthma medication as prescribed and separate client from trigger if possible.

- A good response is characterized by absence of wheezing, no shortness of breath, and/or no rapid breathing after proper administration of the prescribed rescue inhaler by school nurse or trained staff, if approved DPH program, or by the client when possible. It is also characterized by the client returning to baseline function.
    - Staff will notify Health Services and/or if not available their staff supervisor. The school nurse will continue to monitor client for recurrent symptoms.
- An incomplete response is characterized by persistent wheezing, shortness of breath, and rapid breathing after proper administration of the client's prescribed rescue inhaler by trained staff or by the client when possible.
    - Staff will contact Health Services immediately for further instruction and notify the staff supervisor. The nurse will be notified and will assess the client when available. A client's health care provider shall be notified.
- A poor response is characterized as continued marked wheezing, rapid breathing, shortness of breath, or cessation of breathing.
    - If distress is severe and non-responsive to initial treatment, Health Services shall be notified immediately, and staff will call 911.

The nurse will provide a list of staff members trained in administering inhalers in an emergency to the Program Director and site supervisor. The nurse, in consultation with the Program Director will determine inhaler storage location for easy access and will inform staff of the location.

The staff member who has administered the emergency medication will ensure that the asthma inhalers are returned to their designated storage location following their use. In all instances a description of the asthmatic episode will be documented in the client's record. The staff member who has administered the medication will inform the shift supervisor of the episode and will document it in the daily log.

7. Seizures

When the normal workings of the brain are disrupted by injury, disease, fever, or infection, the electrical activity of the brain becomes irregular. This can cause a loss of body control known as a seizure. The location of the disruption of electrical activity in the brain, how it spreads, how much of the brain is affected, and how long it lasts all may have profound effects. These factors determine the characteristics of a seizure and its impact on the individual. The symptoms of a seizure can affect any part of the body.

Seizures may be precipitated by extreme heat, a diabetic condition, an injury to the brain, high temperature, or a drug reaction or overdose. Sometimes the cause of a seizure is unknown. Other commonly reported triggers of seizures include but are not limited to: a specific time of day/night, sleep deprivation, fever or other illness, flashing bright lights or patterns, alcohol or drug use, hormonal changes, not eating well or having a low blood sugar, specific foods such as excess caffeine, and use of certain medications.

Seizures may be caused by a chronic disease. The chronic disease is known as epilepsy. Epilepsy is a neurological disease which effects the nervous system. Epilepsy means the same thing as "seizure disorder". Epilepsy is characterized by unpredictable, recurrent, unprovoked seizures and can cause other health problems. Epilepsy is a spectrum condition with a wide range of seizure types and control which vary from person to person. Epilepsy may be controlled with medication. Some people with epilepsy have seizures from time to time even when medication is effective in controlling most of their seizures.

A client with seizures may experience an aura before the seizure occurs. An aura is an unusual sensation or feeling such as a visual hallucination, strange sound, taste, smell, or an urgent need to get to safety. If the client recognizes the aura, they may have time to tell others and get to a safe place before the seizure occurs. Seizures range from mild, short blackouts that others may mistake for daydreaming to sudden and uncontrolled muscular contractions (convulsions) which may last several minutes. It may be frightening to see someone unexpectedly having a seizure.

There are many different types of seizures. These include seizures with altered awareness, seizures without any change in awareness, and seizures with loss of consciousness. During a seizure without any change in awareness, the client may remain fully awake and alert and remember everything that occurred during a seizure. During a seizure with altered awareness, a client may look awake, but they are not aware or only partly aware of what is going on around them. In this situation, the client may walk around during the seizure but not know what they are doing and may not be able to protect themselves. A client with altered awareness during a seizure may have difficulty talking about or remembering what happened during the seizure afterwards. During a seizure with loss of consciousness, the client will not remember what happened during the seizure and may not be aware of what happened afterwards. In any type of seizure, the most important objective

is to keep the client safe and provide general comfort measures until the seizure resolves itself and seek emergency medical help if necessary; as outlined in Seizure Protocol Guidelines below.

It is important to be aware of the impact epilepsy may have on someone's life. There are some health problems or symptoms which are seen more often in people with seizures than people without seizures. This could be related to the seizures, or it could be due to whatever is causing the epilepsy. Awareness of these symptoms can help them be addressed promptly by the client's health care provider, so they can receive the appropriate treatment if necessary.

A seizure is considered an emergency when it lasts greater than 5 minutes (if not otherwise stated) or when seizures occur close together and the client doesn't recover between the seizures. Just like there are different types of seizures, there are different types of seizure emergencies. Being aware of the different types of seizure emergencies is important in order to recognize them and get the appropriate medical help.

At Intake:
The nurse will meet with the parent or guardian at or prior to admission to obtain a comprehensive health history and review current health conditions. If a client is known to have seizures, the nurse will:

- ✓ Obtain from the parent/guardian information specific to the client about the condition. The program nurse will request that the parent/guardian obtain written guidelines from the client's neurologist to guide management while the client is in the program.
- ✓ Obtain a written order for any medication the client is currently taking to control seizures.
- ✓ Inform all staff who will be working with the client of the condition, the possible triggers, and guidelines for management.
- ✓ The nurse will inform the client's health care provider of the seizure medication for review in relationship with other medications prescribed for the client.
- ✓ The nurse will enter the anti-seizure medication order on the *Medication Administration Record*.

Integrated Care:
The nurse will include guidelines for epileptic seizure prevention, monitoring, and management in the *Individual Health Services Plan*.
This plan will include:

- ✓ Anti-seizure medication
- ✓ *Seizure Action Plan*: a specific plan of action for staff in case of a seizure (see Appendix)
- ✓ A clearly defined emergency plan
- ✓ Field trip guidelines
- ✓ A specific plan for staff members to educate, counsel and support the client in self-management of the condition, in collaboration with the physician, parent and guardian

The nurse will promote opportunity for the client, staff and guardian to develop a working partnership in management of the seizure disorder.

Seizure First Aid Protocol:

CDC Guidelines - First aid for generalized tonic-clonic (grand mal) seizures:

When most people think of a seizure, they think of a generalized tonic-clonic seizure, also called a grand mal seizure. In this type of seizure, the person may cry out, fall, shake or jerk, and become unaware of what's going on around them.

Steps for what to do if someone is having a generalized tonic-clonic seizure:

- ✓ Ease the person to the floor.
- ✓ Clear the area around the person of anything hard or sharp. This can prevent injury.
- ✓ Loosen ties or anything around the neck that may make it hard to breathe.
- ✓ Time the seizure. Pay attention to how long it takes someone to become fully aware after the seizure has ended.
- ✓ Put something soft and flat, like a folded jacket, under his or her head.
- ✓ Remove eyeglasses.
- ✓ Turn the person gently onto one side. This will help the person breathe.
- ✓ Always stay with the person until the seizure is over and the person is fully aware.
- ✓ Keep onlookers away and stay calm.

Never do any of the following things:

- ✓ Do NOT hold the person down or try to stop his or her movements.
- ✓ Do NOT put a pillow under someone's head who is having a seizure. This can cause suffocation.
- ✓ Do NOT put anything in the person's mouth. This can injure teeth or the jaw. A person having a seizure cannot swallow his or her tongue but may choke on objects placed in their mouth.
- ✓ Do NOT try to give mouth-to-mouth breaths (like CPR). People usually start breathing again on their own after a seizure.
- ✓ Do NOT give the person anything by mouth (food, water, medication, etc.) until they are fully awake and alert. If they have never had a seizure before or you are unsure, do not give them anything by mouth until emergency assistance arrives.

Call 911 if:

- ✓ The person has never had a seizure before.
- ✓ The person has difficulty breathing or waking after the seizure.
- ✓ The seizure lasts longer than 5 minutes.
- ✓ The person has another seizure soon after the first one.
- ✓ The person is hurt during the seizure.
- ✓ A head-strike is observed or suspected during the seizure.
- ✓ The seizure happens in water.

✓ The person has a health condition like diabetes, heart disease, or is pregnant.

General First Aid for All Seizure Types:
The first line of response when a person has a seizure is to provide general care and comfort, and to keep the person safe. There are many types of seizures. Most seizures end in a few minutes. Seizures may vary from one person to the next.

These are *general* steps to help someone who is having any type of seizure:

✓ Stay with the person until the seizure ends and he or she is fully awake.
✓ Comfort the person and speak calmly.
✓ Check to see if the person is wearing a medical bracelet or other emergency information.
✓ Keep yourself and other people calm.
✓ Keep onlookers away to give the person experiencing the seizure privacy and space.
✓ After it ends, help the person sit in a safe place. Once they are alert and able to communicate, tell them what happened in very simple terms.
✓ Make sure the person is fully aware of what is going on before they are left alone.

First aid for seizures without any change in awareness:
Characteristics: A person remains fully awake, aware, and alert during a seizure and may remember everything that has occurred. During these types of seizures, pay attention to the following:

✓ You may not need to do anything.
✓ Stay calm and reassure the person they are safe.
✓ If the person is frightened or anxious, encourage them to take slow deep breaths.
✓ Stay with the person until the seizure is over. Make sure they are fully awake and alert before they are left alone.

First aid for seizures with altered awareness:
Characteristics: A person may look awake during a seizure, but they are not aware of what is going on around them. They may not remember what happened during the seizure, or may have difficulty talking about it during or after it. The person may walk around during the seizure, but have no control of where they are going, and they may not be able to protect themselves. These behaviors may be seen with complex partial seizures or clusters of absence seizures, which can also present as "daydreaming." During these episodes, in addition to basic first aid, pay attention to the following:

✓ If the person has an aura, or 'warning' before they lose awareness, help them to a safe place.
✓ Stay with the person and do not let them wander away. Let them walk in an enclosed, safe area if necessary.
✓ Keep the person away from sharp objects or dangerous places, such as heights, stairs, or sharp objects.

- ✓ Time the seizure - these seizures are usually longer than convulsions or tonic-clonic seizures. It may be hard to tell when the seizure ended, or when the recovery period begins and ends.
- ✓ If the seizure turns into a convulsive seizure, follow first aid steps for tonic-clonic seizures.

First aid for seizures with loss of consciousness:
Characteristics: A person may lose awareness completely and be considered unconscious. They are not able to talk, are not aware of what is going on around them and may not realize what occurred afterwards. If they have a warning at the start of the seizure, they may be able to get to a safe place. They are at risk for injury during and after the seizure. *Follow the steps for care and comfort first aid and generalized tonic-clonic seizure first aid* with attention to the following:

- ✓ Watch how long the seizure lasts - Call 911 for emergency medical help if a generalized or tonic-clonic seizure lasts 5 minutes or longer.
- ✓ Watch their breathing - turn them on their side to help keep their airway open.
- ✓ If breathing problems occur or if the person appears they are choking, call 911.
- ✓ Don't put anything in their mouth.
- ✓ Do not give the person anything by mouth after the seizure until they are fully awake, alert, and oriented.
- ✓ Always stay with the person until they have regained consciousness and are fully awake, alert, and oriented.

Epilepsy and Associated Impact:
To provide holistic care, we must consider associated consequences that epilepsy may have on a person's life. Some health problems or symptoms are seen more often in people with seizures than in people without seizures. These may be related to the seizures, related to whatever is causing the epilepsy, or completely unrelated to the seizures. Recognizing when any of these concerns occur can help them be addressed promptly by a health care professional. Some related conditions include:

- ✓ "Not doing well" at home, school, work, or with friends
- ✓ Cognitive or learning problems that require special help or accommodations
- ✓ Symptoms of depression, anxiety, or other changes in mood or behavior
- ✓ Problems sleeping
- ✓ Unexplained injuries, bruises, falls, or other illnesses

Seizure Emergencies:
A seizure is considered an emergency when it lasts greater than 5 minutes (unless otherwise stated by emergency action plan), or when seizures occur close together and the person doesn't recover between seizures. Just like there are different types of seizures, there are different types of emergencies. Certain risk factors may increase someone's chances of having a seizure emergency.

Types of Seizure Emergencies:

- ✓ *Seizure clusters*: These may not be an emergency by itself, but a cluster of seizures that occur close together or get longer could develop into an emergency situation. By recognizing a cluster or group of seizures, appropriate

medical help can be obtained, and the development of an emergency may be prevented.

- ✓ *Status epilepticus*: This is a **medical emergency** when seizures last longer than 5 minutes or occur too close together. Status epilepticus can be convulsive or non-convulsive. The person may be confused, not fully aware of what is going on, or unconscious. **This can be life threatening - everyone should know how to recognize what status epilepticus is, and when to call for emergency help.**

  Signs of status epilepticus:
  - Any seizure lasting longer than 5 minutes
  - A person goes into a second seizure without recovering consciousness from the first one
  - A person is having repeated seizures for 30 minutes or longer
  - A person who has non-convulsive seizures has seizures which last longer and occur more often than their typical seizure
- ✓ *Injury or illness:* The most common types of injuries from a seizure are cuts, bruises, and burns. Seek prompt medical attention for the following serious seizure-related injuries:
  - Serious cuts, bruises, burns, or swelling
  - Head trauma which is observed or suspected
  - A seizure occurs in water - get the person out of the water and call 911

If problems or new symptoms occur days or hours after a seizure, do not ignore them. These include: fever, pain, shortness of breath, cough, headache, or other changes.

Epileptic Seizure Triggers and Prevention:

There are many triggers of seizures, which may vary from person to person. Some common triggers of epilepsy and the best ways to prevent them are outlined below:

- ✓ Illness: Being sick with an acute infection or illness is a common trigger for seizures in people with epilepsy. These may include head colds, lung infections, or sinus infections.

  Steps to avoid seizures related to illness:
  - Keep a 'seizure diary' and note any triggers that occur, such as infection, cold, or other illness.
  - Get an adequate amount of sleep.
  - Stay hydrated and receive adequate nutrition. Dehydration related to vomiting and diarrhea can worsen seizures.
  - Continue to take seizure medication as prescribed by the health care provider. Contact the prescriber if nausea and vomiting is present to determine appropriate dosing.
  - Handwashing is the best way to avoid becoming sick and spreading infection.
  - Photosensitivity (Photosensitive epilepsy): Some people with certain types of epilepsy may be triggered by exposure to television screens, computer monitors, video games, strobe lights, and visual patterns. Not all of these stimuli trigger seizures, and the frequency and speed of flashing light differs from person to person. If a person is suspected of having photosensitive epilepsy, they should check with their physician.

- Avoid watching television.

✓ Sleep deprivation: A lack of "good sleep" makes most people more likely to have seizures, and can increase the intensity of length of seizures. Sleep deprivation may be a trigger alone, or when combined with other triggers.
Steps to avoid sleep deprivation:
  - Avoid caffeine at least 6 hours before bedtime
  - Keep a regular sleep and wake schedule
  - Make sure the sleeping environment is quiet and dark
  - Exercise regularly

C. Medication Follow-Up Protocols (labs, EKGs, vital signs, etc.)

The following are protocols for monitoring individual medications:

Psychostimulants

Methylphenyldate and Dextroamphetamine
Baseline: VS, ht/wt, BMI, CBC, LFT's, EKG, clarify any history of tic disorder
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC

Pemoline
Baseline: VS, ht/wt, BMI, CBC, LFT's, EKG
Stabilizing Dose: VS, ht/wt, BMI
q. 2 weeks: ALT (SGPT)
q. 3 months: LFT's

Antidepressants

SSRI's
Baseline: ht/wt, BMI, VS, CBC, LFT's
q. 6 months: ht/wt, BMI, VS
q year: CBC, LFT's

Tricyclics
Baseline: ht/wt, BMI, VS, CBC, LFT's, EKG
Stabilizing Dose: Vital signs, ht/wt, BMI, TCA level(s), EKG
q. 3 months: Vital signs, ht/wt, BMI
q. 6 months: TCA level, CBC, LFT's, EKG

Venlafaxine (Effexor)
Baseline: ht/wt, BMI, VS, CBC, LFT's
Stabilizing Dose: VS
q. 3 months: ht/wt, BMI, VS
q. year: CBC, LFT's

Buproprion (Wellbutrin)
Baseline: VS, ht/wt, BMI CBC, LFT's, confirm no history of seizure or abnormal EEG
Stabilizing Dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Trazadone (Desyrel)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing Dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Nefazodone (Serzone)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing Dose: VS
q. 3 months: VS, ht/wt, BMI, LFT's
q. year: CBC

Mirtazapine (Remeron)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing Dose: VS
q. 3 months: VS, ht/wt, BMI, CBC
q. year: LFT's

Antipsychotics

Typical Antipsychotic Agents
Baseline: VS, ht/wt, BMI, CBC, LFT's, prolactin, AIMS, **EKG**
Stabilizing dose: VS, EKG (thioridizine and mesoridizine)
q. 3 months: VS, ht/wt, BMI
q. 6 months: LFT's, AIMS, EKG (thioridizine and mesoridizine)
q. year: CBC

Atypical Antipsychotic Agents
Olanzapine (Zyprexa), Rispiridone (Rispiridal), Aripiprazole (Abilify)
Baseline: VS, ht/wt, BMI, waist circumference, CBC, LFT's, glucose, lipid profile, cholesterol, prolactin, AIMS
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI, waist circumference
q. 6 months: CBC, LFT's, glucose, lipid profile, cholesterol, AIMS

Quitiapine (Seroquel)
Baseline: VS, ht/wt, BMI, waste circumference, CBC, LFT's, glucose, lipid profile, cholesterol, prolactin, slit lamp eye exam, AIMS
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI, waste circumference
q. 6 months: CBC, LFT's, glucose, lipid profile, cholesterol, eye exam, AIMS

Ziprasidone (Geodon)
Baseline: VS, ht/wt, BMI, waste circumference, CBC, LFT's, glucose, lipid profile, cholesterol, prolactin, EKG, AIMS
Stabilizing dose: VS, EKG
q. 3 months: VS, ht/wt, BMI, waste circumference
q. 6 months: CBC, LFT's, glucose, lipid profile, cholesterol, EKG, AIMS

Clozapine (Clozaril)
Baseline: VS, ht/wt, BMI, waste circumference, CBC, LFT's, glucose, lipid profile, cholesterol, prolactin, EKG, results of any prior EEG or history of seizures, AIMS
Stabilizing dose: VS
Weekly to every other week: CBC
q. 3 months: VS, ht/wt, BMI, waste circumference
q. 6 months: LFT's, glucose, lipid profile, cholesterol, EKG, AIMS

Mood Stabilizers

Lithium (Eskalith, Lithobid)
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, calcium, LFT's, TSH,U/A, EKG
Stabilizing dose: Lithium level
q. 3 months: VS, ht/wt, BMI, Lithium level, CBC, electrolytes, BUN, creatinine, LFT's, TSH, U/A
q. year: Calcium, EKG

Valproate (Depakote, Depakene)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing dose: Valproate level, CBC, LFT's
q. 3 months: VS, ht/wt, BMI, Valproate level, CBC, LFT's

Carbamezapine (Tegretol)
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, TSH, T4, U/A
Stabilizing dose: Carbamezapine level, CBC, LFT's
q. 3 months: VS, ht/wt, BMI, Carbamezapine level, CBC, electrolytes, BUN, creatinine, LFT's

Oxycarbazepine (Trileptal)
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, TSH, T4, U/A
Stabilizing dose (1-2 months): VS, electrolytes, BUN, creatinine
q. 3 months: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, T4, TSH

Gabapentin (Neurontin)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Lamotrigine (Lamictal)
Baseline: VS, ht/wt, BMI, CBC, LFT's, clarify history of rash reactions to medications
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Topirimate (Topamax)
Baseline: VS, ht/wt, BMI, CBC, bicarbonate, LFT's, clarify any preexisting eye disease/tendency toward glaucoma
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI, bicarbonate
q. year: CBC, LFT's

Alpha 2 Agonists

Clonidine (Catapress) and Guanfacine (Tenex)
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, EKG
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's, EKG

Anxiolytics

All benzodiazapines, clonazapam. alprazolam, buspirone
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC, LFT's

Benedryl, Atarax, Vistaril
Baseline: VS, ht/wt, BMI
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI

Beta Blockers

All beta blockers
Baseline: VS, ht/wt, BMI, CBC, LFT's, EKG
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. 6 months: CBC, LFT's, EKG

Other Agents

Strattera (Atomoxitine)
Baseline: VS, ht/wt, BMI, CBC, LFT's
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. year: CBC,LFT's

DDAVP
Baseline: VS, ht/wt, BMI, CBC, electrolytes, BUN, creatinine, LFT's, U/A
Stabilizing dose: VS
q. 3 months: VS, ht/wt, BMI
q. 6 months: CBC, electrolytes, BUN, creatinine, LFT's, U/A

IV. Preventative Health Care

A. Physical Exams & Screenings Requirements

The Home for Little Wanderers recognizes the importance of an interdisciplinary team approach when coordinating and providing preventative health care services to our clients. HLW promotes routine preventative health care services for our client to promote wellness, build healthy habits, and help our client reach their fullest potential and maximize their quality of life.

A copy of all screenings and physicals are requested annually from caregivers and kept in client's medical records. A dated copy of request is kept in medical record until copies are obtained. If guardian requires help with any screenings, the nurse can assist in this process.

Physical Exams
Unity House's nursing staff work with the client's parents/guardians to ensure that each client receives an annual comprehensive medical and dental examination as well as hearing, vision, and posture screenings in a timely manner according to M.G.L. regulations. When screenings are not conducted at the program site, they are included in the yearly physical exams through the client's primary care physician's office or clinic. All findings are documented in the client's record. Written informed consent is obtained from the parent/guardian. Parent/guardians are also asked to provide the school with a copy of all physician reports, including any recommendations for the client's care.

Physical 105 CMR 200.100(B)(1)
Every client shall be separately and carefully examined by a duly licensed physician, nurse practitioner or physician assistant 105 CMR 200.100 (B)(1):

- Upon admission (within one year prior to entrance to the program or within 30 days after program entry)
- Clients 14-16 years old requesting employment certificate
- Annually, prior to a client's participation in competitive athletics

Unity House requires a written report from the physician(s) of the results of the examination and any recommendation and/or modification of the client's activity.

Hearing 105 CMR 200.400(C)
The hearing of each client in the program is to be screened, using DPH guidelines:

- In the year of program entry
- Annually through Grade 3 (by age 9 in ungraded classrooms)
- Once in Grades 6-8 (ages 12-14 in ungraded classrooms)
- Once in Grades 9-12 (ages 15-18 in ungraded classrooms)

For any client who does not pass, a written plan for follow-up is required.

Vision 105 CMR 200.400 (B)

The vision of each client in the program is to be screened, using DPH guidelines:

- In the year of program entry
- Annually through Grade 5 (by age 11 in ungraded classrooms)
- Once in Grades 6-8 (ages 12-14 in ungraded classrooms)
- Once in Grades 9-12 (ages 15-18 in ungraded classrooms)

For any client who does not pass, a written plan for follow-up is required.

Dental 603 CMR 18.05(9)

Routine dental cleanings and exams will be completed on an annual basis or as indicated by client's dentist and/or hygienist.

Posture M.G.L. c.71, 57

Postural screenings are completed at minimum at least once annually in Grades 5-9 (ages 12-15 in ungraded classrooms). For any client who does not pass, a written plan for follow-up is required.

Height & Weight 105 CMR 200.500

The height and weight measurements of each client is to be recorded:

- In Grade 1 (by age 7)
- In Grade 4 (by age 10)
- In Grade 7 (by age 13)
- In Grade 10 (by age 16)

BMI is to be calculated by trained personnel.

B. Immunizations

HLW requires that all clients receive proper medical treatment and immunizations unless the client's parents object on the grounds that such treatment conflicts with a religious belief (except in the event of an emergency or epidemic of disease is declared by the Department of Public Health). All clients are required to present complete Immunization Records before intake. In ungraded classrooms, grade 7 requirements apply to all clients ≥12 years. Requirements apply to all clients, even if over 18 years of age. Annual renewal of religious or medical exemptions to immunizations is required. As required by the DPH, all clients shall have the necessary immunizations:

- Tdap 1 dose; and history of DTaP primary series or age appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td should be given if it has been ≥10 years since Tdap.
- Polio 4 doses; 4th dose must be given on or after the 4th birthday and ≥6 months after the previous dose, or a 5th dose is required. 3 doses are acceptable if the 3rd dose is given on or after the 4th birthday and ≥6 months after the previous dose.
- Hepatitis B 3 doses; laboratory evidence of immunity is acceptable
- MMR 2 doses; first dose must be given on or after the 1st birthday and the 2nd dose must be given ≥28 days after dose 1; laboratory evidence of immunity acceptable
- Varicella 2 doses; first dose must be given on or after the 1st birthday and 2nd dose must be given ≥28 days after dose 1; a reliable history of chickenpox* or laboratory evidence of immunity acceptable
- Meningococcal 1 dose; 1 dose MenACWY (formerly MCV4) required for newly enrolled full-time clients attending a secondary school with grades 9-12 (in ungraded classrooms, those with clients ≥13 years) who live in a congregate living arrangement approved by the secondary school (e.g., dormitory). Clients may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form provided by their institution. Meningococcal B vaccine is not required and does not meet this requirement.
    - Waiver; for clients grades 9-12 (13 yrs and up) https://www.mass.gov/files/documents/2018/02/08/meningococcal-info-waiver.pdf

Current best practices will be followed regarding administration and record of immunization history according to Center for Disease Control and Prevention General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (2011).

- Only written, dated records will be accepted as evidence of immunizations.
- If immunization status is unknown or written and dated records are unavailable, the client shall be considered disease susceptible.
- Recommended immunizations will be initiated without delay according to the disease schedule appropriate for the patient. There is no evidence in the current literature which suggests that revaccination is harmful to the patient.
- Serologic testing is an appropriate alternative for certain antigens (measles, rubella, hepatitis A, and tetanus) at the discretion of a Health Care Provider.

C. Promoting Responsible Sexual Activity/Condom Availability

Client in HLW programs are at risk of engaging in unsafe sexual activity with other adolescents in the community. In this context, clinicians and health services staff will provide client with appropriate education about sexual health as well as the medical and psychological risks of sexual activity. Client are informed that abstinence is the safest way to prevent pregnancy and sexually transmitted diseases. Client are also informed that the proper use of condoms is highly effective in preventing pregnancy and the transmission of sexually transmitted diseases including HIV. In order to help prevent the transmission of sexually transmitted diseases (STD's) as well as to help prevent unwanted pregnancy, HLW programs will make condoms available, when clinically appropriate. Client who are provided with condoms must also be provided with appropriate counseling and instruction. Parents and guardians will be informed that programs provide basic health education around sexuality and that condoms are made available in this context. Clinical practice within HLW programs endeavors to be respectful both of the desire of parents and guardians to have knowledge of their clients' health care and wishes and rights to confidentiality.

This policy applies to all residential, day school, therapeutic foster care and after school programs serving client age 12 and older.

Screening for high-risk sexual behavior is a routine part of the clinical and health assessments for client in HLW programs. This assessment includes an evaluation of each client's understanding of safe sex practices and a determination of the client's ability to maintain their safety and their partner's (or partners') safety in the context of relationships that may have a sexual component.

As part of the regular admissions process, programs will inform the parents/guardians that the program offers education around sexuality and health. In this context, parents/guardians are informed that condoms may be made available to client. Parents/guardians are also informed that health services staff provides education about the risks of sexual behavior as well as instruction in the appropriate use of condoms.

In the context of family work, clinicians and health services staff will attempt to engage client and parents/guardians and appropriate family members in discussions about sexuality and risk reduction.

Client are instructed that sexual activity is prohibited on site at HLW programs and between HLW client.

Clinical, health services and milieu staff will consult together in offering appropriate structure, guidance and resources to client at high risk to engage in sexual behavior.

D. Dangerous Substances

All toxic substances, sharp objects, medications, and matches are kept in a secure, locked location away from client access. Toxic substances are stored in a separate locked cabinet, away from medications, and each product is clearly labeled with contents and antidote. Material safety data sheets (MSDS) are available by request. The phone number for poison control is clearly posted at every phone. Sharps are stored in appropriate receptacles in the medication cabinet.

E. Illicit Substance and Tobacco Use Policy and Procedure

To ensure that client are not under the influence of alcohol or drugs while being treated by a program of The Home for Little Wanderers and to ensure that any visitors or family members do not carry, use, or sell drugs or alcohol or use cigarettes on the premises.

Substance use/abuse is common among the age group that is served by The Home. Client who are struggling with emotional and behavioral problems are less likely to benefit from treatment interventions when actively using substances. It is therefore in the interest of providing good and effective care to our client that programs have best practices and safe protocols for determining current or recent substance abuse in our client. These protocols must be grounded in a sound clinical approach involving the client and family. In addition, they are to be integrated into a larger program of substance abuse prevention and education. Drugs of abuse and un-prescribed medication may represent a heightened risk for client taking prescribed psychotropic medications. Recognizing these factors, the following guidelines have been established for use in HLW programs, in accordance with M.G.L. c71, 37H and the Education Reform Act of 1993.

The Home prohibits the use, possession, or distribution of controlled substances and the use of cigarettes, vaping, or other smoking materials within or on the premises of all of its programs, including at HLW sponsored events or in HLW program vehicles. This applies to all employees, client, and visitors.

The Home will not provide treatment when a person is under the influence of alcohol or controlled substances because it is neither safe to do so nor does it contribute to treatment.

All of The Home's facilities and campuses are smoke-free.

Definitions

Tobacco/Vape Products: Cigarettes, cigars, chewing tobacco, snuff, vape or any other form of tobacco.

Confiscation of Visible Tobacco/Vape Products: Clients

Visible tobacco or vape products (as defined above) will be confiscated and returned to the parent(s) or guardian(s) upon request.

Any violation of the Tobacco Free School policy by a client will be reported to the Principal.

This policy applies to all residential and day programs.

Protocol:

1. Education of Parent/Guardian and Client of HLW Practice

a. During the admission process, the parent/guardian will be informed of the indications and the process of substance screening through the *Authorization and Consent for Routine Health Care*.
b. The client is informed of the indications and the process of substance screening during the orientation process in the program and in an ongoing way as is clinically appropriate.

2. Outpatient and Community-Based Programs
Persons who appear to be under the influence of drugs and/or alcohol upon arrival to or during, treatment will be:
   a. If an adult,
      i. evaluated for immediate safety and have their safety ensured to the extent feasible.
      ii. asked to leave the treatment session until sobriety returns, assisted in accessing substance abuse treatment if appropriate.
   b. If a client,
      i. evaluated for immediate safety and have arrangements made to ensure their continued safety. The parent/legal guardian will be notified.
      ii. where possible, staff will obtain a second observer/opinion.

3. Residential Treatment Center/Group Homes
An educational program component of substance use/abuse prevention will be provided at all residential sites.

Drugs and/or drug paraphernalia and alcohol may not be carried, used, or sold anywhere on the premises of residential /programs.
   a. Prohibited items will be confiscated.
   b. If a resident appears to be under the influence of a controlled substance, they will be evaluated for safety and, based on this evaluation, emergency action will be taken as needed.
   c. If a client is found to be carrying, using, or selling controlled substances, action will be taken on a case-by-case basis in consultation with the treatment team. Evaluation of the substance use/abuse concern will be conducted. The parent/legal guardian or funding source will be notified and will be included in the discussion of action to be taken to address the concern.
   d. Actions may include, but not be limited to:
      i. Inclusion of substance use/abuse issues in the comprehensive treatment plan
      ii. Adjustment in Behavioral Management plan to provide for increased structure and support
      iii. Drug screening, e.g. testing urine, blood, or hair follicle
      iv. Room search
      v. Referral to drug use/abuse groups
      vi. Notification of law enforcement

4. Schools
   a. The schools of The Home are smoke free
   b. Drugs and/or drug paraphernalia, alcohol and smoking materials may not be carried, used, or sold anywhere on the premises
   c. Prohibited items will be confiscated

i. The parent/legal guardian will be notified to make arrangements for the day client to be picked up from the school and supervised until sobriety returns.
ii. Staff will make arrangements for the day client to be monitored until the parent/legal guardian or their identified representative has taken over supervision of the client.
iii. In consultation with the parent/legal guardian, staff will encourage the day client to be evaluated for substance use/abuse.
iv. The client may be suspended from school.
v. Law enforcement officials may be notified.

5. In Case of Medical Emergency Related to Substance Use
   a. As in other medical emergencies, in the case of a medical emergency related to substance use, program staff will call emergency services (911) immediately. Program staff will inform the program director/program administrator on-call and parent/guardian as soon as possible.
   b. If the client requires transport to an emergency service, the client will be transported by ambulance.

6. In Case of Non-Emergent Situations Related to Substance Use
   a. If a staff member suspects that a client is actively using substances, he or she will inform the supervisor responsible for the shift.
   b. The supervisor will then inform the Program Director or the Administrator-On-Call. The Program Director or the AOC will consult the nurse or on-call psychiatrist to determine the appropriate action. Urine screens will be used in all situations unless otherwise ordered by psychiatrist or on-call psychiatrist. The following are indications for considering either a urine or serum toxic screen:
      i. When a client is AWOL from the program in which there is either a past history of substance abuse or the current presentation is suggestive that the client may have used substances directly prior or during the elopement,
      ii. The client presents with the odor of alcohol or another substance,
      iii. The client appears intoxicated or under the influence, such as slurred speech, appears disoriented, uninhibited, pupil dilation,
      iv. The client presents with a marked and sudden change in behavior,
      v. The parent or guardian expresses concern regarding the client's recent substance use,
      vi. The client, who is considered at high risk of substance abuse, might be routinely screened upon return from LOA, or randomly tested as part of a treatment plan,
      vii. The client is found in possession of any alcohol, drugs, or substances of abuse.
   c. The AOC/shift supervisor will inform the parent/guardian of the events, the plan, and the results, as clinically appropriate.
   d. If it is determined to get the sample at the program, the psychiatrist or the on-call psychiatrist will order the tests.
   e. Staff should not complete a full body search with client. Staff will search client's pockets, shoes, and socks for possible adulterants (contaminants) just prior to the client providing the urine sample. In general, client searches are to be in accordance with Commonwealth of New Hampshire EEC regulations.

f. The nurse will develop programs-specific guidelines for obtaining and storing urine samples.
g. The staff member directly connected with the event will document the incident in the Incident Reporting system.

V. Emergency Management

A. General Statement

Informed Consent and Written Authorization
Emergency first aid or medical treatment will not be administered to a client without written authorization from a parent or guardian. Any preexisting conditions or allergies should be noted in addition to associated emergency treatment the client may have been prescribed (i.e. rescue inhaler or epinephrine auto-injector). Health care provider orders for these emergency treatments and the authorization to provide such treatment should be completed upon admission and renewed annually or as needed. Medications should be checked regularly for expiration.

Local emergencies numbers are posted by all telephones. Individuals' emergency contacts numbers are kept up to date. List of persons CPR /First Aid trained is available.

Emergency Supplies
Comprehensive first aid supplies will be kept in the nursing office. First aid kits will be easily accessible and kept in major activity areas (i.e. floor supervisor's office, residences, gymnasium, kitchen, classrooms and program vehicles). The first aid kits will include, but will not be limited to bandages, exam gloves, gauze, adhesive tape, and cleaning solutions. All first aid kits will be marked conspicuously.

First aid kits will be checked and replenished monthly and as needed as directed by Health Services.

Emergency Procedures
Emergencies can be classified into three major categories based on client's signs & symptoms:

1. Emergency Medical Conditions (Life-Threatening): Life-threatening or potentially disabling situations that require immediate intervention are outlined in Red Cross training. **911 must be called immediately** to activate the Emergency Response System (ambulance). The nurse should be contacted as soon as possible to support the situation. The nurse will contact parent/guardian as soon as possible to communicate the emergency.

   Examples of emergency medical conditions may include, but are not limited to:
   - Cardiac and/or Respiratory Arrest
   - Unconscious or Unresponsiveness – not due to known seizure
   - Anaphylaxis – life-threatening allergic reaction such as difficulty breathing, etc.

- Seizure lasting longer than 5 minutes unless there is a specific physician's order or protocol that gives other instructions
- Severe Bleeding
- Chest Pain (unexplained or cause unknown)
- Breathing Difficulty as demonstrated by:
  - Rapid breathing (greater than 40 breaths per minute)
  - Labored or difficulty breathing or "catching one's breath"
- Any Seizure experienced by someone who has no seizure history
- Choking even if immediately resolved by chest thrusts
- Suspected Poisoning Incident
- Major Trauma/Injury
- Temperature of 94°F or below. Apply blankets and keep person warm until EMS (ambulance) arrives.

2. Urgent Medical Conditions (Potentially Life-Threatening & Requiring Immediate Medical Evaluation): Urgent medical conditions are serious, potentially life-threatening, or potentially disabling and because these may soon result in a life-threatening situation or may produce permanent damage, medical help is sought immediately. The **nurse and/or the physician should evaluate the client as soon as possible**. The nurse will contact parent/guardian as soon as possible to communicate the situation. When an urgent condition is observed, the individual's **physician/HCP should be contacted immediately**. If the physician/HCP cannot be contacted, there should be no delay in the evaluation or treatment of the individual. They should be **taken to the nearest Health Care Facility or Emergency Room**.

   Examples of urgent medical conditions may include, but are not limited to:
   - Temperature of 103°F or greater
   - Known Diabetic with Blood Sugar of 60 or below, or as indicated in diabetic protocol, and not responding to sugar, orange juice, glucose tablets, etc.
   - Profuse (large, frequent amounts) vomiting or diarrhea; vomiting which is followed by a change in respiration- choking, unable to "catch his/her breath"
   - Vomiting of fluids that look like coffee grounds or containing red blood
   - Taking a medication not intended for that individual or in an amount that exceeds the therapeutic dose, Note: physician/HCP or Poison Control Center (1-800-222-1222)

3. Non-Life-Threatening Injury or Illness: These are defined as any injury or illness that may affect the persons' general health, i.e. sprains, minor cuts. The **nurse and/or the physician should evaluate the client as soon as possible**. Medical

staff performing the onsite assessment will consult with the client's health care provider as needed. Onsite staff will follow physician recommendations. If transport to a medical facility is required, attending staff will also ensure that the client's medical information accompanies him/her. When signs & symptoms of a potentially health-threatening condition have continued for more than 24-48 hours or there are additional concerns, staff should contact their immediate supervisor and Health Services, which will notify the client's physician/HCP.

Examples of non-urgent medical conditions may include, but are not limited to:

- Temperature 100°F – 101°F by mouth OR Temperature of less than 97° but greater than 94°F
- Mild diarrhea, nausea or occasional vomiting
- Cold symptoms such as cough, runny nose, and congestion
- Any physical or behavioral signs and/or symptoms which lead you to believe the health and/or safety of the person is at risk.

4. Medication Occurrence Procedure: A Medication Occurrence is defined as a breach of one of the five "R's", namely Right individual, Right medication, Right time, Right dose, and Right route.

There are five types of reportable occurrences: wrong individual, wrong medication (which includes administering a medication without an order), wrong time/ omission (which includes a forgotten dose), wrong dose and wrong route. (Refer to the Training Curriculum, for additional information).

Follow this procedure for a Medication Occurrence:

a. Check that the person is okay
b. Call 911 as needed- as described in emergency health manual section
c. Contact the Prescribing Physician / Poison Control
d. Follow recommendations
e. Notify the Program Director, Principal and Director of Nursing
f. Document medication occurrence
g. Fill out a Medication Occurrence Form (see Appendix)
h. Notify Guardian
i. Notify DPH as required: MDPH School Health Medication Error Report Form

Condition-Specific Emergency Protocols:

Note: If you are unsure whether a condition is urgent, call Health Services, Shift Supervisor, or Administration-On-Call to assist with evaluation.

Falls: When a person falls, the following protocol should be implemented:

1. If the person does not get up on their own, *do not move* the individual unless they are in danger of further injury if not moved, (e.g. fire, in the middle of a busy street, etc.)
2. Assess the individual for any emergency conditions as outlined in this policy. **If any emergency condition is present, immediately call 911** to activate the Emergency Response System (ambulance) and provide any First Aid measures needed, (e.g. keeping airway open, CPR, pressure to bleeding wound, etc.) while waiting for emergency personnel.
3. If no obvious emergency condition exists, **examine the individual from head to toe** for signs of any injury (bruising, swelling, redness, bleeding, cuts, abrasions etc.)
4. As soon as the above steps are completed, call your supervisor for further instructions. If any fall resulting in the need for medical/evaluation/treatment by either Primary Care Physician/urgent care or emergency room physician, the legal guardian will be notified.
5. Document what happened, what the findings were, what action was taken, and what follow-up instructions were given in the incident report.

Head Injury/Head Banging: Injury to the head, with or without loss of consciousness or other visible signs is to be reported to Health Services, the Shift Supervisor and the Administrator-On-Call for further instructions. The presence or absence of swelling at the injury site is not necessarily related to the seriousness of injury. External trauma to the head is capable of damaging the brain, even if there is no external evidence of damage.

1. Staff should monitor the individual for the following signs and symptoms and **call 911** if any of the following is observed:
    - severe head or facial bleeding
    - seizure
    - repeated vomiting
    - blood/drainage from nose or ears
    - unequal pupils or difficulty seeing
    - slurred speech
    - difficulty walking or using arms
    - change in breathing (labored or sporadic)
    - unusual behavior (agitation/confusion)
    - new or worsening neck pain
    - loss of consciousness
    - any new or severe symptoms including balance loss
    - difficulty being awakened
    - bruising especially below the eyes or behind the ears
2. Following a head injury, the individual should be monitored closely for the next 24 hours.
3. Staff should keep individual awake and check for symptoms every 2-4 hours.
4. Any signs and symptoms as noted above should be reported immediately to the individual's physician, Health Services, and shift supervisor.
5. Document observations for a minimum of 24 hours in a *Narrative Note* (see Appendix).

Staff Responsibilities During Any Medical Emergency:

- Attending staff will ensure that the client's *Travelling Medical Binder accompanies them to the emergency facility*.
- *As soon as initial emergency needs are met, contact Health Services and the program director or shift supervisor*. If person is being transported to a hospital, obtain the name of the hospital from EMS and convey the information to Health Services, the Program Director, Shift Supervisor and Administrator-On-Call.
- The *parent/guardian will be contacted at the time of the emergency*. The information will include the nature of the emergency, location of the client, name of hospital if transported to such, and name of the staff member accompanying the client. If the parent/guardian cannot be reached or the parent-designated person to contact cannot be reached, calls made and attempts to reach them will be documented and filed in the client's record. In all cases, the parent/guardian will be notified as soon as possible. Attempts to contact the parent/guardian or designee will continue until either is reached.
- The staff person accompanying the client to the Emergency facility must request the facility staff to *complete the Health Care Provider Orders form* if needs are prescribed.
    - In the case of a new prescription for an epinephrine auto-injector, that prescription must be filled right away before the client returns to the program. This will require the staff to advocate for obtaining the epinephrine auto-injector with the Emergency Room physician to fax it to the local pharmacy in order to have available for a client who may have a rebound response within hours of returning to the program.
- Upon return to the program the staff member will give these forms; the Health Care Provider Orders, the emergency facility's evaluation report, and prescriptions *directly to the nurse, program director, or his/her designee*.
- The parent/guardian, Health Services, Shift Supervisor, Principal, Program Director or Administrator-On-Call will be notified of the incident and any actions taken. Necessary health care documentation will be completed by nursing. Attending staff will *complete an incident report*, if needed.

B. Psychiatric Emergency

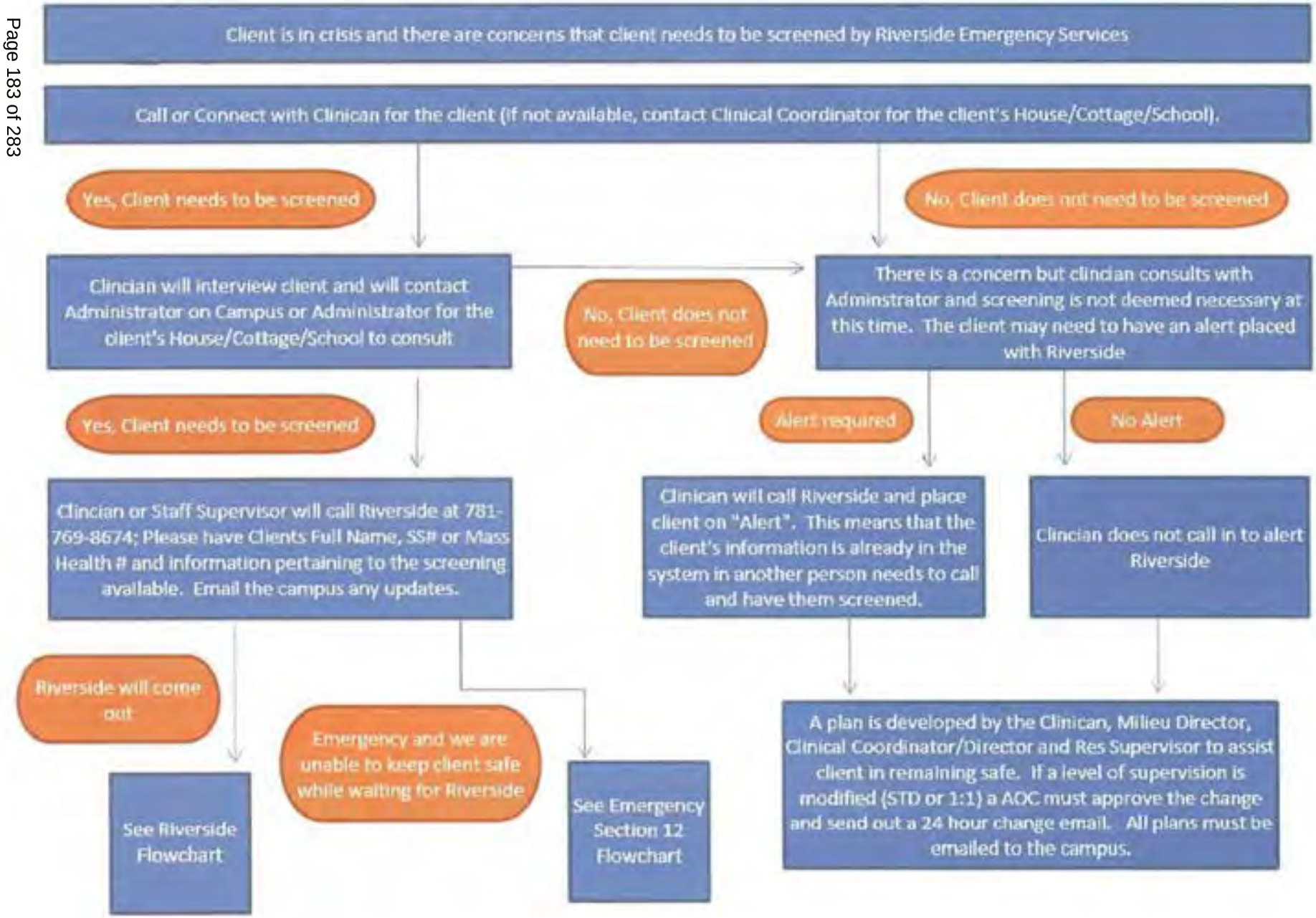
Client presenting with high risk crisis behaviors outside of their typical baseline could be experiencing a psychiatric emergency. Direct care staff and the client's primary clinician will proactively maintain open lines of communication. The clinician can meet with the client to assess the severity of the symptoms and work with staff to develop a support plan or modify the level of supervision provided as appropriate.

If the client's primary clinician has continued concerns about the client's presentation following assessment or if staff identifies that there is an emergent threat to the client's safety, a licensed clinician (LICSW, LMHC, or psychiatrist) will be contacted to conduct a risk assessment. If the licensed clinician or psychiatrist finds that the client can remain safely on campus, a detailed plan to help assist the client will be sent out and Riverside Emergency Services may be called and the client placed on an "Alert Status". An Alert can assist Riverside to facilitate a quick screening response if the client's status changes in the near future. If the licensed clinician or psychiatrist finds that the client is in a psychiatric emergency and may require a higher level of care due to the severity of risk, Riverside Emergency Services (1-781-769-8674) will be contacted.

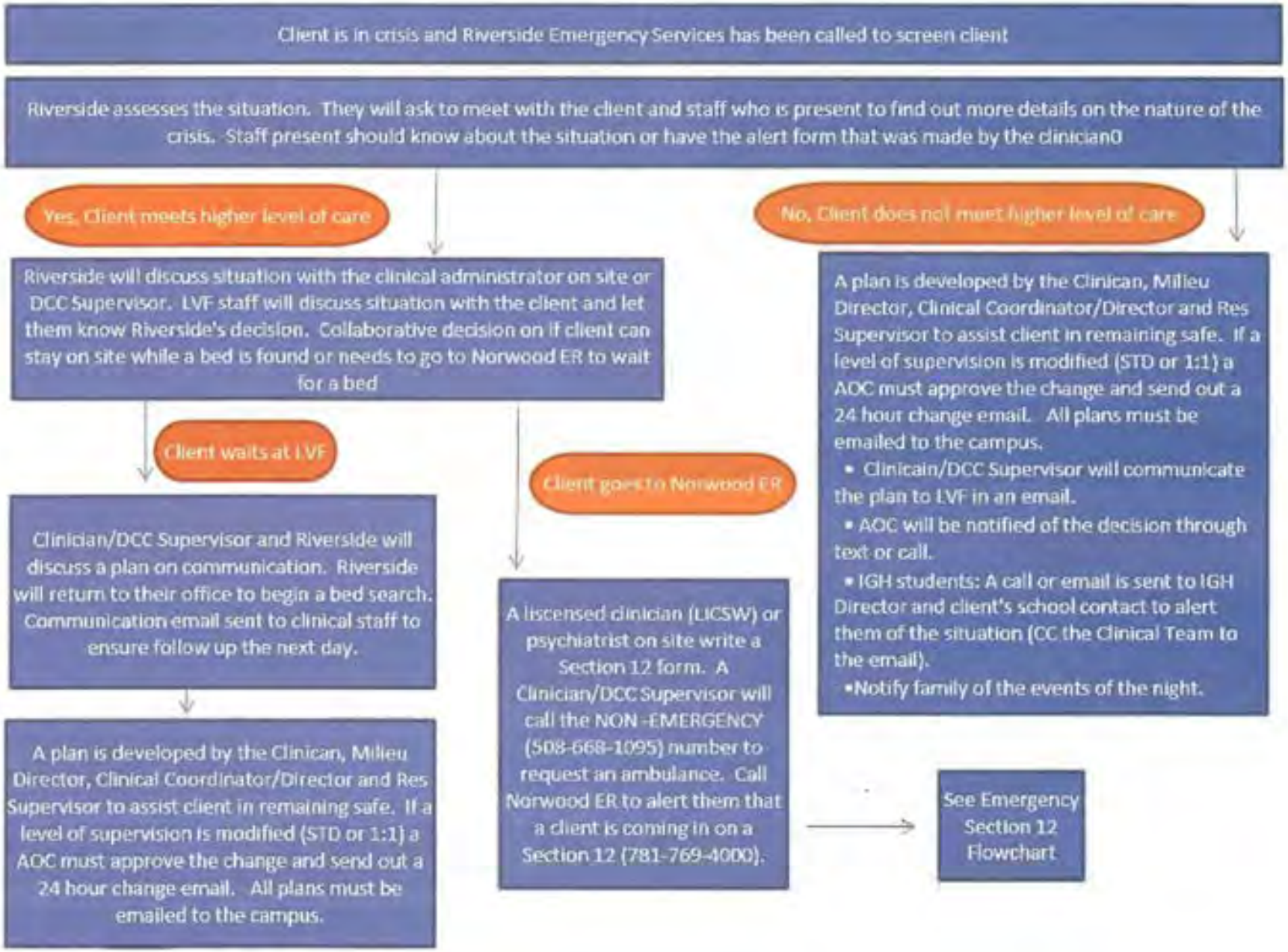
Riverside can come out to conduct an in-person assessment and determine whether the client requires a higher level of care. In the event that the client does not meet criteria for a higher level of care, Riverside may continue to monitor the situation and check in by phone or in person for up to 72 hours. Client requiring a higher level of care but can be safely maintained on campus while Riverside searches for a bed in an inpatient or Community Based Acute Treatment (CBAT) Center will have a specific plan communicated to the rest of the campus to ensure safety for the client and others. Client requiring a higher level of care but who are unable to safely remain in their current environment while waiting for an in-patient or Community Based Acute Treatment bed will follow the procedure for a Section 12 and be transported to Norwood ER via ambulance.

See below for detailed psychiatric emergency flowcharts regarding Client in Crisis, Riverside, and Section 12 procedures.

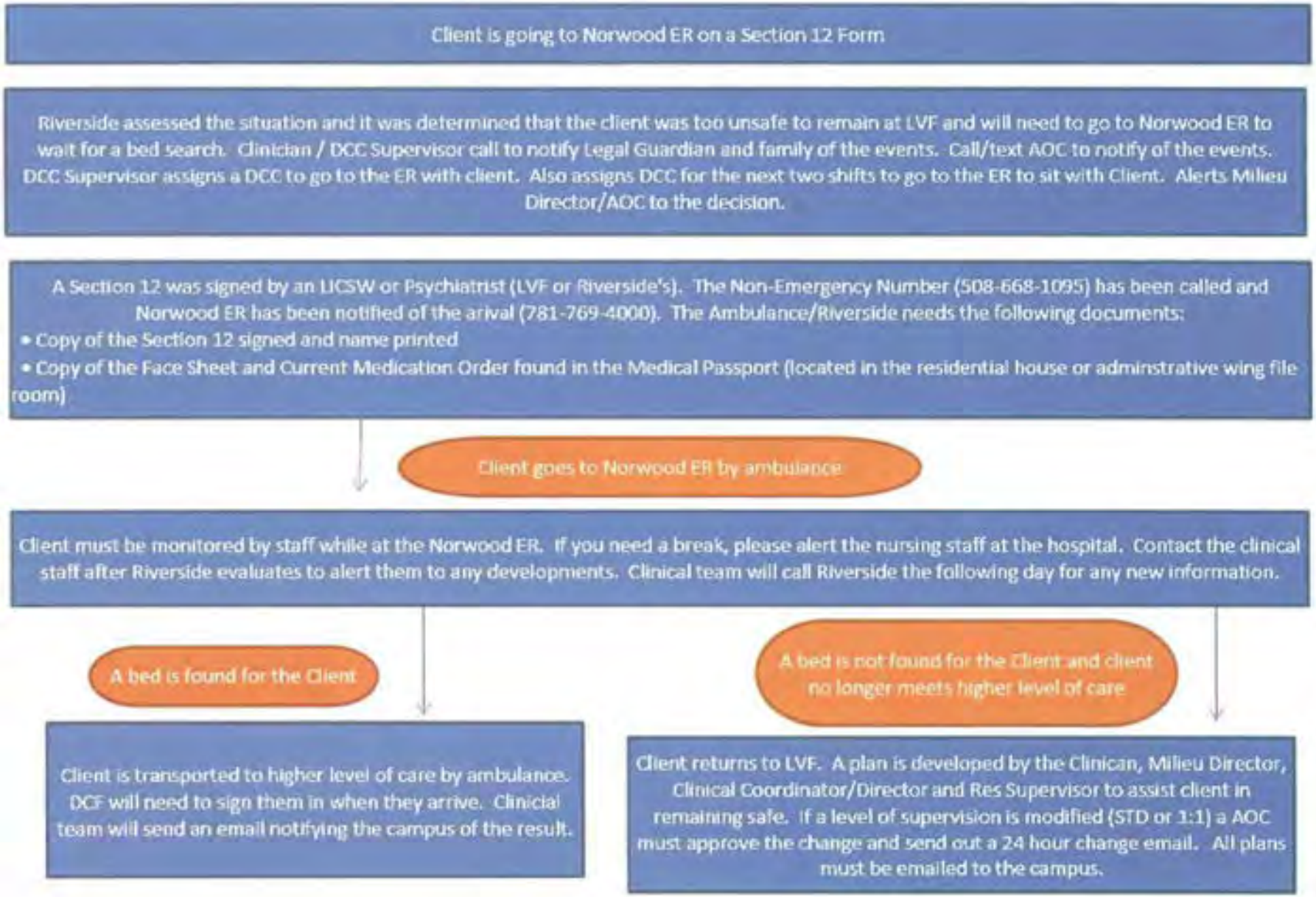
Client In Crisis



Riverside


Client is in crisis and Riverside Emergency Services has been called to screen client
Riverside assesses the situation. They will ask to meet with the client and staff who is present to find out more details on the nature of the crisis. Staff present should know about the situation or have the alert form that was made by the clinician0
Yes, Client meets higher level of care
No, Client does not meet higher level of care
Riverside will discuss situation with the clinical administrator on site or DCC Supervisor. LVF staff will discuss situation with the client and let them know Riverside's decision. Collaborative decision on if client can stay on site while a bed is found or needs to go to Norwood ER to wait for a bed
A plan is developed by the Clinican, Milieu Director, Clinical Coordinator/Director and Res Supervisor to assist client in remaining safe. If a level of supervision is modified (STD or 1:1) a AOC must approve the change and send out a 24 hour change email. All plans must be emailed to the campus.
• Clinicain/DCC Supervisor will communicate the plan to LVF in an email.
• AOC will be notified of the decision through text or call.
• IGH students: A call or email is sent to IGH Director and client's school contact to alert them of the situation (CC the Clinical Team to the email).
•Notify family of the events of the night.
Client waits at LVF
Client goes to Norwood ER
Clinician/DCC Supervisor and Riverside will discuss a plan on communication. Riverside will return to their office to begin a bed search. Communication email sent to clinical staff to ensure follow up the next day.
A plan is developed by the Clinican, Milieu Director, Clinical Coordinator/Director and Res Supervisor to assist client in remaining safe. If a level of supervision is modified (STD or 1:1) a AOC must approve the change and send out a 24 hour change email. All plans must be emailed to the campus.
A liscensed clinician (LICSW) or psychiatrist on site write a Section 12 form. A Clinician/DCC Supervisor will call the NON-EMERGENCY (508-668-1095) number to request an ambulance. Call Norwood ER to alert them that a client is coming in on a Section 12 (781-769-4000).
See Emergency Section 12 Flowchart

Section 12


Client is going to Norwood ER on a Section 12 Form
Riverside assessed the situation and it was determined that the client was too unsafe to remain at LVF and will need to go to Norwood ER to wait for a bed search. Clinician / DCC Supervisor call to notify Legal Guardian and family of the events. Call/text AOC to notify of the events. DCC Supervisor assigns a DCC to go to the ER with client. Also assigns DCC for the next two shifts to go to the ER to sit with Client. Alerts Milieu Director/AOC to the decision.
A Section 12 was signed by an LICSW or Psychiatrist (LVF or Riverside's). The Non-Emergency Number (508-668-1095) has been called and Norwood ER has been notified of the arival (781-769-4000). The Ambulance/Riverside needs the following documents:
• Copy of the Section 12 signed and name printed
• Copy of the Face Sheet and Current Medication Order found in the Medical Passport (located in the residential house or adminstrative wing file room)
Client goes to Norwood ER by ambulance
Client must be monitored by staff while at the Norwood ER. If you need a break, please alert the nursing staff at the hospital. Contact the clinical staff after Riverside evaluates to alert them to any developments. Clinical team will call Riverside the following day for any new information.
A bed is found for the Client
Client is transported to higher level of care by ambulance. DCF will need to sign them in when they arrive. Clinicial team will send an email notifying the campus of the result.
A bed is not found for the Client and client no longer meets higher level of care
Client returns to LVF. A plan is developed by the Clinican, Milieu Director, Clinical Coordinator/Director and Res Supervisor to assist client in remaining safe. If a level of supervision is modified (STD or 1:1) a AOC must approve the change and send out a 24 hour change email. All plans must be emailed to the campus.

C. Anaphylaxis Emergency & Epinephrine Auto-injector Training

Anaphylaxis is a life-threatening health emergency. The American Academy of Pediatrics in School Health: a Guide for Health Professionals (1993) defines anaphylaxis as "an allergic reaction that may be triggered by an insect bite, a drug allergy, or a food allergy." This generalized whole-body allergic reaction requires prompt intervention, proper management, and prompt transportation to an appropriate health care facility. A client may exhibit any or all of the signs and symptoms outlined in this section within minutes of exposure to the allergen, or the reaction may be delayed for several hours after exposure to the allergen.

ANAPHYLACTIC EMERGENCY PROTOCOL

If the exposed client is known to have a severe sensitivity or severe allergic reactions to the allergen, **call 911 immediately**. Do not wait for symptoms to occur.

If the client has had a serious allergic reaction in the past, there should be a physician's order for an epinephrine auto-injector. Please note: trained staff administer the epinephrine auto-injector only with a written directive from a physician, at DPH approved programs.

- An auto-injector administered to a client must be prescribed specifically for the client, unless directed otherwise by a physician. Epinephrine is available in two different dosages and two different types of auto-injectors.
- Following administration of an epinephrine injector, the client must be taken to an emergency facility. The effects of an injection of epinephrine begin to wear off in 10-20 minutes: Therefore, it is essential to call 911 immediately. The auto-injector should be immediately capped following use and brought to the emergency facility with the client.
- Care should be taken when handling an auto-injector. Accidental injection into the hands or feet may result in loss of blood flow to the affected area and will require immediate treatment in the Emergency Room.
- Staff attending to an anaphylactic emergency will document a comprehensive description in the client's record, record the epinephrine administration on the MAR, and complete an Incident Report describing the emergency.

Nurse and Staff Responsibility in Preventing Anaphylactic Emergencies:

- If a client has been diagnosed with a history of severe allergic reaction and an epinephrine auto-injector has been prescribed by a physician, the program nurse will develop an emergency plan for the client based on the guidelines of the prescribing physician for management of the allergy. It is each staff member's responsibility to know the allergy status of each client for whom they are responsible, to be familiar with the individual plan and to follow the specific plan in an allergic emergency.
- The program nurse will notify staff of (1) the client's allergy, (2) past reactions and associated symptoms, and (3) measures to reduce exposure to the allergens in the residence, school and off-campus settings, and physician recommended responses.

- The program nurse shall be responsible, if approved by DPH, for staff delegation of proper epinephrine auto-injector administration. All direct support staff dealing with supported individuals who require assistance with epinephrine auto-injectors shall be familiar with the emergency action plan. Staff training and competency must be renewed annually. If a client has been deemed to be capable of self-administering their epinephrine auto-injector by prescribing health care provider and assessed for such, by the school nurse. The program nurse shall also ensure there is a physician's order on file for epinephrine auto-injector self-administration. The program nurse shall teach the client how to self-administer their epinephrine auto-injector and document competency. Documentation of the client's ability to self-administer their epinephrine auto-injector shall be signed by the prescribing health care provider, kept in the client's record and be readily available for reference by staff.

EPINEPRHINE AUTO-INJECTOR CURRICULUM

What is Anaphylaxis?
Anaphylaxis is one of the most serious and life-threatening medical emergency situations to which staff may have to respond. The American Academy of Pediatrics in School Health: a Guide for Health Professionals (1993) defines anaphylaxis as "an allergic reaction that may be triggered by an insect bite, a drug allergy, or a food allergy." This generalized whole-body allergic reaction requires prompt intervention, proper management, and prompt transportation to an appropriate health care facility. Anaphylaxis is always an emergency. Appropriate intervention usually results in a positive body response, while a delayed intervention can be fatal.

A person may exhibit any or all of the following signs and symptoms within a short time (within five minutes), or the reaction may be delayed for several hours. If a client is known to have a severe sensitivity and severe allergic reactions, don't wait for signs and symptoms to become worse. Call 911 immediately. Staff will follow the Emergency Guidelines in the Health Service manual to activate the emergency medical system, and to activate agency help and communication. The effects of an injection of epinephrine begin to wear off in 10-20 minutes; therefore calling 911 immediately is essential even if the client's emergency plan indicates that epinephrine may be administered.

Signs and symptoms of anaphylaxis may include any or all of the following:

Skin:	Cold to touch, may be clammy and moist, itching, hives, and swelling of lips
Color:	Pale at first, then mottled or bluish
Respiration:	Wheezy, change in voice quality due to swelling of larynx, feeling of fullness in throat, difficulty breathing, shortness of breath, breathing may cease
Pulse:	Rapid, weak
Blood Pressure:	Low, progressively lower, or unattainable

Other:	Restlessness, severe headache, nausea, vomiting, diarrhea, loss of consciousness, swelling of eyelids/lips/neck, difficulty swallowing

Common causes of allergic emergencies:
Insect bites: wasps, bees, hornets, spiders, fire ants, among others
Drugs: Antibiotics and many other categories of medication
Foods: shellfish, peanuts, and many other foods
Anaphylactic shock has also been known to be triggered by exercise in some people.

Prevention of allergic emergencies:
The Home for Little Wanderers strives to provide a safe environment for all client and implements a peanut and tree nut free campus at its school and residential programs and will make efforts to be latex free for the safety of client.

To avoid insect bites:

- Cover bare skin: do not go barefoot, wearing long sleeve shirts and pants, socks in insect inhabited areas.
- Do not use scented soaps, shampoos, perfumes, etc.
- Put picnic foods in covered containers as soon as possible after eating.

To avoid drug emergencies:

- Ensure that client and all those prescribing and administering medications are informed of specific known drug allergies.
- Ensure that drug allergy information is brought to medical appointments and communicated to outside providers and to attending staff when client are seen for medical emergencies.
- All staff take responsibility for knowing about all known allergies among the client they supervise.

Role of Epinephrine Auto-Injectors (i.e. Epi-Pen):
Epinephrine is the treatment of choice for severe allergic emergencies because it quickly constricts blood vessels, relaxes smooth muscle in the lungs to improve breathing, stimulates the heartbeat, and works to reverse hives and swelling around the face and lips.
Epinephrine is available in two different dosages and two different types of auto-injectors. For client with known anaphylaxis response to an allergen, it is important to use the client's individual injector. This will be labeled with the client's name, the name of the medication, and the dose. A copy of the client's individual allergic reaction response plan will be kept with the injector at all times. The location of injectors will be accessible and known to all trained staff who provide direct care and/or accompany a client on an off-site trip. Staff responsible for taking a client on an off-site trip must be trained by the nurse in the specifics of the client's allergic response and in the use of the client's individual auto-injector, if approved by DPH. Training would include identification of:

- the right individual
- the right medication
- the right dose

- ☐ the right route and location of injection
- ☐ The right time (based on client's symptoms, and/or time since exposure to the allergen, e.g., hives spreading over the body, wheezing, difficulty swallowing or breathing, swelling in face or neck, tingling/swelling of tongue, vomiting, signs of shock such as extreme paleness/gray color, clammy skin, loss of consciousness or any other client-specific known symptoms following the client's exposure to the allergen)

The prescribing physician may instruct the client in self-administration. However, the school nurse will further assess the client's capacity with multidisciplinary input, along with feasibility in safe school health practice. Approved staff trained in epinephrine administration under nurse delegation, if approved by DPH, would still assist and observe the client as they administer the medication. The staff member holding the client's medication for the trip must be accessible and known to the client.

After use, place the auto-injector in an impermeable container, if available, and give to Emergency medical personnel to take to the hospital. Inform them of the time of injection.

How to handle and store epinephrine:
The auto-injector is quite durable but may be damaged if mishandled. The medication is stable at room temperature until the marked expiration date, it should not be refrigerated, frozen or exposed to extreme heat or sunlight. Exposure to light and heat cause epinephrine to oxidize and turn brown. Before administration, make sure that solution is clear and colorless; if brown, replace immediately. Health Services and/or trained staff should check at least monthly to be sure that the epinephrine prescription is current, and it is not expired, damaged, oxidized, and/or unusable.

Note: Accidental injection into the hands or feet may result in loss of blood flow to the affected area and will require immediate treatment by emergency services.

Client with no known allergies:
It is possible that a client with no known allergies experiences an anaphylactic reaction or that a client with previously milder response to a bee sting or other allergen develops an anaphylactic reaction. If a client previously unknown to have an allergy is displaying any of the symptoms described above, **call 911**, accurately report what you are seeing, and follow the emergency response team's suggestions for care. Ensure that you have a cell phone available for all off-site trips.

Observation of a client after exposure or possible exposure to an allergen is extremely important. Continue observation for an extended period. Observe client who report they have been bitten by an insect that may trigger an allergic reaction even if the client had not had a previous severe allergic reaction.

For any individual with no previous history of life-threatening allergic reactions, the use of epinephrine as an emergency medication requires written protocols and a written order from the school physician. Unity House will ensure that this standing order and protocol are completed,

signed, and in place. Only a nurse may administer epinephrine to a person who has no previous history of a life-threatening allergic reaction. If the school nurse is unavailable, the school must immediately activate the EMS system, provide first aid as applicable, and then notify the school nurse and the parents/guardians. Anyone who has received epinephrine treatment must be transported by trained emergency personnel to a hospital emergency facility immediately, via ambulance. Upon the client's return to school, the school nurse should develop an *Individual Health Care Plan* and ensure that a policy for the care of the client with a life-threatening allergy is in place.

Procedure for Administration of Epinephrine via Auto-Injector:

- ☐ Follow all procedures for preparation of medications for administration according to nurse delegation, if approved DPH program.
- ☐ Inform client what is being done.
- ☐ Form a fist around the pre-filled auto-injector with the tip [usually it is an orange tip] facing down and pulls off the safety cap. (NEVER put fingers over the tip)
- ☐ Place the pre-filled auto-injector device at a 90-degree angle on the outer thigh. (It is not necessary to remove clothing since the auto-injector device is designed to work through clothing.)
- ☐ With a quick motion, push the pre-filled auto-injector firmly against the outer thigh. (Hold in place and slowly count to 10 before removing needle.)
- ☐ Even though a small amount of liquid remains inside the auto-injector after use, the device cannot be used again.
- ☐ Call 911 immediately for transportation to emergency room.
- ☐ After ER personnel arrive and individual is cared for, notify client's health care provider and Health Services, and follow all emergency procedures.
- ☐ Properly dispose of the used auto-injector.
- ☐ Document administration according to nurse delegation, if approved DPH program.

D. Asthma & Inhaler Training

Overview:

I. Asthma is a disease that affects the lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medication and avoiding triggers which aggravate asthma. Removing triggers from the environment which make asthma worse can help to improve it.

II. Triggers for asthma include dust mites, tobacco smoke, outdoor air pollution, cockroach allergen, pets, mold, smoke from burning wood or grass, infection, strong emotions that lead to hyperventilation, and exercise.

III. Goals of asthma treatment focus on:

a. Reducing impairment – the frequency and intensity of symptoms and functional limitations currently experienced by a client.

b. Reducing risk – the likelihood of future asthma attacks, progressive decline in lung function, or medication side effects.

Asthma Action Plans:

- Describe daily treatment for controlling asthma long-term, such as what kinds of medications to take and when to take them
- Describe early signs, symptoms, and peak flow meter measurements that can indicate worsening asthma
- Describe how to give the client medications and how to manage environmental factors contributing to exacerbations
- Describe how to handle asthma attacks, including when to call the doctor or go to the emergency room and any additional notifications that should be made
- Should be developed with the client's health care provider, in partnership with the client/family
- Should be available to all the people who provide care, so that they can help the client follow the action plan

For clients who do not have an asthma action plan, general guidelines for Management of Acute Asthma Exacerbations should be followed as outlined below.

Link to Asthma Action Plan: http://www.lung.org/assets/documents/asthma/asthma-action-plan-for-home.pdf

Asthma Triggers:

- A health care provider may recommend ways to control exposures to allergens, irritants, and pollutants.

- Avoiding or limiting exposure to asthma triggers helps decrease incidence of asthma exacerbations.
- If a client has an asthma exacerbation which may be related to an asthma trigger, consider removing the client from the trigger if possible.

Types of inhaler medications:
Quick-relief asthma medicines are bronchodilators. They work by relaxing the muscles around the airways of the lungs. This helps air to flow more freely through the lungs. Quick-relief medicines are typically used to relieve symptoms when they occur. Administer the medication through inhaler within minutes to relieve sudden asthma symptoms. If it does not relieve symptoms quickly, notify health care provider immediately.

**If the inhaler medication is a corticosteroid (commonly Flovent/fluticasone):*

- *Wash mouth out with water after administration to prevent oral infection, do not swallow the water!*

Management of Acute Asthma Exacerbations:
It is essential to teach client how to monitor signs and symptoms of worsening asthma, and to take appropriate action.

- Symptoms of a more serious exacerbation:
  1. Marked breathlessness
  2. Inability to speak short phrases
  3. Drowsiness
  4. Increased breathing effort
- Initial treatment: Give asthma medication as prescribed.
  1. Good response:
     - Characterized by no wheezing, no shortness of breath, and/or rapid breathing
     - Continue to monitor the client
  2. Incomplete response:
     - Persistent wheezing, shortness of breath, and rapid breathing
     - **Call 911**
     - Follow-up with Health Services
  3. Poor response:
     - Continued marked wheezing, rapid breathing, and shortness of breath
     - **If distress is severe and non-responsive to initial treatment, Call 911**
     - Follow-up with Health Services

Follow these steps every time you use a rescue inhaler:

Step 1. Make sure the canister fits firmly in the actuator. The counter should show through the window in the actuator.

Shake the inhaler well before each spray.

Take the cap off the mouthpiece of the actuator. Look inside the mouthpiece for foreign objects and take out any you see.

Step 2. Hold the inhaler with the mouthpiece down. **See Figure C**

Step 3. Breathe out through your mouth and push as much air from your lungs as you can. Put the mouthpiece in your mouth and close your lips around it. **See Figure D.**

Step 4. Push the top of the canister **all the way down** while you breathe in deeply and slowly through your mouth. **See Figure D.**

Step 5. After the spray comes out, take your finger off the canister. After you have breathed in all the way, take the inhaler out of your mouth and close your mouth.

Step 6. Hold your breath for about 10 seconds, or for as long as is comfortable. **Breathe out slowly as long as you can.**

If your health care provider has told you to use more sprays, wait 1 minute and shake the inhaler again. Repeat Steps 2 through Step 6.

Step 7. Put the cap back on the mouthpiece after every time you use the inhaler. Make sure it snaps firmly into place.

E. Diabetes Mellitus Training

What is Diabetes?

- In diabetes, the body does not make or properly use insulin. Insulin is needed to move glucose from blood into cells for energy.
- If insulin isn't working on the body's cells or there is not enough of it, high blood glucose results with symptoms of low energy, dehydration, and other complications.

Definitions:

- *Glucose* - simple sugar found in the blood; fuel that all body cells need to function
- *Carbohydrate* - source of energy for the body which raises blood glucose level; includes bread, rice, pasta, potatoes, vegetables, fruit, sugar, yogurt, and milk
- *Quick-acting glucose* - sources of simple sugar that raises blood glucose levels, like juice, regular soda, glucose tabs or gel, hard candy
- *Glucose tablets or gel* - special products that deliver a pre-measured amount of pure glucose, they are a fast-acting form of glucose used to counteract hypoglycemia
- *Glucagon* - hormone given by injection that raises level of glucose in the blood
- *Hypoglycemia* - a LOW level of glucose in the blood
- *Hyperglycemia* - too HIGH a level of glucose in the blood
- *Ketones (ketone bodies)* - Chemicals that the body makes when there is not enough insulin in the blood and the body must break down fat for its energy
- *Diabetic ketoacidosis (DKA)* - An acute metabolic complication of diabetes characterized by excess acid in the blood which can be life threatening
- *Ketone testing* - a procedure for measuring the level of ketones in the urine or blood

Type 1 Diabetes:

- Autoimmune disorder where insulin producing cells are destroyed and daily insulin replacement is necessary
- Most common type of diabetes in children and adolescents
- Onset: relatively quick, usually childhood or young adulthood
- Symptoms: increased urination, tiredness, weight loss, increased thirst, hunger, dry skin, blurred vision
- Cause: uncertain, but both genetic and environmental factors are involved

Type 2 Diabetes:

- Over time the body's ability to properly use insulin deteriorates or the body fails to produce sufficient amounts of insulin, known as insulin resistance
- Age at onset: most common in adults but increasingly common in client

- Risk factors: Being overweight, inactivity, genes, ethnicity
- Symptoms: tired, thirsty, hunger, increased urination
  - Some are symptomatic with very high blood glucose levels
- Cause: The pancreas is not able to make enough insulin to meet the body's needs, which can be related to being overweight, not getting enough exercise, a genetic predisposition, or ethnicity.

SIGNS, SYMPTOMS, AND EMERGENCY MANAGEMENT

High blood sugar: Hyperglycemia

- *Signs & Symptoms*
  - Severe: Labored breathing, confusion, profound weakness, unconsciousness
  - Moderate: Dry mouth, stomach cramps, vomiting, nausea
  - Mild: Lack of concentration, thirst, frequent urination, flushing of skin, sweet-fruity breath odor, weight loss, stomach pains, blurred vision, increased hunger, fatigue/sleepiness
- *Onset*
  - Usually slow to develop severe levels
  - More rapid with pump failure/malfunction, illness, infection
  - Can mimic flu-like symptoms
  - Greatest danger: may lead to diabetic ketoacidosis (DKA) if not treated
- *Risks & Complications*
  - If left untreated, hyperglycemia can lead to DKA (diabetic ketoacidosis), and potentially to coma/death
  - May interfere with a client's ability to participate in daily routines and activites
  - Serious long-term complications may develop when glucose levels remain above target range over time or recur
- *Possible Causes*
  - Late, missed, or too little insulin
  - Food intake exceeds insulin coverage
  - Decreased physical activity
  - Expired or improperly stored insulin
  - Illness, injury
  - Stress
  - Other hormones or medications
  - Hormone fluctuations, including menstrual periods
  - Any combination of the above

- *Prevention*
  - Follow *Diabetes Action Plan* as recommended by the client's health care provider (see Appendix)
  - TIMING is very important. Client should be encouraged to stick to schedules:
    - Meal time, insulin administration, physical activity
  - ACCURACY is very important.
    - **If client will have the responsibility for blood glucose monitoring, they must be proficient and approved for self-monitoring.** Inaccurate monitoring of blood glucose levels and/or inaccurate use of insulin can lead to an emergency situation.
    - Results of glucose monitoring should be documented and reported to the client's health care provider as indicated in their *Diabetes Action Plan*.
- *Hyperglycemia: What to do*
  - Goal: Lower the blood glucose levels to target range
    - If client exhibits **signs of severe hyperglycemia (unconsciousness, labored breathing, confusion) call 911**
    - If client exhibits **signs of moderate-severe hyperglycemia, or you are not sure, contact Health Services**
    - Action steps will follow client's *Diabetes Action Plan*, which may include:
      - Verify high blood sugar with blood glucose check.
      - Check ketones in urine
      - Allow free use of bathroom and access to water
      - Administer insulin per client's individual health care protocol
      - Recheck blood glucose per client's individual health care protocol
      - Client self-monitoring blood glucose should be encouraged to keep journal of blood glucose levels.

Low blood sugar: Hypoglycemia

- *Signs & Symptoms*
  - Mild: Hunger, shakiness, weakness, paleness, blurry vision, sleepiness, changes in behavior, sweating, anxiety, dilated pupils, increased heart rate or palpitations
  - Moderate to severe: Yawning, irritability/frustration, extreme tiredness/fatigue, inability to swallow, sudden crying, confusion, restlessness, dazed appearance, unconsciousness/coma, seizures
- *Onset*
  - Sudden, must be treated immediately
  - May progress to unconsciousness if not treated
  - Can result in brain damage or death
- *Risks & Complications*
  - Early recognition and intervention can prevent an emergency
  - Greatest immediate danger
  - Not always preventable
  - Impairs cognitive and motor functioning
- *Possible Causes*
  - Too much insulin
  - Too little food or delayed meal or snack
  - Extra/unanticipated physical activity
  - Illness
  - Medications
  - Stress
- *Prevention*
  - Timing is very important in all aspects of diabetes management
  - Physical activity, insulin, eating, checking BG, should all be per schedule
  - Client should always have a quick-acting sugar source with them
  - Treat at onset of symptoms
  - Ensure reliable insulin dosing, per client's health care protocol
  - Ensure insulin dosing matches food eaten
- *Mild/Moderate Hypoglycemia: What to do*
  - Seek assessment from Health Services
  - Follow the client's *Diabetes Action Plan*
  - Client checks blood glucose using proper blood glucose monitoring meter technique
  - When in doubt, always treat. Untreated may progress to more serious events.
  - "Rule of 15":
    - Have client eat or drink fast acting carbs (15g)

        - 15g Carbohydrate: 4 oz fruit juice, 15g glucose tablet, 1 tube glucose jel, 4-6 hard candies, 1-2 tablespoons of honey, 6 oz (half a can) regular soda, 3 tsp table sugar
        - Limit to 15 g or the client will experience high blood glucose level
    - Check blood glucose 10-15 minutes after treatment
    - Repeat treatment if blood glucose level remains low or if symptoms persist.
    - **If symptoms continue, call 911**
- *Severe Hypoglycemia: What to do*
    - Symptoms include convulsions (seizures), loss of consciousness, inability to swallow
    - **HYPOGYLCEMIC EMERGENCY**
        - **Call 911 and notify Health Services**
        - Place client on their side.
        - Lift chin to keep airway open.
        - Follow Diabetes Action Plan or client's health care protocol.
        - NEVER give food or put anything in client's mouth.
        - Client should respond in 10-20 minutes after treatment.
        - Remain with client until help arrives.
        - If the client is awake and able to swallow, give juice or other quick acting form of glucose followed by snack while waiting for EMS. *If you are not sure, do not put anything in the client's mouth!

BLOOD GLUCOSE MONITORING

Overview

- *Goal*: maintain blood glucose within target range
- *Challenge*: Many variables impact blood glucose
    - Include insulin, food, activity, stress, and injury.
- *Using glucose monitoring as a tool*:
    - Know the client's established parameters. This should be clearly identified in the client's individual health care protocol, if applicable
    - When parameters are indicated they must be specific, written parameters that are obtained from the client's health care provider

Rationale

- TIMING is very important in the management of diabetes.
- Blood glucose monitoring as recommended by a health care professional is the best way to control diabetes and avoid high or low blood sugars and long-term complications.
- *Immediate benefit*: identification, treatment, and prevention of lows and highs
- *Long-term benefit*: decrease risk of long-term complications, maximize health

Safe Glucose Monitoring Procedure for Trained Staff:

- Any change in health care provider order for glucose monitoring requires a review.
- A copy of the manufacturer's requirements for the glucometer being used for the client's glucose monitoring must be available for staff reference.

Blood Glucose Monitoring: Approved Client

1. Gather blood glucose monitoring supplies: lancet, test strip, meter.
2. Wash hands and dry them thoroughly.
3. Turn the meter on if necessary. Some meters turn on automatically when the strip is inserted.
4. Check code number that appears on meter with the code number found on the container of the test strips. Correct meter code if codes do not match.
5. Insert a strip into the meter (some meters turn on automatically when the strip is inserted).
6. Hold the lancet device to the side of the finger and press the button to stick the finger. Use the side of the finger, as the tip and pad of the finger have more sensitive nerve endings. Express an adequate drop of blood.
7. Apply small amount of blood to end of strip.
8. Wait until blood glucose level is displayed on the meter.

9. Dispose of lancet and strip in biohazard sharp container.
10. Record blood glucose result and take action per client's *Diabetes Action Plan* and Health Care Provider parameters.

Importance of gloves, clean technique and proper hand washing:

- Infection control requirements (CDC, 2016):
    - Fingerstick devices should never be used for more than one person.
    - Whenever possible, blood glucose meters should not be shared.
        - If they must be shared, the device should be cleaned and disinfected after each use.
    - Insulin pens and other medication cartridges and syringes are for single-patient-use only and should never be shared.
    - Used lancet and strips should be disposed of in a biohazard sharp container which is kept in a secured location.

F. Opioid Overdose & Nasal Naloxone Training

In the midst of the opioid overdose epidemic in the Commonwealth of New Hampshire, HLW recognizes that safe and effective management of opioid pain reliever or narcotic related overdose preparedness is necessary to avoid preventable opioid-related deaths. Every effort to prevent clients from misusing opiates will be made. Intra-nasal Narcan may prevent opioid related deaths when used properly in the event of an opiate or narcotic related overdose. When administered quickly and properly, Naloxone may restore breathing and save lives. Naloxone has no potential for abuse and has been used by paramedics in ambulances and in emergency rooms for decades (mass.gov). Use of Naloxone shall be implemented in emergency response protocols at HLW. Naloxone is not a controlled substance but does require a prescription under New Hampshire Law.

In accordance with New Hampshire Law Ch. 192 of the Acts of 2012:

- A person acting in good faith may receive a Naloxone prescription, possess Naloxone and administer Naloxone to an individual appearing to experience an opioid-related overdose.
- Naloxone may lawfully be prescribed and dispensed to a person at risk of experiencing an opiate-related overdose, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.
- New Hampshire Law stipulates that a bystander or victim of an overdose cannot be charged with "possession of a controlled substance" if they seek medical attention during an overdose.

In the school setting (105 CMR 210, M.G.L. 71:54B, M.G.L. C. 94C, 19(d)):

- Given a protocol signed by the school physician, a school nurse may administer nasal naloxone to individuals who experience a life-threatening overdose in the school setting. Stock supplies of nasal naloxone may be maintained by the school nurse for this purpose.
- All nurses in all practice settings, including schools, as part of their professional responsibility may teach individuals to administer nasal naloxone in the school setting. The school nurse may manage the training program with full decision-making authority, in consultation with the school physician, in DPH approved programs.
- Nasal naloxone may be stored in any school building in an area that is secure but not locked during those times when nasal naloxone is most likely to be administered, as determined by the school nurse.

The HLW opioid overdose prevention plan is developed from the New Hampshire Department of Public Health Opioid Overdose Education and Narcan Distribution Core Competencies for Naloxone: Core Competencies.

PROTOCOL FOR MANAGEMENT OF OPIOD OVERDOSE

First, determine if the person may be overdosing:

1. Signs of overdose include:
    a. Pale, clammy skin
    b. Very infrequent or no breathing
    c. Deep snoring or gurgling
    d. Not responsive to shaking, yelling, sternal rub, or other stimuli
        i. A person may not respond when you yell their name
    e. Slow heart beat/pulse
    f. Blue lips/fingertips

Then, respond:

1. Call 911 and follow general emergency protocol.
2. Perform CPR
3. Administer Naloxone (Narcan)
    a. Naloxone may work immediately or can take up to 8 minutes to take effect. Effects last for 30 to 90 minutes. Always call 911 before or after administering Naloxone.
4. Place the person in recovery position

5. Stay with the person until help arrives.

Do Not:

1. Put the victim in a bath, they could drown.
2. Do not induce vomiting. The person may choke.
3. Do not give the victim anything to drink. They may choke.
4. Do not put ice down the victim's pants or attempt to cool down their temperature.
5. Do not try to stimulate the victim in a way that may cause harm (slapping hard, kicking the testicles, burning the bottom of the feet, etc.)
6. Do not inject the victim with anything.

Possible Side Effects of Naloxone:

- Hypersensitivity (rash, worsening difficulty breathing, anxiety) is rare.
- Too much naloxone can cause withdrawal symptoms such as: anxiety, runny nose and eyes, chills, muscle discomfort, disorientation, combativeness, nausea/vomiting, diarrhea.

For further information, refer to the Protocol, Procedures, and Standing Medical Orders for the Administration of Naloxone (see Appendix).

G. Do Not Resuscitate / Comfort Care

The New Hampshire Department of Education in consultation with Department of Public Health Legal Office has promulgated a Guideline for the care of clients with Comfort Care/Do Not Resuscitate Orders. This Guideline reads as follows:

Purpose: Client with terminal illnesses are attending school in increasing numbers. As the status of a client's health declines, a family may make the difficult decision not to prolong the client's life and request a "Do Not Resuscitate" order (DNR). A DNR order is executed by a physician, authorized nurse practitioner, or authorized physician assistant, with the consent of the parent or legal guardian, and issued according to the current standard of care.

Scope: Client attending a HLW school who have a "Do Not Resuscitate" or "Comfort Care" order. If a client has a DNR order, a physician can submit a Comfort Care/DNR Order Verification to the Office of Emergency Medical Services in the New Hampshire Department of Public Health and obtain a Comfort Care form and an identifying bracelet.

Comfort Care identification (either the bracelet or the fully executed original form) is the only authorized way for pre-hospital emergency care providers (EMTs, first responders) to recognize a patient with a current, valid DNR order. EMTs and first responders called to a school will honor a DNR only if the client has a Comfort Care identification. Without a Comfort Care bracelet or original form, EMTs and other first responders who are called to a school will provide emergency treatment, including resuscitation, in accordance with standard EMS protocols, and transport to a hospital. The following website provides further information: http://www.mass.gov/dph/oems/comfort/ceprot2a.htm.

1. Special consideration must be given to meeting client and family needs, as well as the needs of the client and staff.
2. The client should be placed only in a school that has a full-time school nurse.
3. The local emergency medical services should be informed (with written permission from the parent or guardian) that there is a client in the specific building with a DNR/Comfort Care order.
4. An individualized care plan should be developed with the family in collaboration with the client's physician and the school physician. It should include:
   (a) how the client will be moved to the health room or other designated area if serious distress or death should occur at another location in the school;
   (b) What, if any, comfort measures should be given to the client;
   (c) Protocols for notification of the family; and, if the client has died in school;
   (d) Who will do the pronouncement of death (physician, nurse practitioner, or physician assistant)[1];
   (e) how the deceased will be removed from school. This may involve planning with the family's designated funeral home and include such factors as type of vehicle, where it will park, who will clear the corridors, and what kind of stretcher or other method of transport will be used. (Please note: by law, EMS providers are not permitted to move the deceased.)

5. The plan should also address what will happen if the client is in distress but does not appear to face an imminent risk of death. The response should include immediate consultation with the parents and, consistent with the plan, contact with the local EMS provider. If EMS is called, and the client has a Comfort Care bracelet or form, the EMT or first responder can provide comfort care and transport to a hospital. The type of care that EMS is able to provide in this situation is spelled out in the Comfort Care Protocol, available on the above-referenced website.
6. When a plan is in place, the school nurse should convey the plan to the appropriate school staff and administrators, answering any questions that they may have.
7. Whenever a death occurs in the school, the crisis team must be activated immediately to assist the family, staff and other client to cope with the loss. Special consideration must be made for any other client or staff who witnesses the death especially, if (per DNR orders) no treatment was performed either by school staff or EMS. Questions such as, "What if this happens to me?" and "Will they do anything for me?" may need to be addressed.

[1]Nurse practitioner (NP) and physician assistant (PA) pronouncements function as "removal permits" thereby allowing the deceased to be removed from the school grounds by a funeral director. However the NP or PA who pronounces the death must (a) before the pronouncement, try to reach the attending doctor so that the doctor can declare the death and complete the death certificate, and (b) after the pronouncement, notify the attending doctor as to the location to which the body has been removed so that the physician can complete the death certificate. State law (M.G.L. Chapter 46, section 9) requires that a physician or the medical examiner complete the death certificate.

VI. Prevention and Control of Communicable and Infectious Disease

All HFW staff are trained in infection control procedures. Any client or staff member who contracts a communicable disease will receive authorization from their physician to continue to be present at the program. The program notifies all parents/guardians and referring agencies of the reported communicable disease within the program. Also, the local board of health is notified in accordance with M.G.L.. c. 111, §111. Criteria for exclusion from work and school is outlined in the attached section from the health care manual (see Appendix).

A. Preventing the Spread of Infectious Disease

Purpose: To reduce the risks of acquiring and transmitting infectious disease among clients, families, employees, volunteers, and visitors of The Home for Little Wanderers (HLW).

Statement of Policy: Infection control is a shared responsibility requiring cooperative effort, which is undertaken by all services/areas for the safety and well-being of all in the HLW environment. It is undertaken in keeping with the best practice guidelines of monitoring, regulatory, and accrediting agencies.

HLW ensures surveillance, analysis of risk, and implementation of prevention and control strategies to break the chain of transmission of infectious disease.

HLW ensures that while in its care, client will receive appropriate medical care throughout the course of the illness and will be referred for professional diagnosis and treatment as needed.

HLW is aware of, and in compliance with, laws and regulations governing confidentiality of infectious disease status.

B. Procedure for Preventing the Spread of Communicable Diseases

General Procedures:

The Home will maintain all policies, procedures, and medical records regarding communicable diseases in a manner which is consistent with requirements of local, state, and federal law.

The Home does not mandate communicable disease testing of client. If a client or parent/legal guardian requests testing or the treatment team recommends testing due to high risk behaviors, the client will receive counseling concerning communicable disease assessment and requested testing.

If a client or parent/legal guardian discloses communicable disease information about themselves or their child,

- The person to whom information is disclosed may encourage the client or parent/legal guardian to sign a release form allowing information to be shared with the client's treatment team. The members of this team have direct accountability and responsibility for the treatment and physical care of the client.
- For all DCF referred clients, the DCF social worker is considered part of the treatment team. It is the practice of The Home to work cooperatively with DCF regarding any client concerns, including any communicable disease related information, once the client or parent/legal guardian has given permission.
- If the client would prefer to designate specific people with whom the information can be shared, this shall be noted on the release form.

Infectious Disease:

1. If a case of infectious disease is expected or diagnosed, staff will implement appropriate infectious disease precautions. Among the symptoms which may indicate, and which may need to be evaluated for diagnosis of an infectious disease are: sore throat, fever, weeping or bloody skin or mouth sores, nausea, and/or vomiting, bloody or explosive diarrhea, unexplained rash, unexplained swelling, unexplained redness of the eye and persistent, painful or deep coughing. Infectious disease precautions will vary based on the type and severity of the illness. In all situations attention to handwashing will be observed. In diseases requiring isolation, every possible attempt should be made to eliminate direct contact with others during the period of communicability. Isolation shall include the least restrictive measures which will prevent the spread of disease while also addressing a client's emotional well-being. Infected client's eating utensils, bedding and bathing materials, etc. will be kept separate from others. Common diseases requiring isolation include chicken pox, hepatitis, meningitis, tuberculosis, salmonellosis, scarlet fever, and strep throat.

2. Client may not attend school and after school programs during the communicable stage of the illness.

3. Following a diagnosis of strep throat, conjunctivitis, or other contagious illness requiring antibiotic treatment, the client must be on the antibiotic for a minimum of 24 hours before returning to school, after-school programs, and close interaction with others.

4. Staff will make every attempt to ensure that separating a client from others is done in a way that considers the emotional needs of the client.

C. Practice Guidelines Dismissal from School Protocol

If a client exhibits signs or symptoms of illness, staff shall notify Health Services for further instruction. The Program nurse may exclude a client from school for health reasons if the client:

- Has a temperature of 100.5 degrees or greater. Temperature must be 98.6 for a full 24 hours prior to returning to school.
- Has an infectious disease (Strep Throat/Pneumonia, etc.) and has not been on antibiotic therapy for 24 hours or as designated by MD.
- Eye drainage yellow/green in color with pink or red eyes, eyelids, etc.
- Any undiagnosed rash.
- Has a culture(s) pending (exceptions can be made at the discretion of the nurse).
- Has Chicken Pox/Shingles, with active, draining rash (rash must be dry, non-weeping, and shingles must be covered). Clients may attend school with poison ivy as it is not contagious. It should be washed thoroughly and covered.
- Has had persistent vomiting and diarrhea; must be symptom free for 24 hours before returning to school.
- Has a condition requiring immediate medical intervention, i.e., emergency dental care, sutures, bone setting, or pending a medical diagnosis for any condition.
- Has a condition that requires on-going supervision, which cannot be supervised in the school setting.
- Is very sleepy or is experiencing excessive bleeding after a dental visit.
- Has untreated Pediculosis, Scabies or body lice.
- Poses a significant health risk to others in the normal course of school activities.

Significant health risk is defined by:

- Any client is in the infectious stage of a serious airborne transmitted disease (T.B., Viral Pneumonia, Influenza, etc.).
- Clients who are unable to hygienically manage their bowel and bladder functions and/or are in the infectious stage of an oral/fecal transmitted disease. Such diseases are, but are not limited to, Hepatitis A, Clostridium Difficile (c-diff), gastro-intestinal viruses (Salmonella, Shigella, Rotovirus) and parasites (Pinworms, Girdiasis.) and has not completed treatment.
- Clients who have a disease which may be transmitted by body fluids, and have open lesions and whose developmental level makes it difficult for them to refrain from touching lesions and others, therefore, spreading the underlying infection to others. Such diseases are, but not limited to, Herpes, Impetigo, Hepatitis B virus, Staph Aureus, Beta Hemolytic Strep, and Conjunctivitis.

D. Practice Guidelines for Client Returning to Work and School

In the interest of promoting the health and well-being of all client, there may be some cases when a client's illness or symptoms prevent them from attending school or work. The *Practice Guidelines for Client Returning to Work and School* (see Appendix) outlined below includes common symptoms and infectious diseases and criteria for exclusion.

Clients should not come to school if they are ill. General guidelines for return to school or work after illness include:

- Fever free for 24 hours, without medication
- No vomiting or diarrhea within 12 hours
- 24 hours on antibiotic prescription for conditions such as, but not limited to, strep, impetigo, conjunctivitis, ringworm, scabies

Client and staff may return to work or school when the individual conditions are met, as outlined in chart. In addition, a physician's note is required before return following surgery, concussion, hospitalization, rash with unknown origin, fracture, or sprain.

E. Reportable Infectious Disease and Response

Infectious diseases outlined in the Appendix noted with an asterisk (*) are Reportable by Health Care Providers under the New Hampshire Department of Public Health 105 CMR 300.000: Reportable Diseases, Surveillance, and Isolation and Quarantine Requirements. Suspected or confirmed cases should be reported to the local board of health; or if unavailable the New Hampshire Department of Public Health promptly (within 24hours). See Appendix regarding reportable. This includes both suspected and confirmed cases.

Refer to the New Hampshire Department of Public Health website for the most up-to-date information:
https://www.mass.gov/files/documents/2016/07/vo/rprtbldiseases-hcp.pdf

Animal bites should be reported immediately to the designated local authority.

F. Handwashing

Clean Hands Save Lives!

Keeping hands clean is one of the most important steps we can take to avoid getting sick and spreading germs to others. It is best to wash your hands with soap and clean running water for 20 seconds. However, if soap and clean water are not available, use an alcohol-based product to clean your hands. Alcohol-based hand rubs significantly reduce the number of germs on skin and are fast-acting.

When washing hands with soap and water:

- ☐ Wet your hands with clean running water and apply soap. Use warm water if it is available.
- ☐ Rub hands together to make a lather and scrub all surfaces.
- ☐ Continue rubbing hands for 20 seconds. Need a timer? Imagine singing "Happy Birthday" twice through to a friend!
- ☐ Rinse hands well under running water.
- ☐ Dry your hands using a paper towel or air dryer. If possible, use your paper towel to turn off the faucet.

Remember: If soap and water are not available, use alcohol-based gel to clean hands.

When using an alcohol-based hand sanitizer:

- ☐ Apply product to the palm of one hand
- ☐ Rub hands together
- ☐ Rub the product over all surfaces of hands and fingers until hands are dry

Always wash your hands:

- ☐ Before preparing or eating food
- ☐ After going to the bathroom
- ☐ After changing diapers or assisting a child who has gone to the bathroom
- ☐ Before and after tending to someone who is sick
- ☐ After blowing your nose, coughing, or sneezing
- ☐ After handling an animal or animal waste
- ☐ After handling trash
- ☐ Before and after treating a cut or wound

Information provided by: http://www.cdc.gov/cleanhands

G. Standard Precautions

Standard Precautions should be used for the care of all client, regardless of their diagnosis or presumed infection status.

Standard precautions apply to:

1. Blood
2. All bodily fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood
3. Non-intact skin
4. Mucous membranes.

Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection.

Standard precaution measures include use of:

1. Hand washing
2. Appropriate personal protective equipment such as gloves, masks, and/or face shields whenever touching or exposure to client's bodily fluids is anticipated.

Plan for Infection Control

All staff will be trained in infection control procedures upon employment. Handwashing is the first line of defense against the spread of infections. The School shall ensure that staff and client wash their hands with liquid soap and running water using friction. Hands shall be dried with individual disposable towels.

Staff and client shall wash their hands at the following times:

- Before eating or handling food
- After using the toilet
- After coming in contact with blood or any other potentially infectious body fluids
- After handling any animals or their equipment at the School
- After cleaning
- Before giving any medications or providing First Aid Care

Standard Precautions

1. All blood and body fluids will be treated as if they were potentially infectious.
2. Latex or vinyl gloves will be worn by all staff when they come in contact with blood or body fluids. Specifically, gloves will be worn during toileting and when administering First Aid.

3. Gloves will be made available to all staff at all times. Whenever a staff person is outside the building with client, gloves will be readily available, either in a First Aid kit present in the immediate area or in the possession of the staff person.
4. If a staff member has an allergy to a specific type of glove, the program will provide another type of glove to ensure the staff member's safety without causing an allergic reaction. Gloves will never be reused and will be changed between client. Handwashing will always occur when gloves are removed.
5. Proper disposal of infectious materials is required. Any disposable materials that contain liquid, semi-liquid or dry, caked blood will be double bagged and disposed of separately from the regular trash. Biohazard containers are not necessary in the school.
6. Cloth items that come into contact with blood or body fluids will be double bagged and sent to be laundered.
7. Staff members will have a change of clothes on site in case their clothing becomes contaminated.
8. Each staff member will be trained in Standard Precautions Procedures upon employment and then annually.
9. The school will have an exposure control plan.
10. Any blood spill will be cleaned up by first using a disposable absorbent material* and then disinfecting the area thoroughly with a bleach solution. All materials will be thrown away using the double bagging method. Employees will wear gloves during this procedure and thoroughly wash their hands after removing the gloves.
    ** a commercial blood spill kit or disposable paper towels will be accepted for this procedure*

H. Maintaining Continence and Personal Hygiene

Some client will need help with managing continence and related hygienic needs while at school. Client who have social, emotional, cognitive or physical disabilities may be partially or totally dependent for all hygiene needs. IEP and treatment teams will determine clear plans for client, that meet individualized hygiene needs, and promote independence when possible.

Staff working with client with continence or other hygiene needs may be involved with

- Changing clothing or disposable hygiene textiles (DHT), such as sanitary napkins, tampons, incontinence products, panty shields, or wipes
- Bathing or showering client
- Transferring and positioning client
- Cleaning client after a bladder or bowel movement
- Cleaning and disinfecting bathroom or change areas
- Appropriately disposing of DHT or laundering clothing
- Providing both verbal and/or physical prompting

General Principles

1. The client's treatment and educational teams will assess the client's need on a case-by-case basis to support with related individualized planning. Where possible, client should contribute to their own personal hygiene plan with their personal preferences and needs being noted. All written plans will include procedures for the client's personal hygiene routine and assistance with DHT; disposal of DHT or laundering of clothing; and FERPA compliant protections of client privacy.
2. All staff involved in personal hygiene procedures should be trained in standard universal precautions. The nurse provides oversight for implementation of these procedures. There should be sufficient staff available to ensure the safety of client and staff to meet the needs of the individual personal hygiene plan.
3. Spare clothes and DHT will be in a designated closet with a private space available to change if needed.
4. Scheduled personal hygiene routine times will be established throughout the day.
5. Each client will also have accessibility to completing their personal hygiene routine immediately when necessary. Client level of assistance will be described in their individualized plan along with plans for increasing independence as appropriate.
6. Staff must wear gloves while assisting client with their personal hygiene routine and dispose of the gloves immediately when finished. Staff will ensure routine is completed in a safe and private location.
7. Disposable wipes will be used for personal hygiene.

8. Before and after assisting client with their personal hygiene routine, staff must wash or sanitize their hands. Prior to use of latex gloves, allergies will be determined to protect client against exposure to latex when allergies are present.
9. Clothing, DHT and gloves that are soiled by feces, urine, vomit, or blood must be double bagged and disposed of or washed separately.
10. Staff and client must wash hands after completing personal hygiene tasks.

I. Disposal of Waste

Disposal Procedure & Cleaning Precautions for Regulated Waste:
Regulated waste must be disposed of according to federal, state, and local regulations. All body fluid spills should be cleaned up quickly to help protect clients, staff and visitors from potential infections and to ensure we have a safe environment. All spillages of body fluids and material used during the cleanup should be treated as 'regulated waste' and disposed of appropriately. Red biohazard bags should be used to dispose of waste and should be securely tied/sealed and disposed of in the Biohazardous bin. The bin is located in the Health Service Office in the Main School on the 3rd floor. Each primary container shall: (1) Be marked prominently with the universal biohazard warning symbol and the word "Biohazard" in a contrasting color; and (2) Be secured so as to prevent leakage and to preclude loss of contents during handling, storage, and/or transport. Discretion should be used to determine when red bags are ready for disposal.

Regulated waste is removed from HLW by contracted company, Stericycle Inc. 855-408-1982

Sharps:
Discarded medical articles that may cause puncture or cuts, including, but not limited to, all needles, syringes, lancets, pen needles, pipettes, broken medical glassware/plasticware, scalpel blades, suture needles, dental wires, and disposable razors used in connection with a medical procedure. Sharps shall be segregated from other wastes and aggregated immediately after use in red, leakproof, rigid, puncture-resistant, shatterproof containers that resist breaking under normal conditions of use and handling, and that are marked prominently with the universal biohazard warning symbol and the word "Biohazard" in a contrasting color. A sharps container may be removed when the container is filled. The closed container must be placed inside of the red-bag lined box.

Sharps are removed from HLW by contracted company, Stericycle Inc. 855-408-1982

Medications:
Discontinued or outdated medications are returned to the parent. If not picked up within one week, medications may be destroyed with the destruction recorded by supervisor with DPH, Drug Control Policy.

Non-Regulated Waste (DHT products):
Body waste products such as urine and feces without blood are not considered regulated waste. Waste such as disposables containing non-fluid blood (i.e.: soiled sanitary napkins, dressings, gauze and cotton balls with a small amount of dried blood or other body fluids) are not regulated waste. These can be disposed of in plastic bags with regular garbage.

VII. Medication Administration

A. Practice Guidelines for the Administration of Medication

This guideline outlines regulations put in place by the New Hampshire Department of Public Health and the policies adopted by the Home for Little Wanderers Board of Directors regarding the administration of prescription medications in school. The HLW Board of Directors approves the following policies under its jurisdiction. Consent forms, medication protocols, and other pertinent information are available in the Health Services office.

Unity House will not assume any responsibility for clients not in compliance with these policies. Any questions regarding medication in school should be referred directly to Health Services.

I. Management of the Medication Administration Program 105 CMR 210.003

A. The school nurse shall be the supervisor of the prescription medication administration program in the school.

B. The school nurse and the school physician/consultant shall develop and propose to the HLW Board of Directors, policies and procedures related to the administration of prescription medications.

C. Medication Orders/Parental Consent

1. The school nurse shall ensure that there is a proper medication order from a licensed prescriber which is renewed as necessary, including the beginning of each academic year. Only the school nurse shall receive a telephone order or any change in medication (see Appendix). Any such verbal order must be followed by a written order within three school days. Whenever possible, the prescription medication order shall be obtained, and the medication administration plan, specified in 105 CMR 210.005(E), shall be developed before the client enters or re-enters school. Any change of medication, dosage, or frequency must be authorized by a new order. No medications will be administered without a current order.

    a. In accordance with standard medical practice, a prescription order from a licensed prescriber shall contain: (see Appendix)
        1) The client's name
        2) The name and signature of the licensed prescriber and business and emergency phone numbers
        3) The name, route and dosage of medication

4) The frequency and time of administration
5) The date of the order and the discontinuation date
6) A diagnosis and any other medical condition(s) requiring medication, if not a violation of confidentiality or if not contrary to the request of a parent, guardian or client to keep confidential
7) Specific directions for administration

b. Every effort shall be made to obtain from the licensed prescriber the following additional information, if appropriate:
   1) Any special side effects, contraindications and adverse reactions to be observed;
   2) Any other medications being taken by the client;
   3) The date of return visit, if applicable.

c. Special Medication Situations
   1) For short-term prescription medications, i.e., those requiring administration for ten school days or fewer, the pharmacy-labeled container may be used in lieu of a licensed prescriber's order. If the nurse has a question, she may request a licensed prescriber's order.
   2) For "over-the-counter" medications, i.e., Non-prescription medications, the school nurse shall follow the Board of Registration in Nursing's protocol regarding administration of over-the-counter medications in schools.
   3) Investigational new drugs may be administered in the schools with
      a) A written order by a licensed prescriber,
      b) Written consent of the parent or guardian, and
      c) A pharmacy-labeled container for dispensing. If there is a question, the school nurse may seek consultation and/or approval from the school physician/consultant to administer the medication in the school setting.

2. The school nurse shall ensure that there is a written authorization by the parent/guardian (see Appendix) which contains:
   a. the parent/guardian's printed name, signature and a home and emergency phone number
   b. a list of all medications the client is currently receiving, if not a violation of confidentiality or contrary to the request of the parent, guardian, or client that such medications not be documented
   c. approval to have the school nurse, or school personnel designated by the school nurse, administer the medication

d. persons to be notified in case of a medication emergency, in addition to the parent or guardian, and licensed prescriber

D. Medication Administration Plan (see Appendix)

1. The school nurse, in collaboration with the parent or guardian whenever possible, shall establish a medication administration plan for each client receiving a prescription medication. Whenever possible, a client who understands the issues of medication administration shall be involved in the decision-making process and his/her preferences respected to the maximum extent possible (The Department of Education Guidelines require client consent for the 18-21 age group and client participation in planning age 14, if appropriate). If appropriate, the prescription medication administration plan shall be referenced in any other health or educational plan developed pursuant to the New Hampshire Special Education Law (Individual Education Plan under Chapter 766) or federal laws, such as the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973.

2. Prior to the initial administration of the medication, the school nurse shall assess the client's health status and develop a medication administration plan which includes:
   a. the name of the client
   b. an order from a licensed prescriber, including business and emergency telephone numbers
   c. the signed authorization of the parent or guardian, including home and business telephone numbers
   d. any known allergies to food or medications
   e. the diagnosis, unless a violation of confidentiality or the parent, guardian client requests that it not be documented
   f. the name of the prescription medication
   g. the dosage of the medication, frequency of administration and route of administration
   h. any specific directions for administration
   i. any possible side effects, adverse reactions or contraindications
   j. the quantity of medication to be received by the school from the parent or guardian
   k. the required storage conditions
   l. the duration of the prescription
   m. the designation of unlicensed school personnel, if any, who will administer the medication to the client in the absence of the nurse, and plans for back-up if the designated persons are not available

n. plans, if any, for teaching self-administration of the prescription medication
o. with parental permission, other persons, including teachers, to be notified of medication administration and possible adverse effects of the medication.
p. a list of other prescription and over-the-counter medications being taken by the client, if not a violation of confidentiality or contrary to the request of the guardian or client that such medication not be documented
q. when appropriate, the location where the administration of the medication will take place
r. a plan for monitoring the effects of the medication
s. provision for medication administration in the case of field trips and other short-term school events. Every effort will be made to obtain a nurse or school staff trained in medication administration to accompany clients at special school events. When this is not possible, the school nurse may delegate medication administration to another responsible adult. Written consent from the parent or guardian for the named responsible adult to administer the medication shall be obtained. The school nurse shall instruct the adult on how to administer the medication to the client.

3. The school nurse will positively identify the client who receives the medication by:
   a. Referencing the client's picture in their file
   b. Asking the client their name
   c. Confirming correct identification with support staff accompanying the client.

4. The school nurse shall communicate significant observations relating to the prescription medication's effectiveness, adverse reactions, or other harmful effects to the client's parent/guardian and/or licensed prescriber.

5. In accordance with standard nursing practice, the school nurse may refuse to administer or allow to be administered any medication, which, based on her/his individual assessment and professional judgment, has the potential to be harmful, dangerous or inappropriate. In these cases, the parent/guardian and licensed prescriber shall be notified immediately by the school nurse and the reason for refusal, explained and documented.

6. For the purposes of medication administration, the licensed practical nurse functions under the general supervision of the school nurse who has delegation authority. Prescription medication administration is within the scope of practice for the licensed practical nurse under M.G.L. Chapter 112.

7. The school nurse shall have a current pharmaceutical reference available for her/his use, such as The Physician's Desk Reference (PDR) or U.S.P.D.I (Dispensing Information) Facts and Comparisons.

E. Delegation/Supervision (this section applies to school districts or private schools which have been registered by the New Hampshire Department of Public Health to permit school nurses to delegate responsibility for administration of medication to trained nursing supervised unlicensed school personnel).

The HLW Board of Directors, in consultation with the New Hampshire Board of Health, where applicable, ___ authorizes ___ does not authorize that the responsibility for the administration of medication may be delegated to the following categories of unlicensed school personnel according to criteria delineated in CMR 210.004 (B)(2):
_____ Administrative Staff_____ Teaching Staff_____ Licensed Health Personnel
_____ Direct Care Health Aides

For the purpose of administering emergency medication to a client, including parenteral administration (i.e., by injection) of epinephrine pursuant to 210.004 (B) (4), the school nurse may identify individual school personnel or additional categories. Said school personnel shall be listed on the medication administration plan and receive training in the administration of emergency medication to a specific client.

1. The school nurse, in consultation with the school physician, shall have final decision-making authority with respect to delegating administration of medications to unlicensed personnel in school systems registered with the Department of Public Health.

2. When medication administration is delegated by the school nurse to unlicensed school personnel, such personnel shall be under the supervision of the school nurse for the purposes of medication administration.

3. A school nurse shall be on duty in the school system while medications are being administered by designated unlicensed school personnel, and available by telephone should consultation be required.

4. The administration of parenteral medications may not be delegated, with the exception of epinephrine where the client has a known allergy or preexisting medical condition and there is an order for administration of the medication from a licensed prescriber and written consent of the parent or guardian.

5. Prescription medications to be administered pursuant to p.r.n. ("as needed") orders may be administered by authorized school personnel after an assessment by or consultation with the school nurse for each dose.

6. For each school, an updated list of unlicensed school personnel who have been trained in the administration of medications shall be maintained. Upon request, a parent shall be provided with a list of school personnel authorized to administer medications.

7. Supervision of Unlicensed Personnel

   Authorized unlicensed personnel administering medications shall be under the supervision of the school nurse. The School Committee or HLW Board of Directors, in consultation with the Board of Health where appropriate, shall provide assurance that sufficient school nurse(s) are available to provide proper supervision of unlicensed school personnel. Responsibilities for supervision at a minimum shall include the following:

   a. After consultation with the principal or administrator responsible for a given school, the school nurse shall select, train and supervise the specific individuals, in those categories of school personnel approved by the School Committee or HLW Board of Directors, in consultation with the Board of Health when appropriate, who may administer medications. When necessary to protect client health and safety, the school nurse may rescind such selection.

   b. The number of unlicensed school personnel to whom responsibility for medication administration may be delegated is determined by:
      1) the number of unlicensed school personnel the school nurse can adequately supervise on a weekly basis as determined by the school nurse; and
      2) the number of unlicensed school personnel necessary, in the nurse's judgment, to ensure that the medications are properly administered to each client.

   c. The school nurse shall supervise the training of the designees consistent with the Department of Public Health's requirements in CMR 210.007 of the Regulations Governing the Administration of Prescription Medications in Public and Private Schools.

1) The school nurse shall document the training and evidence of competency of unlicensed personnel designated to assume the responsibility for medication administration.
2) The school nurse shall provide a training review and informational update, at least annually, for those school staff authorized to administer medications.

d. The school nurse shall support and assist persons who have completed the training to prepare for and implement their responsibilities related to the administration of medication.

e. The first time that an unlicensed school personnel administers medication, the delegating nurse shall provide supervision at the work site.

f. The degree of supervision required for each client shall be determined by the school nurse after an evaluation of the appropriate factors involved in protecting the client's health including, but not limited to the following:
1) health condition and ability of the client;
2) the extent of training and capability of the unlicensed school personnel to whom the medication administration is delegated;
3) the type of medication; and
4) the proximity and availability of the school nurse to the unlicensed person who is performing the medication administration.

g. Personnel designated to administer medications shall be provided with the names and locations of school personnel who have documented certification in cardiopulmonary resuscitation. Schools should make every effort to have a minimum of two school staff members with documented certification in cardiopulmonary resuscitation present in each school building throughout the day.

h. For the individual client, the school nurse shall:
1) determine whether or not it is medically safe and appropriate to delegate medication administration;
2) administer the first dose of the medication, if (a) there is reason to believe there is a risk to the client as indicated by the health assessment, or (b) if the client has not previously received this medication in any setting;

3) review the initial orders, possible side effects, adverse reactions and other pertinent information with the person to whom medication administration has been delegated;
4) provide supervision and consultation as needed to ensure that the client is receiving the medication appropriately. Supervision and consultation may include record review, on-site observation and/or client assessment; and review all documentation pertaining to medication administration every two weeks or more often as necessary.

II. Self-Administration of Prescription Medications 105 CMR 210.006

"Self-administration" means that the client is able to consume or apply medication in the manner directed by the licensed prescriber, without additional assistance or direction.

A client may be responsible for taking his/her own medication after the school nurse has determined that the following requirements are met:

A. The client, school nurse and parent/guardian, where appropriate, enter into an agreement which specifies the conditions under which medication may be self-administered.

B. The school nurse, as appropriate, develops a medication administration plan, which contains only those elements necessary to ensure safe, self-administration of prescription medication.

C. The client's health status and abilities have been evaluated by the school nurse, who then deems self-administration safe and appropriate. As necessary, the school nurse shall observe initial self-administration of the medication.

D. The school nurse is reasonably assured that the client is able to identify the appropriate medication, knows the frequency and time of day for which the prescription medication is ordered.

E. There is written authorization from the client's parent/guardian that the client may self-medicate, unless the client has consented to treatment under M.G.L.c. 112F or other authority permitting the client to consent to medical treatment without parental/guardian permission.

F. If requested by the school nurse, the licensed prescriber provides a written order for self-administration.

G. The client follows a procedure for documentation of self-administration of medication.

H. The school nurse establishes a policy for the safe storage of self-administered medication and as necessary, consults with teachers, the client and parent/guardian, if appropriate, to determine a safe place for storing the medication for the individual client, while providing for accessibility if the client's health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventative emergency medication, whenever possible, a backup supply shall be kept in the Health Services office or other accessible location.

I. The client's self-administration is monitored based on his/her abilities and health status. Monitoring may include teaching the client the correct way of taking the medication, reminding the client to take the prescription medication, visual observation to ensure compliance, recording that the medication was taken, and notifying the parent/guardian or licensed prescriber of any side effects, variations from the plan, or the client's refusal or failure to take prescription medication.

J. With parental/guardian and client permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the client is self-administering a medication.

III. Handling, Storage, and Disposal of Medications 105 CMR210.003 (4)

A. A parent, guardian, or a parent/guardian-designated responsible adult shall deliver all medications to be administered by school personnel or to be taken by self-medication clients, if required by the self-administration agreement, to the school nurse or other responsible person designated by the school nurse.
   1. The medication must be in a pharmacy-labeled or manufactured labeled container.
   2. The school nurse or other responsible person receiving the medication shall document the quantity of the medication delivered.
   3. In extenuating circumstances, as determined by the school nurse, the medication may be delivered by other persons; provided, however, that the nurse is notified in advance by the parent/guardian of the arrangement and the quantity of medication to be delivered to the school.
   4. A Medication Receiving and Tracking form will be maintained by the school nurse for all medications received for administration. The name of medication, strength, prescribing physician will be documented along with date of quantity received, quantity on hand, and total quantity (see Appendix).

B. All prescription medications shall be stored in their original pharmacy or manufacturer labeled containers and in such manner as to render them safe and effective. Expiration dates shall be checked.

C. All medications to be administered by school personnel shall be kept in a securely locked cabinet used exclusively for medications, which is kept locked except when opened to obtain the medications. The cabinet shall be substantially constructed and anchored securely to a solid surface. Prescription medications requiring refrigeration shall be stored in either a locked box in a refrigerator or in a locked refrigerator maintained at temperatures of 38 to 42 degrees Fahrenheit (see Appendix)

D. Access to stored medication shall be limited to persons authorized to administer medications and to self-medicating clients. Access to keys and knowledge of the location of keys shall be restricted to the maximum extent possible. Clients who are approved to self-medicate shall not have access to other client's medications.

E. Parents or guardians may retrieve the medications from the school at any time.

F. No more than a thirty (30) school day supply of the medication for a client shall be stored at school.

G. Where possible, all unused, discontinued or outdated medications shall be returned to the parent or guardian and the return appropriately documented. In extenuating circumstances, with parental consent when possible, such medications may be destroyed by the school nurse in accordance with any applicable policies of the New Hampshire Department of Public Health, Division of Food and Drugs. All medications should be returned at the end of the school year.

IV. Documentation and Record-Keeping 105 CMR 210.003 (2)

A. Each school, where school personnel administer prescription medications, shall maintain a prescription Medication Administration Record (see Appendix) for each client who receives prescription medication during school hours.

1. Such record at a minimum shall include a daily log and a prescription medication administration plan, including the prescription medication order and parent/guardian authorization.

2. The prescription medication administration plan shall include the information as described in Section 210.005 (E) of the Regulations Governing the Administration of Prescription Medications in Public and Private Schools.

3. The daily log (see Appendix) shall contain:
   a. The dose or amount of prescription medication administered.
   b. The date and time or administration or omission of administration, including the reason for omission.
   c. The full signature of the nurse or designated unlicensed school personnel administering the prescription medication. If the medication is given more than once by the same person, he/she may initial the record, subsequent to signing a full signature.

4. The school nurse shall document in the prescription medication administration record significant observations of the medication's effectiveness, as appropriate; and any adverse reactions or other harmful effects, as well as any action taken.

5. All documentation shall be recorded in ink and shall not be altered.

6. With the consent of the parent, guardian or client, where appropriate, the completed prescription medication administration record and records pertinent to self-administration shall be filed in the client's cumulative health record. When the parent, guardian or client, where appropriate objects, these records shall be regarded as confidential medical notes and shall be kept confidential.

B. Unity House shall comply with the Department of Public Health's reporting requirement for prescription medication administration in the schools.

C. The Department of Public Health may inspect any individual client medication record or record relating to the administration or storage of medications, without prior notice, to ensure compliance with the Regulations Governing the Administration of Prescription Medications in Public and Private Schools.

V. Reporting and Documentation of Prescription Medication Occurrence 105 CMR 210.003(5)

A. A medication occurrence includes any failure to administer medication as prescribed for a particular client, including failure to administer the medication:
   1. correct time
   2. correct dosage

3. correct route
4. correct client
5. correct medication

B. In the event of a medication occurrence, the school nurse shall notify the parent or a guardian immediately. (The school nurse shall document the effort to reach the parent or guardian.) If there is a question of potential harm to the client, every effort should be made to reach the client's licensed prescriber.

C. The school nurse shall document medication errors on the client accident/incident report form. These reports shall be retained in the principal's office and the client health record. A copy will be submitted to the Director of Nursing. They shall be made available to the Department of Public Health upon request. All prescription medication errors resulting in serious illness requiring medical care shall be reported to the Department of Public Health, Bureau of Family and Community Health. All suspected diversion or tampering of drugs should be reported to the Department of Public Health, Division of Food and Drugs. (*MDPH School Health Medication Error Report Form* – see Appendix)

D. The school nurse shall review report of medication occurrences and take necessary steps to ensure appropriate prescription medication administration in the future.

B. Practice Guideline for the Prescription and Administration of Psychotropic Medications

Psychotropic medications are those medications that are prescribed with the intent to facilitate any number of the following:

- to promote the stability and improvement in an individual's mood and affect;
- to promote an individual's skill development with regard to impulsivity and self-control;
- to promote an individual's ability to function free from psychotic thought processes and experiences;
- to assist individuals in alleviating distressing affective states that may lead to self-destructive, aggressive or dysfunctional behavior patterns;
- to maintain a patient in a state of symptom resolution or reduction and to prevent recurrence of severe psychiatric symptoms.

Rationale and guidelines for psychotropic medication interventions

- Treatment and service is provided to client and families in cooperation with a multidisciplinary team and through development of a comprehensive treatment plan. In many cases, the administration of psychotropic medication is an additive and important component of the comprehensive treatment plan. The medication treatment is intended as an integrated component with other non-somatic interventions in the comprehensive treatment plan. The prescription of psychotropic medications is considered a major intervention.
- In this regard, the prescription of medications is approached with caution and thoughtfulness. Antipsychotic medication prescribed by a licensed physician at HLW will only be prescribed after careful review of a client's medical record and actual observation of the client. In each case, the prescribing physician will attempt to minimize the number of agents prescribed, the duration of treatment and the treatment dosage while taking steps to maximize the potential benefit from the psychotropic medications. In addition, the prescribing physician will closely monitor and attempt to minimize adverse effects of medications. Psychotropic medications are prescribed to address specific target symptoms. The prescribing physician will work with their colleagues on the treatment team, the parent or guardian and the patient to identify and develop specific criteria to monitor the efficacy of medication interventions. Prescribing physicians at HLW maintain current knowledge with regard to prescribing practices of psychotropic medications. Prescribing physicians at HLW maintain a consultative network to facilitate case-based consultation whenever necessary.

The physician shall include in their patient progress notes and discuss at MDT why the medication being prescribed is necessary, potential adverse effects that may or may not require medical attention, the times and dates that the physician will be meeting with the client, and staff monitoring requirements.

The School Nurse will educate staff providing care to a client receiving antipsychotic medication about the nature of the medication, potential side effects that may or may not require medical attention and requiring monitoring or special precautions, if any.

Informed consent for medication administration
The process of informed consent at HLW is described in detail in HLW Policy: "Informed Consent for Psychotropic Treatment." In brief, obtaining informed consent for treatment from the parent/guardian of a minor and assent for treatment from the minor are central components of the treatment process. Informed consent and assent include education about potential benefits of treatment, possible outcomes with and without treatment, potential adverse effects of recommended medication and the projected duration of treatment.

If a client is in parental custody, informed written consent is obtained and the consent for anti-psychotic medication can be revoked at anytime. If the client is in another situation regarding custody, a judicial approval may be required. If a client is in the custody of DCF, a Rogers order must be obtained before the medication is administered to the patient.

The physician prescribing the medication will notify all clients on antipsychotic medication who are twelve years or older, consistent with the clients capacity to understand about the treatment's risk and potential side effects. The program has a refusal process in place for clients who refuse medication.

Prescription and administration of psychotropic medications
The processes of prescribing and administering psychotropic medications in the programs of HLW are described in detail in the HLW Practice Guidelines: "Practice Guidelines for the Administration of Medications." In brief, all patients who are prescribed medications are evaluated regularly by the prescribing physician.

Emergency administration of antipsychotic medication
In an emergency situation an antipsychotic medication may be administered to a client without parental consent or judicial approval for treatment purposes if an unforeseen combination of circumstances or the resulting state calls for immediate action in the best interest of the client to avoid injury or harm and there is no less intrusive alternative to the medication. The treating physician must determine that the medication is necessary to prevent the immediate substantial and irreversible deterioration of a serious mental illness. If the medication continues, proper consent must be obtained as required by law.

C. Procedure for Medication Administration Off-Grounds and During Field Trips

The classroom teacher shall notify the school nurse in advance of a field trip or short-term school sponsored special event. A Medication Delegation for Field Trips Form (see Appendix), if approved DPH program, will be sent to the person responsible for administering the prescription medication during the field trip. All clients requiring medications on school field trips will have an Individual Medication Administration Plan on record in the school Health Office.

The school nurse will provide the responsible designated adult with the client's medication in a pharmacy labeled container. The school nurse will review the information on the container with that adult including: client name, medication, dose, time of administration, any special instructions or cautions.

The classroom teacher or other designated responsible adult will have responsibility for the safe keeping of the medication and for administering the medication. The designated adult will have the responsibility of returning the pharmacy labeled container to the school nurse at end of the field trip or school sponsored short-term special event.

In certain circumstances or in programs not approved by DPH, efforts will be made to have a licensed nurse accompany the client on a field trip.

D. Administering Over-the-Counter Medications and Preparations

Medication administration in New Hampshire schools must be according to protocols written by an authorized prescriber (Physician, Nurse Practitioner, and Dentist) and meet the Board of Registration in Nursing Policy Governing the Administration of Over-the-Counter Medications

Nurses may administer over-the-counter medications to clients in New Hampshire schools based on protocols which have been developed in collaboration with the school department's physician, dentist or nurse practitioner, provided that the appropriate school administrative authority allows the use of such protocols.

Written orders by licensed prescriber include:
Drug Name, Dose, Dosage Interval/Directions
Indications and Contraindications
Potential Adverse Effects
Cautions

Nursing Action/Assessment which must include:
1. Current medications the client is taking
2. Client's History of allergies

Parental/guardian consent for use of a drug according to the protocol must be on file and available to the nurse, as must information about the client's known allergies (see Appendix).

Documentation of over-the-counter medication administered according to such protocols must conform to the school department's regulations for documentation of medication administered to client (see Appendix).

The list of medications approved for administration, as well as the protocols, should be made available in each school's health office (see Appendix). A stock supply for emergency treatment, as approved and consented to by physician and parent/guardian, of epinephrine auto-injector and nasal naloxone is available for nurse administration as per approved written protocol. Sun block and insect repellant are considered medications. It is a current best practice to apply these in the morning before school.

Every effort will be made to contact parents of clients, before a medication is given.

Parent requests for their client to receive over-the-counter medication during the school day that is not included in the current list of over-the-counter medication protocols presently given by a Unity House's nurse will require a signed Parental Medication Consent form and a signed Physician Medication Consent form. This is to protect against drug interactions and to provide for the health and safety of the client. A supply of the clearly labeled over-the-counter medication needs to be provided to the nurse with the client's name along with the signed consent forms.

VIII. Nutrition and Physical Well-being Policy

Unity House recognizes the relationship between client well-being and client achievement as well as the importance of a comprehensive district wellness program. Therefore, Unity House provides developmentally appropriate and sequential nutrition and physical education as well as opportunities for physical activity. The wellness program will be implemented in a multidisciplinary fashion and will be evidence based.

Wellness Committee

Unity House shall establish a Wellness Committee that consists of at least one (1): parent, client, nurse, school nutrition representative, School Committee member, school administrator, teacher, member of the public, and other community members as appropriate. If available, a qualified, credentialed nutrition professional will be a member of the Wellness Committee. Goals will be established on an annual basis. The committee will be co-chaired by the Nurse and the Wellness Project Manager. The Wellness Project Manager, in consultation with the Wellness Committee, will complete an evaluation of the goals each year.

Nutrition Guidelines

It is the policy of the Unity House that school meals offered under the National School Lunch and School Breakfast Programs are consistent with the Healthy, Hunger-Free Kids Act of 2010. Guidelines for reimbursable school meals will not be less restrictive than regulations and guidance issued by the Secretary of Agriculture pursuant to law.

In addition to the School Breakfast and School Lunch programs, competitive foods and beverages sold or provided to clients during the school day must comply with the New Hampshire School Nutrition Standards for Competitive Foods and Beverage Act (52:125) signed into law in New Hampshire on July 30, 2010 and the Smart Snacks in School nutrition standards 7 CFR 210.31(c)(3)(iii). School day is defined as the midnight before through 30 minutes after the end of the school day. Foods and beverages offered to clients in vending machines must comply with the standards at all times.

Unity House Wellness Committee will incorporate procedures that address all foods available to clients throughout the school day in the following areas:

- guidelines for maximizing nutritional value by decreasing fat and added sugars, increasing nutrition density and moderating portion size of each individual food or beverage offered within the school environment based on the "Act Relative to School Nutrition" (July 2010);
- including foods and beverages in the following categories:
  - ✓ foods and beverages included in a la carte sales in the school nutrition program on school campus
  - ✓ foods and beverages offered in school stores
  - ✓ foods and beverages offered as part of school-sponsored fundraising activities
  - ✓ refreshments served at celebrations and meetings during the extended school day (30 minutes before and 30 minutes following the regular school day)

- ✓ any other foods or beverages included in extended school day activities
- ✓ encourage the sale of non-food items or activity drive events as part of the fundraising activities
- ✓ prohibit the use of food and beverage items as a reward or punishment

Nutrition and Physical Education

Unity House will provide nutrition education aligned with state standards. The school district will provide physical education training aligned with the standards established by the Department of Elementary and Secondary Education. The Wellness Committee will collaborate with Unity House to develop procedures that address nutrition and physical education and other school-based activities that promote wellness.

Nutrition Education Goals

- Clients participate in nutrition education that teaches the skills they need to adopt and maintain healthy eating behaviors.
- Parents and community members will receive nutrition information to support clients' healthy behaviors.
- Nutrition information is offered in the school cafeteria and on the School Nutrition website as well as in the classroom, with coordination between the school nutrition staff and other school personnel, including teachers.
- Clients receive consistent nutrition messages from all aspects of the school program.
- Parents will be informed about the policy and the procedures.
- Health education curriculum standards and procedures address both nutrition and physical education.
- Nutrition awareness is integrated into the health education or core curricula (e.g., math, science, language arts), as appropriate.
- Staff who provide nutrition education have nutrition training.

Physical Education Goals

- Clients are given opportunities for physical activity during the school day through physical education (PE) classes, daily recess periods, physical activity breaks, and the integration of physical activity into the academic curriculum where appropriate.
- PE will be taught by certified physical education teachers.
- Clients are also given opportunities for physical activity through a range of before- and/or after-school programs including, but not limited to, intramurals and interscholastic athletics, working toward the goal of sixty (60) minutes of physical activity per day.
- Additional opportunities for physical activity are encouraged, whether within the school, or through private or public facilities and/or organizations.
- Schools, in collaboration with the community, encourage parents and guardians to support their children's participation in physical activity, to be physically active role models, and to include physical activity in family events.
- Schools provide training to enable staff to promote enjoyable, lifelong physical activity among clients.
- Schools will limit exclusion of physical activity as a form of disciplinary action.

Other School-Based Goals

- An adequate amount of time is allowed for clients to eat meals in adequate lunchroom facilities.
- All children who participate in subsidized food programs are able to obtain food in a non-stigmatizing manner.
- Environmentally-friendly practices such as the use of locally grown and seasonal foods, school gardens, compostable and non-disposable tableware have been considered and implemented where appropriate.
- Physical activities and/or nutrition services or programs designed to benefit staff and clients' health have been considered and, to the extent practical, implemented.

Evaluation

The Wellness Committee will assess all education curricula and materials pertaining to wellness for accuracy, completeness, balance and consistency with the federal, state and district's educational goals and standards. The Wellness Project manager shall be responsible for devising a plan for implementation and evaluation of the district wellness policy and is charged with operational responsibility for ensuring that schools work toward achieving the goals of the district wellness policy..

IX. Working with Parents/Guardians as Partners

Client's on-going health promotion and access to the health care systems depends primarily on parents/guardians. Health Service staff work towards collaboration among the client, their families/guardians and the community, including primary care providers, with common goals of improving the client's health and experience of feeling well.

Key features of collaboration include:

- ✓ Involving the client and family in accessing needs, identifying strengths and resources, participating in the development of individual health treatment plans and the development of group programs to meet the needs and build on strengths
- ✓ Communicating the goals, intent and content of the health education program that client take part in at the program and inviting parents to be partners in this education
- ✓ Supporting the invitation by providing parallel opportunities for parents to learn about issues client are learning about in school and about strategies for being effective mentors in promoting their client's health knowledge and skills
- ✓ Helping to facilitate, but not manage family/primary care provider interaction
- ✓ Providing parents with opportunities to discuss the medications their client are taking, express their concerns, ask questions and get answers
- ✓ Work with families on strategies for safe administration and monitoring of medications at home
- ✓ Limited use of medical jargon
- ✓ Respect needs, i.e., language, child-care, transportation
- ✓ Maintain appropriate boundaries
- ✓ Work toward recognition, understanding and respect for the differences of home and program
- ✓ Communicate all health concerns to parents and develop strategies together to address the concern

X. Discharge

The clinician will inform the nurse of a pending discharge as soon as possible. The program nurse will alert the physician/health care provider of the need for the discharge prescription for the parent/guardian for all medications that will be continued after discharge. The nurse will prepare an envelope containing the Health Discharge Summary, MA health or other insurance cards, immunization record and the medication prescription, if it has not been given to the parent/guardian directly from the physician. The envelope will also contain any unopened medication that the client will continue to take following discharge. The nurse will prepare a written statement of any current medical issues or concerns, including the times of upcoming routine screenings.

If possible, the nurse will meet with the client, parent/guardian at the time of discharge to review health and medication issues, answer any questions that may arise, and/or refer questions to the client's psychiatrist for further clarification.

VIII. Appendix

Section I: Admission Forms

The Home for Little Wanderers Initial Health Assessment

To be completed by the program nurse or intake clinician within 24 hours of admission

Client Information

Client Name (Last, First, Middle)	**Birth Date:**	**Date of Exam:**
	Gender (at birth) □Male □Female **Gender Identity:** □Male □Female	**Pronouns:** □They/theirs □His/him □Hers/her
Address (Street, Town, ZIP Code)		
Parent/Guardian Name (Last, First, Middle)	**Emergency Contact Info:**	
School/Grade:	**Primary Care Provider**	
Health Insurance Company/Number* or MassHealth:		

Health Information

PHYSICAL EXAM:
Height: ___in/___%ile **Weight** ___lbs/___%ile **BMI:** ___/___%ile **Pulse**___ **Blood Pressure** ___/___

System	*Normal*	*Describe Abnormal*	*System*	*Normal*	*Describe Abnormal*
Neurologic			Neck		
HEENT			Shoulders		
Lymphatic			Ortho		
Heart			Arms/Hands		
Lungs			Hips		
Abdomen			Knees		
Skin			Feet/Ankles		
Gross Dental			**Postural**	□ No spinal abnormality	*Spine abnormality:* □ Mild □ Moderate □ Marked □ Referral made

The Home for Little Wanderers Initial Health Assessment

To be completed by the program nurse or intake clinician within 24 hours of admission

SCREENINGS:

Vision Screening:
Date performed: / /
Method: □ Snellen □ Tumbling E
□ Other

Type:	**Right**	**Left**
With glasses:	20/	20/
Without glasses:	20/	20/

□ Referral made

Does the client wear:
□ Glasses
□ Contact lenses □ Both

Auditory Screening
Date performed: / /
Method: □ Audiometry □ OAE □Other

Type:	**Right**	**Left**
	□ Pass	□ Pass
	□ Fail	□ Fail

Does child wear a hearing aide? □Y □N

Was child referred for further evaluation? □Y □N

	Date
History of Lead level >5ug/dL □ No □Yes	
HCT/HGB:	
Speech (school entry only)	
Other:	

TB: High-risk group? □No □Yes **PPD date read:** **Results:** **Treatment:**

IMMUNIZATIONS:

□ Up to Date or □ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

CHRONIC DISEASE ASSESSMENT:

Asthma	□ No	□Yes	□ Intermittent □ Mild Persistent □ Moderate Persistent □Severe Persistent □ Exercise Induced *If yes, please provide a copy of the **Asthma Action Plan** to school*
Anaphylaxis	□ No	□Yes	□ Food □Insects □Latex □Unknown source *If yes, please provide a copy of the **Emergency Allergy Plan** to school*
Allergies	□ No	□Yes	If yes, specific allergen(s): Epi pen required □No □ Yes
Diabetes	□ No	□Yes	If yes: □ Type I □Type II
Seizures	□ No	□Yes	If yes, type:

SPECIAL NEEDS:

Chronic medical conditions/related surgeries?	□ No	□Yes	□ *Special care plan attached**	*List special needs/considerations and medications below (other than special care plans attached).*
Medications or treatments?	□ No	□Yes	□ *Special care plan attached**	
Allergies/sensitivities?	□ No	□Yes	□ *Special care plan attached**	
Behavioral issues/mental health diagnoses?	□ No	□Yes	□ *Special care plan attached**	
Limitations to physical activity?	□ No	□Yes	□ *Special care plan attached**	
Special equipment needs?	□ No	□Yes	□ *Special care plan attached**	
Special dietary requirements?	□ No	□Yes	□ *Special care plan attached**	

Signature of Intake Clinician/Licensed Nurse Date signed

Narrative Notes

Name			
Date	**Time**	**Narrative** *Include observations, HCP visits, medication changes, changes from the familiar, reportable events, etc.*	**Staff Signature**

EPINEPHRINE ACTION PLAN

All staff working with supported individuals who require assistance with Epinephrine shall receive formal training provided, by approved DPH programs. Training must be renewed annually.

Primary Care Provider Authorization: Epinephrine Auto-Injector

Name: _____ Date of Birth: _____

Program: _____

Allergy to: _____

Asthma: _____Yes _____No

Signs of an allergic reaction include:

Mouth itching and swelling of the lips, tongue, or mouth
Throat * itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin hives, itchy rash, and/or swelling about the face or extremities
Stomach nausea, abdominal cramps, vomiting, and/or diarrhea
Lung* shortness of breath, repetitive coughing, and/or wheezing
Heart * "thread" pulse, "passing out"
Other individual specific symptoms: _____
_____

***The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!**

Epinephrine auto-injector should be: kept with in the immediate vicinity of the individual unless otherwise noted.

Emergency action for an allergic reaction:
1.Administer emergency medication--- epinephrine auto-injector 0.3mg
2.Call EMS (911)
3.Contact the following people:

Emergency Contact	Telephone #	Relationship

****Do not hesitate to administer medication or call for emergency assistance (EMS)**

Individual specific Instructions: (if applicable) _____
_____

_____ _____
Printed Name of ordering MD Telephone # of MD

_____ _____
MD Signature Date

Competency Evaluation Tool for Epinephrine Administration via Auto-Injector Device

Staff Name: _____

Individual's Name: _____

Date: _____

	Pass (P), Fail (F), N/A	Comments	General Knowledge
1.			Knows that only licensed personnel (nurses) and MAP Certified staff, who have successfully completed specialized training in medication administration of epinephrine via pre-filled auto-injector device training, may administer the epinephrine medication.
2.			Knows that another competency evaluation including a return demonstration with 100% accuracy must be completed annually.
3.			Knows that all MAP regulations must be followed when administering epinephrine via pre-filled auto-injector device.
4.			Knows what an auto-injector device is and knows why this individual has a Health Care Provider order for one.
5.			Knows to compare the Health Care Provider order with the label and the medication sheet at the beginning of the shift.
6.			Knows to check the epinephrine pre-filled auto-injector device expiration date at the beginning of the shift.
7.			Knows the epinephrine solution should be clear and colorless.
8.			Knows if the epinephrine solution is brown it is not to be used and another device obtained.
9.			Knows what an anaphylactic reaction is.
10.			Knows the symptoms of an anaphylactic reaction.
11.			Knows what effect epinephrine has on the body.
12.			Knows the most common effects of epinephrine felt by the individual after the injection.
13.			Knows why 911 is immediately called following epinephrine administration and the importance of informing emergency personnel that epinephrine was administered.
14.			Knows that epinephrine wears off in about 10 to 20 minutes after it is administered.
15.			Knows the Health Care Provider must be notified.
16.			States other emergency procedure guidelines per agency policy.
17.			States what s/he would do if there were an accidental administration of epinephrine via pre-filled auto-injector.
18.			Knows storage requirements of the pre-filled epinephrine via auto-injector device; that it is locked, and kept at room temperature away from heat and sunlight.
19.			Knows disposal requirements specific to the used auto-injector device(s).

	Pass (P), Fail (F), N/A	Comments	Procedure for Return Demonstration of Administration of Epinephrine via Auto-Injector Device:
1.			Follows all procedures for preparation of medications for administration according to MAP regulations and policies.
2.			Informs individual what is being done.
3.			Forms a fist around the pre-filled auto-injector with the tip [usually it is an orange tip] facing down and pulls off the safety cap. (Knows to NEVER put fingers over the tip)
4.			Places the pre-filled auto-injector device at a 90-degree angle on the outer thigh. (Knows it is not necessary to remove clothing since the auto-injector device is designed to work through clothing.)
5.			With a quick motion, pushes the pre-filled auto-injector firmly against the outer thigh. (Holds in place and slowly counts to 10 before removing needle.)
6.			Knows even though a small amount of liquid remains inside the auto-injector after use, the device cannot be used again.
7.			Calls 911 immediately for transportation to emergency room.
8.			After ER personnel arrive and individual is cared for, notifies HCP, and follows all emergency procedures per the provider's policy.
9.			Properly disposes of the used auto-injector.
10.			Documents administration according to MAP regulations and policies.

Based on this Competency Evaluation Tool, I, as Trainer, have determined that the Certified Staff Person named below is competent to administer epinephrine via auto-injector device to the Individual named below.

Staff Person's Printed Name _____ Individual's Printed Name _____

Staff Person's Signature _____ Date _____

Trainer's Printed Name _____ Trainer's Phone Number _____

Trainer's Signature _____ Date _____

Unity House
Diabetes Action Plan

Client's Name: _____ DOB: _____ Grade: _____
Client's Address: _____

Client's Blood Sugar Goal Range: _____

Low Blood Glucose Level (Hypoglycemia)
Blood Glucose Level Less Than: _____

Symptoms

- ☐ Feeling weak or tired
- ☐ Shakiness
- ☐ Pale complexion
- ☐ Hunger
- ☐ Blurred vision
- ☐ Fast heartbeat
- ☐ Sweating
- ☐ Headache
- ☐ Stomachache
- ☐ Irritability or anxiety
- ☐ Dizziness or confusion
- ☐ More quiet than usual

Client specific symptoms include: _____

Actions: _____

Note: symptoms of hypoglycemia may change over time. The symptoms that the client reports today may be different in the future.

Low Blood Glucose Emergency
(Unconscious or Having a Seizure)

Actions:

- **NEVER** attempt to put food or drink into the client's mouth if they are unconscious or having a seizure
- **CALL 911**
- **Call** parent/guardian

Unity House
Diabetes Action Plan (cont'd.)

Client's Name: _____ DOB: _____ Grade: _____

High Blood Glucose Level (Hyperglycemia)
Blood Glucose Level Greater Than: _____

Symptoms

- ☐ Deep and rapid breathing
- ☐ Fast heartbeat
- ☐ Drinking more than usual
- ☐ Urinating more than usual
- ☐ Nausea and vomiting
- ☐ Hunger
- ☐ Stomachache
- ☐ Feeling tired or sleepy
- ☐ Blurry vision
- ☐ Dry skin or lips
- ☐ Irritability

Client specific symptoms include: _____

_____

_____

Actions: _____

_____

_____

Contacts:

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Nurse Signature: _____ Date: _____

Protocol, Procedures, and Standing Medical Orders for the Administration of Naloxone

Purpose:

- Naloxone is an opioid antagonist that is used to reverse the effects of opioids.
- Current research has determined that naloxone administration has been found to prevent death from opioid overdose, as well as reduce disability and injury from opioid overdoses.
- The rapid administration of naloxone may be life-saving in patients with an overdose due to opioid use. (Doe-Simpkins, Walley, Epstein, & Moyer, 2009)

Drug: Naloxone (Narcan)

Dose: 2mg initial dose for individuals > 20kg or > 5years of age naloxone HCl 1mg/ml, in pre-filled 2ml Luer-Lock needless syringe via intranasal automizer

Route: Intranasal only

Indication: Registered nurses may administer naloxone to a person in the event of respiratory depression, unresponsiveness, or respiratory or cardiac arrest when an overdose from opioid is suspected of a client, staff member, or visitor. Person is unresponsive, very low respiratory rate or not breathing, low blood pressure, and there is no response to sternal rub.

Contraindications: diabetic ketoacidosis, electrolyte imbalance, hypothermia, meningitis, apnea, stroke, subdural hematoma, poisoning, toxicity from other drug, allergy to any ingredient in naloxone

Precautions: pregnancy or those who are planning to become pregnant, breast feeding mothers, non-prescription medications, herbal remedies, diet supplements, history of heart disease or substance abuse

Emergency Procedure:

1. **Activate EMS: Call 911**. Nurse or designee will call 911 to activate emergency medical service response
2. Assessment: ABC's: Airway, Breathing, Circulation.
    a. For pulseless individuals, initiate CPR per BCLS guidelines
    b. For apnea with pulse: establish airway and begin rescue breathing
    c. Check for: foreign body in airway, *level of consciousness** or unresponsiveness, very low respiratory rate or not breathing, no response to sternal rub, *respiratory status** gasping for air while asleep or odd snoring pattern, pale or bluish skin, slow heart-rate, low blood pressure, no response to sternal rub. Pin point pupils and track marks may be present, although absence of these findings does not exclude opioid overdose.
    d. ***Level of consciousness**
        i. The nurse determines that the person presents with a decrease in level of consciousness as evidenced by;
            1. difficult to arouse (responds to physical stimuli but does not communicate or follow commands, may move spontaneously)
            2. unable to arouse (minimal or no response to noxious stimuli, does not communicate or follow commands)
    e. ***Respiratory status**
        i. The nurse determines that the person presents with a depression of respiratory status as evidenced by;
            1. decrease in respiration rate
            2. if available, interpretation of pulse oximetry measurement

f. Nurse determines need for naloxone administration

3. Administration: Intranasal administration of naloxone
    a. Assess person for contraindications or precautions to naloxone, per available information
    b. Exclusion criteria also includes: nasal trauma or epistaxis
        i. Assemble naloxone vial and intranasal atomizer:
            1. Pop off two yellow caps from the delivery syringe and one red cap from the naloxone vial
            2. Screw the naloxone vial gently into the delivery syringe
            3. Screw the mucosal atomizer device onto the top of the syringe
        ii. Spray half (1mg) of the naloxone in one nostril and the other half (1mg) in the other nostril for a total of 2 mg
        iii. Continue rescue breathing or BCLS as needed
        iv. If no response, an additional second dose/vial may be administered after 3- 5 minutes
        v. Naloxone duration of action is 30-90 minutes
        vi. Transport to nearest hospital via EMS

Storage: Store at 59° to 86° F, away from direct sunlight

Possible Side Effects: Acute withdrawal symptoms, change in mood, increased sweating, nervousness, agitation, restlessness, tremor, hyperventilation, nausea, vomiting, diarrhea, abdominal cramping, muscle or bone pain, tearing of eyes, rhinorrhea, craving of opioid, rash hives, itching, swelling of face, lips, or tongue, dizziness, fast heartbeat, headache, flushing, sudden chest pain

Nursing Considerations: Withdrawal can be unpleasant; person may just breathe but not have full arousal or person may need continued rescue breathing and support

Documentation: Record encounter in client's school health record and on incident report for client, employee, or visitor, as applicable. Documentation must include patient presentation, route (intranasal), and dose that was administered as well as the patient's response to the naloxone administration.

School Physician's signature: _____ Date _____

Effective date: xxxxx

Reference Doe-Simkins, M., Walley, A., Epstein, A. & Moyer, Peter. (2009). Saved by the nose: Bystander administered intranasal naloxone hydrochloride for opioid overdose. American Journal of Public Health, 99 (5), 788-791.

Practice Guidelines for Client Returning to Work and School

Infectious Disease or Symptom	Signs and Symptoms	Exclusion	Conditions for Return
Infectious diarrhea with vomiting and fever	Vomiting, fever, diarrhea	Yes	May return when diarrhea and fever are absent for at least 24 hours, and the client is able to tolerate eating and drinking.
Gastroenteritis, viral	Nausea and diarrhea. Fever does not usually occur.	Yes	Diarrhea free and afebrile.
Mononucleosis infection (Epstien Barr Virus)	Variable, infants and young children are generally asymptomatic. Symptoms may include fever, fatigue, swollen lymph nodes, and sore throat.	Yes	Physician approval and fever free for 24 hours.
Fever	A temperature of 100°F (37.8°C) or higher. Measure temperature when no fever suppressing medications have been given.	Yes	May return when afebrile (fever free)

Common Cold	Runny nose, watery eyes, fatigue, coughing, sneezing	No, unless febrile	May return when afebrile (fever free)
Otitis media (ear infection/ear ache)	Fever, ear pain	No, unless febrile or extremely ill	May return when afebrile (fever free)
Giardia, Salmonella, and Campylobacter	Diarrhea, abdominal pain, fever, nausea, vomiting	Yes	May return after one state tested negative stool sample and is without diarrhea and fever.
Shigella	Fever, vomiting, diarrhea, which may be bloody	Yes	May return after two state tested negative tool samples and is without symptoms.
Hepatitis A*	Client may have no symptoms; some have flu-like symptoms or diarrhea. Adults can have fever, fatigue, nausea and vomiting, anorexia and abdominal pain. Jaundice, dark urine, or diarrhea may be present.	Yes	Infected person may return one week after the illness began, fever must be absent, and the person has started treatment. Persons who have been exposed to someone ill with Hepatitis A may need to receive a preventative shot of immune globulin.

Norovirus	Acute onset of combination of nausea, vomiting, watery non-bloody diarrhea, abdominal cramps, discomfort,	Yes	After 48 hours after symptoms subside, norovirus may be contagious up to 10 days after resolution of symptoms
Influenza	Rapid onset of fever, headache, sore throat, dry cough, chill, lack of energy, and muscle aches. Client may have nausea, vomiting, and/or diarrhea.	Yes	May return when feeling well, and is without symptoms of nausea, vomiting, diarrhea, cough, muscle aches, headaches and or general weakness.
Chicken Pox (Varicella) and Shingles *	Fluid filled blisters which scab over in 7-10 days	Yes	May return when all blisters are crusted over and dried up, or after 5 days
Meningitis, bacterial *	Sudden onset of **high fever** and **headache**, may have stiff neck, photophobia, and/or vomiting	Yes	May return after treatment is begun and are feeling well with written permission from physician. People exposed to infected person should get preventative treatment as well and may return to work.

Meningitis, viral *	Sudden onset of **fever** and **headache**, may have **stiff neck**, **photophobia**, and/or **vomiting**	Yes	Afebrile (fever free) with written permission from a physician.
HIB, meningitis or epiglottitis	Subacute or sudden fever, lethargy, neck stiffness, photophobia, **drooling, heavy breathing, upper respiratory infection symptoms**	Yes	May return after at least 4 days of appropriate antibiotic treatment
Strep throat	Fever, sore throat, lymph node enlargement	Yes	May return 24 hours after treatment with medication is initiated, with absence of fever.
Active TB, pulmonary*	Gradual onset of fatigue, anorexia, fever, failure to gain weight, and cough	Yes	May return after treatment is completed and with a note from his/her doctor stating that they are no longer contagious.
Impetigo	Blisters on skin which open and become covered with a honey-colored or yellow crust. Fever is not usually present.	Yes	May return 24 hours after initiation of medication, sores must be lightly covered up.

Ringworm	Slowly spreading flat, scaly, ring-shaped lesion on skin. Margins may be reddish and slightly raised. May cause bald patches.	Yes	May return after treatment has started. There is no need to exclude once they are being treated.
Conjunctivitis, bacterial or viral	Red eyes, usually with some glucy discharge or crusting around the eye. May be worse in the morning.	Yes	May return after treatment has begun. If medication is not required, a note from the physician is required before return.
Scabies	Small, raised red bumps or blisters on skin with severe itching, often on thighs, arms, and webs of fingers.	Yes	May return 1 day after treatment has begun.
Head lice	Itching and scratching of scalp Presence of live lice or pinpoint sized white eggs (nits) that will not flick off the hair shaft.	Yes	May return after treatment with Permetherin or other prescription lice medication. Decision may be made for the client to stay out longer based on individual family needs and situation. Client should be checked daily for 10 days after therapy has concluded.
Herpes simplex (cold sore)	Blisters on or near lips that open and become covered with a dark crust. Recurrences are common.	No, unless severe	May return when blisters are crusted over (usually 4-5 days later)

Measles*	Fever, followed by runny nose, watery eyes, and dry cough. A blotchy red rash, which usually begins on the face, and appears between the 3rd and 7th day.	Yes	Must be isolated from public places for 4 days after appearance of rash, then may return when feeling well and are not presenting with any of the following symptoms: Rash, diarrhea, ear infection, and / or pneumonia.
Mumps*	Low grade fever which may last 3 to 4 days, myalgia, anorexia, malaise, and headache, may be followed by classic symptom of parotitis (i.e. acute onset of unilateral or bilateral, self-limited swelling of the parotid or other salivary glands) lasting two days, may last longer than 10 days.	Yes	May return 9 days after parotid glands began to swell, and with absence of symptoms which include low-grade fever, stiff neck, loss of appetite, and/or swelling of the parotid glands has subsided in the jaw area. If exposed to person with confirmed mumps infection and non-specific respiratory symptoms develop, should be excluded for incubation period of mumps (12-25 days) even with absence of parotitis.

Rubella (German Measles)*	Mild illness, symptoms may include low-grade fever, sore throat, and rash which starts on the face and spreads to the rest of the body.	Yes	May return on the 8th day after the rash began, with absence of symptoms.
Polio*	Sore throat, fever, tiredness, headache, stomach pain, paralysis	Yes	May return 6 weeks from onset of disease, with absence of symptoms, and with note from physician that the person is no longer contagious.
Diphtheria*	Weakness, sore throat, fever, swollen glands in the neck	Yes	Infected person should be isolated until 2 successive pairs of nose and throat cultures, obtained at least 24 hours apart and at least 24 hours after completion of antimicrobial therapy, are negative. If there was no antimicrobial therapy, 2 sequential pairs of cultures may be taken after symptoms resolve and more than 2 weeks after their onset.

Lyme disease	Vary and occur in stages, may include "Bulls-eye' rash around tick bite (erythema migraines), usually not itchy or painful, rash on other parts of the body, flu-like symptoms, joint pain, joint swelling. A small red bump that lasts for a few days at the site of a tick bite usually does not indicate Lyme disease.	No, unless per HCP order	Not contagious, may attend school/work unless extremely sick with note from HCP.
Pertussis*	Minimal fever, similar to the common cold but with nonspecific cough, bursts of rapid coughing, person may turn blue during coughing fits. May hear inspiratory "whoop" during coughing fits. Coughing may be so severe it can cause vomiting.	Yes	Symptomatic persons should be excluded for the first 5 days of a full course of antimicrobial treatment. Symptomatic persons who do not take antimicrobial treatment should be excluded from child care or school for 21 days from onset of cough. Asymptomatic contacts who elect not to take antibiotics or are not up to date with their pertussis immunizations may be considered for exclusion from work or school for 21 days after their last exposure

Unity House

Telephone Order Form

Date of Order:_____ Time:_____

Name of Client:_____ DOB:_____

Allergies:_____

Discontinue:_____

Medication Name:_____

Dose:_____ Frequency:_____ Route:_____

Reason for Medication/Change:_____

_____

_____

Special Instructions/Precautions (include instructions for common side effects, labs, include parameters if vital signs need to be taken):_____

_____

_____

Discontinue Date (if applicable):_____

HCP's Name:_____

Nurse Signature/Title:_____

Signature of HCP:_____ Date:_____

UNITY HOUSE

MEDICATION RECEIVING AND TRACKING

Date: _____

Name: _____ Allergies: _____ DOB: _____

Date	Medication	Strength	Prescribing HCP	Quantity on Hand	Quantity Received	Total Quantity	Received by Signature

Medication Refrigerator Temperature Log

Refrigerator containing medication is required to be at +38° to 42° F. +40° F is the ideal temperature. * Notify pharmacy if temperature out of range.

Record Temperatures & Initial each business day. Temperatures are recorded in Fahrenheit.

Month/Year _____

Date	Temp	Initial	Date	Temp	Initial
1	F		16	F	
2	F		17	F	
3	F		18	F	
4	F		19	F	
5	F		20	F	
6	F		21	F	
7	F		22	F	
8	F		23	F	
9	F		24	F	
10	F		25	F	
11	F		26	F	
12	F		27	F	
13	F		28	F	
14	F		29	F	
15	F		30	F	
			31	F	

Month/Year _____

Date	Temp	Initial	Date	Temp	Initial
1	F		16	F	
2	F		17	F	
3	F		18	F	
4	F		19	F	
5	F		20	F	
6	F		21	F	
7	F		22	F	
8	F		23	F	
9	F		24	F	
10	F		25	F	
11	F		26	F	
12	F		27	F	
13	F		28	F	
14	F		29	F	
15	F		30	F	
			31	F	

UNITY HOUSE
Medication Occurrence Report

A medication error is defined as: "failure to administer the prescribed medication within the time frame, in the correct dosage, in accordance with accepted practice, to the correct client".

Date of Report _____ School _____

Prepared by _____
Name of Client _____ DOB _____ Sex _____ Grade ____
Home Address _____ Phone # _____
(Street)
_____
(City/Town) (Zip code)

Date Error Occurred _____ Time Noted _____
Person Administering Medication _____
Name Title Licensed Prescriber _____
(Name) (Address)
Reason Medication was Prescribed _____
Date of Order _____
Instructions for Administration _____
Medication _____ Dose _____ Route ___ Scheduled time _____
Describe the error and how it occurred (use reverse side if necessary): _____
_____
_____

Action Taken:
Licensed Prescriber Notified: Yes____ No ____ Date _____ Time _____
Parent/Guardian Notified: Yes____ No ____ Date _____ Time _____
Other Persons Notified: _____
Outcome: _____

Name _____ Signature _____
Title _____ Date _____

Health Services Signature/Date _____
Copies to Principle __ Program Director__
rev____

The Home for Little Wanderers'

Preparing for an Emergency

Revised October 2020
(Manual)

Scope: All employees, interns, volunteers, foster parents, Board members, and third party vendors		
Effective Date: January 1, 2014	Revised: April 2020	Next Review: 2022

Preparing for an Emergency

1. Purpose

(A) ACTIONS

2. Threat Command procedures
3. Evacuation/Shelter in Place
    a. Temporary off-site locations
4. Internal Notifications

(B) BEFORE an emergency: Planning and Preparing

5. Training
6. Preparedness
    a. Equipment/vans
    b. Mobility challenges
    c. Supplies and storage capacity
    d. Disaster supply kits/go bags
7. Collaboration with Governing Authorities
8. Communications of the Plan

(C) COMMUNICATION: Notifications and Aftermath Management

9. Media Communications
    a. Media communications
    b. Confidential information
10. Aftermath Management
    a. Disaster recovery team
    b. Debrief and assessment of emergency response
    c. Documentation and record-keeping

Additional Resources:

A. Evacuation guidelines
B. Shelter in place guidelines
C. Executive on call procedures
D. Media response team
E. Bomb threat procedures
F. Bomb threat checklist
G. Hurricane checklist

PURPOSE:

The Home for Little Wanderers maintains a response system that provides a shared manner of practices and procedures to guide personnel and programs through emergency and/or disaster events. Essentially, the manual is designed to provide a common approach to safely manage the unpredictable circumstances that can occur in the course of an emergency and/or disaster. The manual is not designed to address the specifics of every conceivable emergency.

The Home's emergency preparedness plan is a living document, meaning that it is reviewed regularly and updated as necessary.

All questions and inquiries regarding the agency's emergency preparedness plan should be directed to Heidi Ferreira, Vice President of Risk Management, Evaluation, and Outcomes or The Home's members of the Core Safety Team.

Important to note: One area of the plan is not considered to be more important than another area. nor is there a specific chronology of what to know. All of the areas must work well together in order to properly manage an emergency.

(A) ACTIONS during an Emergency Event

THREAT COMMAND PROCEDURES:

The following is a set of **Command Protocols** all staff must be familiar with:

A. LOCK DOWN:

When: Fugitive in the immediate area, gun shots in the neighborhood, unsafe external circumstances and one option under ALICE when violent intruder is close by

- Command is made to LOCK DOWN

-Move all staff and clients to a room or area that can be locked—DO NOT HUDDLE OR CONGREGATE IN ONE AREA

-Be Quiet

-Lock all doors and windows

-Shut off light

-Barricade the doors with furniture, belts, ropes, etc.

- Cover windows, if possible

- Stay away from windows

-If possible, hide in cabinets, closets, under desks with backing

-Ignore FIRE ALARM (Lock Down anticipates a threat inside the building whereby an intruder could deliberately activate the alarm.)

-Wait for further instructions. Prepare for the possibility of the need for an **emergency exit from the building.**

-Await further instructions and only come out when the authorities say it is safe to do so.

B. DROP COVER AND HOLD:

When: High Winds, Nearby Explosion, Earthquake

-DROP & COVER command is given.

-Take cover, preferably under a desk, table, or strong doorway

-Cover eyes with arm

-Hold onto furniture

-Remain in "Drop" position until further instructions are given

C. SHELTER IN PLACE:

When: Toxic Air Quality, High Winds, Dangerous External Environment

-SHELTER Command is given.

-Bring as many clients and staff into the building as possible

-Call 911 if the program or location **has not already been** advised of the imminent danger

-Close and lock all windows and doors

-Turn off HVAC systems

-If the event is related to high winds, move to lowest level of the building.

-If threat is environmental, for example toxic air, attempt to tape all windows and doors.

-Attempt to assess duration of emergency

-Wait for further instruction from the authorities.

D. EMERGENCY EVACUATION/ESCAPE:

When: Nearby disaster or explosion, order of local authorities, building systems failure, Option under ALICE to escape or danger in the building or area

-Emergency Evacuation Command is given to evacuate the premises:

-Circumstances permitting, instructions will be given to leave the building and or site or identify specific exit routes. In an emergency evacuation staff should plan to meet at a designated rally point no less than 500 yards from the building.

-Use all means of transportation available.

-Use Fire Drill procedures to exit ***even though the Fire Alarm system may not be in use.***

- Provide assistance to injured clients or staff.

-Contact authorities for further instructions.

EVACUATION/SHELTER IN PLACE:

Longer Evacuation Plans

During extenuating circumstances, it may be decided internally or through local officials that the hazards are serious and reach the level that requires mandatory evacuations. Evacuations may be advised to avoid situations that have the potential to become more dangerous. When evacuations are necessary in a community, local officials will provide information to the public through the media or reverse 911 calls. Other warnings, such as sirens, text alerts, e-mails, or telephone calls are used.

In cases of a weather alert, such as a hurricane, there may be a day or two to make plans for an evacuation. Plans to evacuate shall be decided by program leadership, the Senior Director, Vice President of Program Operations, and the Director of Facilities. If it is determined that an evacuation is the safest option, the program director or designee is required to notify the clients' guardians, Department of Early Education and Care, Department of Mental Health, Department of Children and Families, or other collaterals within 24 hours of the evacuation.

Other emergencies may not allow time for people to gather necessities prior to evacuation. Planning for an evacuation beforehand is essential. Therefore, it is important that all sites and site personnel are familiar with their pre-determined destinations (listed below) in case an evacuation must take place. Site personnel must have access to the information specific to the evacuation routes to get their destinations.

If time allows:

- ✓ The site's on-site Safety Officer or designee shall secure the site by closing and locking doors and windows
- ✓ The Safety Officer or designee shall unplug electrical equipment such as radios, television, and small appliances. Refrigerators and freezers can remain plugged in unless there is risk of flooding.
- ✓ In addition to making proper notifications by phone, text, e-mail, etc.; or when external communications fail, the Safety Officer may leave a note at the site, notifying employees, parents, and others where clients and staff members are being evacuated to.

Each site/program shall have a check-in system in place to assure that clients and staff members are accounted for once they have exited the building during an evacuation.

Temporary Evacuation Re- Location Sites *

The following sites are pre-determined destinations for an evacuation:

Program/Site to be evacuated:	Pre-determined destination for evacuation:
10 Guest Street, Brighton (when necessary to activate mobile unit)	1) CFCC (portable office) in Roslindale 2) Walpole Campus
Redfield Street-IFC/Adoption; CSA Park Street; SAH Boston	1) Employees instructed to work from home 2) 10 Guest Street, Brighton
Roslindale-Clinic; CSA Hyde Park; POP; TASP	1) Employees instructed to work from home 2) 10 Guest Street, Brighton
Children's Community Support Collaborative	1) Walpole Campus 2) Southeast Campus in Plymouth 3) CFCC in Roslindale
Harrington House	1) Walpole Campus 2) Southeast Campus in Plymouth 3) CFCC in Roslindale
The Home in Walpole	1) Southeast Campus in Plymouth 2) CFCC in Roslindale 3) Local evacuation sites in town
Roxbury House & Roxbury Village	1) Walpole Campus 2) Southeast Campus in Plymouth 3) CFCC in Roslindale
SAH Somerville	1) Employees are instructed to work from home

	2) 10 Guest Street, Brighton
Southeast Campus	1) Walpole Campus 2) Local evacuation sites in town 3) CFCC in Roslindale
Waltham House	1) Walpole Campus 2) Southeast Campus in Plymouth 3) CFCC in Roslindale
FRC	1) Employees are instructed to work from home
Sommerville Village	2) Walpole Campus 3) Southeast Campus in Plymouth 4) CFCC in Roslindale

If local authorities direct staff members and clients to stay in the vicinity, they will be required to stay in the local/town or city designated evacuation sites rather than travel to The Home's alternative evacuation site.

CFCC in Roslindale will be the 3rd option for all sites unless indicated otherwise.

Please note: Family Networks is not included in the table. Because the program is located at the DCF Park Street location, Family Networks follows DCF protocol for evacuation.

*approved by EMT and Senior Leadership on 8/28/2014

Shelter in Place

Shelter-in-Place means to seek immediate shelter and remain at the location rather than evacuate during the emergency. A Shelter-in-Place command is typically called when an evacuation is not safe. Once a decision is made to shelter-in-place, the site's/agency's Incident Commander notifies all other staff members using all means of communication available.

INTERNAL NOTIFICATIONS

1. **If the emergency requires that 911 be called immediately, 911 is the first contact.**

2. Every staff member shall know their program's on-call structure, which includes the program's rotation for the Administrator-on-Call (AOC); and the agency's executive on-call procedure. Once emergency responders are notified of the emergency, the program's AOC is the first contact once it is safe to do so. The program's AOC must be notified of all emergencies.

3. The AOC, if not the Program Director, is responsible for notifying the Program Director.

4. The Program Director shall contact the Senior Director, Vice President or Executive on Call. (See Appendix B for additional details)

5. In some instances, a phone system will be enacted, which allows automated contact to Facilities personnel, Executive Management Team members, and other appropriate personnel. Each contact shall be contacted on their cell phone, office phone, and home phone through the automated system.
    a. The initial message in the automated system shall announce the nature of the incident, instructions to personnel about what actions to take, or shall tell personnel to wait for further instructions.

6. When it is safe to do so, and in accordance to our ICT System, the assigned liaison officer in the program is responsible for notifying the DCF hotline, the parents and guardians of the clients, and state agencies, including Department of Children and Families (DCF) and Department of Early Education and Care (EEC), when applicable.

(B) BEFORE an Emergency: Planning and Preparing

Employee training and safety meetings

1) All new employees shall be trained in the emergency preparedness plan as part of their initial new hire orientation. The orientation will include a general overview of contents in the emergency plan, threat command procedures, and evacuation procedures.

2) All Programs and Departments will review components of the emergency preparedness plan with all staff. Additionally, managers and supervisors shall be required to participate in regular discussions with a focus on their roles during an emergency.

3) Each site shall have assigned Safety Officers available to review the emergency plan with their colleagues, provide input to the emergency plan when modifications are made, and to serve as the liaison between the sites and the Core Safety Team. Safety Officers and the Core Safety Team shall meet twice a year to review elements of the emergency plan.

4) Members of the agency's Core Safety Team shall check in with programs and sites periodically to ensure that employees have an understanding of the emergency plan.

5) Significant changes to the emergency plan will be communicated to all staff in a timely manner.

6) General safety shall be discussed at least twice annually in the town hall meetings scheduled for all employees to attend.

Practice Drills and Training

Aside from the state required fire drills, programs/sites are required to complete one drill annually using the threat command procedures, , and/or other relevant components of the emergency preparedness plan.

The program/site's designated Safety Officer shall complete documentation to provide information about the practice drill such as: date, time, participants, successes, issues, and corrective action steps to address any issues noted. The documentation shall be maintained at the site and at The Home's Administrative offices.

PREPAREDNESS:

Work areas are examined frequently to establish that the work environment is safe for all clients, employees, and others. Aside from emergencies listed in the plan's purpose section, programs may encounter their own set of risks and dangers such as an explosion at a power plant or a chemical truck overturned on a local highway. Programs/sites should conduct an individual assessment to proactively address other potential risks and develop a plan to address any of these factors that could potentially impact the program/site's safety.

a. Equipment/Vans

During events that require an emergency response such as evacuation/escape and when warranted, programs shall implement a transportation plan that supports the evacuation. If agency vehicles are not an adequate resource, the plan may require staff to use their own vehicles in addition to the program's vehicles. At some locations, town resources will coordinate transportation in accordance to their own emergency planning.

Agency vehicles shall be properly maintained and determined to be in a safe operating condition by appropriate staff of The Home. Programs are required to regularly schedule appointment for routine program vehicle maintenance. A standard first aid kit must be present in all agency-owned vehicles.

Suggested items for personal vehicles include:

- Whistle
- Flashlight
- Seatbelt cutter/glass breaker
- Program contact list
- Wet wipes

b. Mobility Challenges

It is imperative that programs and sites are prepared to safely transport and manage clients, visitors, and employees with mobility challenges when an emergency occurs. To avoid confusion, employees should be assigned prior to any emergency as the individuals responsible to assist in moving or transferring people with mobility challenges.

Every site shall have a wheelchair in a designated area that is easily accessible to staff members.

All employees in congregate care programs and selected employees at the remaining sites shall be trained in proper carrying techniques in regularly scheduled CPR/First Aid training or as a separate training.

c. Supplies and Storage Capacity

Most sites that accommodate clients have designated areas to maintain emergency supplies such as water, canned food, and emergency equipment. The areas must be easily accessible and in a dry and secure location at the site.

Emergency supplies in the designated storage areas may include the following:

1. Bottled water (one week supply)
2. Purification tablets (for water)
3. Can opener
4. Sealed instructions as to where master keys are located
5. First aid kit (serves 15 people) and first aid manual
6. Hygiene/sanitation supplies-wet wipes, purel/hand sanitizer, bleach
7. Latex gloves
8. Portable or hand cranked radio
9. Flashlights, and extra batteries
10. Shovel and other useful tools-hammer, scissors, whistle, tarp, crow bar
11. Matches in a waterproof container
12. Duct tape
13. Face masks
14. Safety glasses
15. Blankets, space blankets and extra clothing
16. Small child's needs (if applicable)
17. Agency forms and documents: agency contact/on-call list, emergency phone numbers, staff emergency contact list (e.g. staff phone numbers), emergency manual; client face sheets with list of current medications (where applicable); emergency medical care releases for clients (where applicable); emergency contact information for all staff members and clients; emergency numbers for town or city

Storage Tips

- Keep food in the dry and cool areas at the site.
- Keep food sealed at all times.
- Empty opened packages of sugar, dried fruits and nuts into screw-top jars or air-tight cans to protect them from pests.
- Inspect all food containers for signs of spoilage before use.

d. Disaster Supply Kits/ Go Bags

Programs/sites must be ready at a moment's notice to leave the premises when employees and clients are instructed to immediately leave the facility or an emergency has occurred at the program/site. Each site shall maintains a disaster supply kit or "go bag", which must be readily accessible for easy exit.

Each site's assigned Safety Officer is responsible for regular checks to ensure that the "go bags" are intact and up to date. The check shall be noted on the Facility Safety Checklist.

COLLABORATION WITH GOVERNING AUTHORITIES:

Programs/sites must be proactive and know the local town/city's protocols relative to emergency preparedness, response, mitigation and management.

1. Programs/sites shall determine if the town/city where they are located has an Emergency Management Agency (EMA) or Office of Emergency Management (OEM). Most EMA/OEM's have established Emergency Preparedness/Response Plans and are directly affiliated with the Massachusetts Emergency Management Agency (MEMA).
2. The Program Director and/or site liaison schedules a meeting with the EMA/OEM either at the program or the EMA/OEM office and provides the following information:

    - Program profile information, who, what, where, assets/resources, etc.
    - Services provided (clinical, behavioral, CBAT, respite, residential, etc.)
    - Population served, such as latency age, adolescents, DMH, Court ordered, etc.
    - Licensing information, such as EEC, DPH, DMH, etc. (as applicable)
    - Program type, i.e., congregate care, day school, group home, etc.

3. The Program Director and/or site liaison establishes annual review/evaluation meetings with local EMA/OEM to ensure the program continues to meet the standards established by the EMA/OEM and apprise them of changes at the program level.

4. The program/site's Safety Officer contacts the program's local law enforcement agency to register the program as a service organization providing human services to a youth population.

5. The program/site's Safety Officer contacts the local hospitals and schools to establish what protocols/resources are available for the program, and the population served, in case of manmade or natural disaster. Many first responders prioritize youth and elderly for initial response in emergency situations.

6. Depending on the County the program resides in, there may be a County Technical Rescue Team. The County Technical Rescue Team assists towns within their respective

county and surrounding counties with extra emergency personnel and equipment that may be needed, at any given time, to protect the public. This includes events such as dive rescues, structural collapses, natural or manmade crisises.

The Home's private special education day schools should expect to receive a higher level of prioritization for response due to the EMA/OEM's obligation to MEMA and the Department of Elementary & Secondary Education.

7. Programs can register to connect with the Emergency Broadcast System (EBS) in program/site's area and make sure the program is registered to receive notifications in the event of an emergency. For example, in Plymouth County, the Plymouth County Sheriff's Department has contracted to license the Emergency Communications Network's (ECN) CodeRED high-speed notification system. The CodeRED system provides Plymouth County and Bristol County officials the ability to quickly deliver messages to targeted areas throughout these two counties.

It's anticipated that the local authorities will give the programs and sites further instructions regarding emergency management.

Communications of the Plan

In preparing the document, The Home shall share the manual for preparing for an emergency with relevant licensing agencies and funders such as the Department of Early Education and Care, the Department of Children and Families, Department for Mental Health, the Department of Early and Secondary Education and Department of Public Health. The Home shall further determine if the external agencies provide resources to assist in emergency preparedness, response, mitigation and management.

(C) COMMUNICATION: Notification and Aftermath Management

MEDIA & EXTERNAL COMMUNICATIONS:

The Vice President for Development & Communications and the Public Relations Manager, working closely with the CEO, is responsible for communicating with the media. The VP for Development & Communications will also work closely with The Home's outside public relations firm to plan, coordinate and execute the media response to a crisis.

A. Media Communications

The Media Response Team (MRT) is responsible for handling all media aspects of an emergency or crisis situation outside of the immediate emergency, and will automatically be activated. (This is not to be confused with the ICT system.) This includes developing and implementing a strategy to get the situation under control and communicating with the public, media, government officials and agencies, personnel, and the Board. Once a crisis situation has been identified and the President & CEO or Executive Vice President & CFO is notified, all communication with external audiences and within any of The Home's various programs should be coordinated by the Media Response Team. (Please see Appendix for the Media Response Team)

During off hours, the Home's switchboard will direct personnel and the media to the Vice President of Communications and Development, or designee.

The CEO or VP for Development & Communications will be the **chief spokesperson** in communicating The Home's position regarding the crisis and the actions taken to resolve it. The VP for Development & Communications will determine the need to contact the agency's crisis communications consulting agency.

All other staff members involved in the emergency or crisis situation shall refer any inquires from the media to the VP of Development and Communications. Unless directed to do so, staff members shall have minimal contact with the media in an emergency or crisis situation. The Liaison Officer assigned on the ICT is responsible for fielding media inquires.

B. Confidential Information

A crisis at a program or site run by The Home will be of interest to the media. The public and concerned parties (clients' families, employees' families, etc.) have a right to be informed and it is important to ensure that they get the facts in a timely fashion. In most cases they will hear the latest information through the media. The expectation is that all personnel are as cooperative as possible in providing information without jeopardizing the emergency response efforts or exposing The Home or individuals involved in the crisis to potential liability.

Operators, front desk staff, and other employees that are likely to field calls should be notified as soon as possible, and instructed not to give out any information and refer all media calls to the VP for Development & Communications and all other calls to the CEO or Executive Vice President & CFO. A member of the Communications Team will send at least one communication, which will inform and update all staff with the status of the crisis.

Confidential information may include:

- Personal information about clients
- Personal information about employees
- Estimates of damage as a result of the accident
- Extent of injury to clients, personnel, or visitors
- Whether or not such incidents have occurred in the past
- Individual or group of individuals responsible for incident
- Home phone numbers of key personnel or victims
- Salaries or other information regarding executive staff or Board
- Names of contractors who worked on a building (if there is a building failure)

AFTERMATH MANAGEMENT:

A. Disaster Recovery Team

Effective disaster management requires that the proper action steps are taken in the immediate emergency but it also includes planning to ensure required resources are available and coordination of those resources are available in disaster recovery. The first step after the emergency is creating a disaster recovery team involving key functional managers from all of The Home's departments and effected programs. The Disaster Recovery Team is responsible for assessing and implementing resources necessary to support the impacted site or sites in order to resume routine operations. The resources can include crisis counseling, staffing resources, repairs, temporary relocation of a site, etc. Officials from local fire, police and emergency-management offices as well as city, county or state officials may also be important members of the team.

B. Debriefing and Assessment of Emergency Response

Following any emergency, the agency is responsible for maintaining the continuity of operations and conducting an assessment of the response in areas such as communication internally; communication with families, providers, and youth; management of staff; information systems, management of facilities, and collaboration with partners and local authorities. An assessment may include the following questions:

How was the ICT instituted? Were there gaps?

What could the ICT have done differently or more effectively?

What agency/program responsibilities work effectively during the emergency?

Was the ICT and agency personnel able to stay connected to clients, families, and other providers?

Was the ICT and agency personnel able to effectively communicate with staff regularly to provide information, updates, and instructions?

How did the agency help clients, families, and staff members deal with stress of the emergency?

Was the agency able to contact all staff members quickly?

Did technology work effectively to communicate to clients, families, and staff members?

Did sites have the proper supplies and equipment for the emergency? If not, how come?

Were clients and staff members able to properly follow threat commands and additional instructions?

C. Documentation and Record Keeping

When possible, everyone involved in the response should document relevant information throughout the crisis, with specific information regarding who called whom, who stated what, response activities, and the date and time of all major events. This record will be especially important later, if managers need to reconstruct events for the media, insurance, or liability claims.

Accurately recording requests from the public, media, donors, regulatory agencies, etc. will be a critical factor in the overall response effort as well. In all staff functions, documentation will be crucial in later claims and litigation (if they occur) and may also be required by government regulators.