Care, Treatment, And Services Policy and Procedure Manual

Revised: 09/10/2024

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 01.01.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Eligibility Criteria

PURPOSE
To establish written criteria to determine eligibility for care, treatment or services.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to have a written process for determining eligibility of individuals that includes the following:
    a. The criteria to determine eligibility for care, treatment, or services
    b. The information to be collected to determine eligibility for care, treatment, or services
    c. The population of individuals accepted or not accepted by the organization
    d. The process for accepting referrals

PROCEDURE

Admissions Eligibility Criteria

It is the policy of Jones Wellness Center to refer to the screening guideline for mental health diagnosis in the most current revision of the diagnostic and statistical manual for professional practitioners, to determine the appropriate treatment modality for prospective individuals who are requesting services.

PROCEDURE
1. A face-to-face or telephone screening interview will be conducted with all potential clients, prior to admission to any level of care within Jones Wellness Center based on the clinical impression resulting from that screening and the subsequent use of the DSM manual treatment recommendations will be formulated.
    a. A consultation with the Founder may be required if the individual has a history of mental illness and/or significant medical history.
2. Basic Admission Criteria:
    a. An individual has a history of mental health.
    b. Individuals must be 13 or older.
3. Medical Admission Criteria:
    a. All individuals must be free of contraindicated medical conditions that would make participation physically dangerous or impossible.
4. Financial Admission Criteria:
    a. Individuals must have the ability to pay for services. Jones Wellness Center accepts most in-network insurance benefits, out-of-network insurance benefits and cash pay.
5. Legal Admission Criteria:
    a. Individuals may have current EAP program.
    b. Individuals must be 13 years or older.
    c. All individuals must voluntarily enter treatment.
    d. All individuals must be willing to commit to attending the groups as scheduled.
6. Assessment Admission Criteria:
    a. All individuals will receive several assessments to determine the most appropriate, least restrictive level of treatment.

b. If the individual is not appropriate for treatment services, the individual will be referred to appropriate community resources for services.

7. Mental Admission Criteria:
    a. Individuals whose psychiatric symptomatology is stabilized with medication.
    b. Individuals must be mentally stable and free of any major mental disorder symptoms that would interfere with the treatment process.
8. Complicating Admission/Exclusionary Criteria:
    a. The following conditions may deem a client unsuitable for treatment services at Jones Wellness Center:
        i. Organic or psychiatric symptomatology impedes the individual's ability to participate in the treatment program
        ii. Physical symptoms which are evaluated as life threatening in which an acute care hospital setting is warranted
        iii. Individuals who are registered sex offenders
        iv. Individuals who have legal issues pending for violent crimes
        v. Individuals with high-risk suicide assessment results
        vi. An individual who has a family member or romantic relationship with a client who is currently admitted in the facility

Information Collected to Determine Eligibility

POLICY

It is the policy of Jones Wellness Center to identify the information to be collected to determine eligibility for care, treatment, or services.

PROCEDURE

1. Jones Wellness Center utilizes an Electronic Medical Record. Upon the initial contact with Jones Wellness Center the following information is collected:
    a. Name of Contact
    b. Time
    c. Referral Source
    d. Interested in help for self, friend, family member, employee
    e. Potential Client Information:
        i. Name
        ii. SSN
        iii. Address
        iv. DOB
        v. Phone
        vi. Age
        vii. Presenting factors for call now
        viii. Any history of mental health issues, if so please describe. Current DSM diagnosis
        ix. Description of what physically happens when the individual experiences mental health episode
        x. Substances currently being abused and amount.
        xi. Has the individuals recently completed detox
        xii. Prior mental health treatment if so when, what type (OP vs Inpatient) where and response to the previous treatment episode
        xiii. Type of discharge from previous treatment
        xiv. Current physical issues which may interfere with treatment services
        xv. Current legal issues
        xvi. Financial ability to pay for services: Cash payment or insurance

   f. Person responsible for payment
   g. Insurance information
   h. Type of insurance
      i. Policy number
      ii. Verification phone number
   i. Primary policy holder:
      i. Name
      ii. Address
      iii. Phone
      iv. Relationship to potential client
2. The individual is provided with information pertaining to the location and hours during which care, treatment or services are provided; Individuals are offered an email webpage to review Jones Wellness Center and its services.
3. Initial Screening and Intake is reviewed and if deemed Jones Wellness Center may be appropriate to treat the individual for services, the individual is linked with the Assessment Center to undergo an assessment to determine the most appropriate level of care within Jones Wellness Center.
   a. Recommendations for specific modalities of care are based on DSM diagnosis.
   b. Admission recommendations for non-medical levels of care are to be approved by the Founder/Qualified Professional on staff.
4. Individuals are provided with information pertaining to the resources available for the care of his or her dependents when warranted.

Populations Served

POLICY
It is the policy of Jones Wellness Center to have written guidelines for the populations of individuals accepted or not accepted by the organization.

Jones Wellness Center provides services for youth 13-17 and adults 18+. Individuals must be deemed capable of self-preservation, medically and psychiatrically stable to participate in a cognitive behavioral approach to mental health issues. Jones Wellness Center's Medical Director has the authority to decline admission to anyone based on the physical and psychiatric assessment at time of admission.

PROCEDURE

1. It is the responsibility of the Founder to determine the population in which it is to be served.
2. Admission staff are to assess all individuals to ensure they meet the minimum guidelines for admission.
3. Any deviation from Jones Wellness Center 's established target population must be approved by Jones Wellness Center 's Medical Director, i.e. pregnant females, etc.
4. Documentation justifying the admission to Jones Wellness Center must be maintained in the client's file.

Admission Referrals

POLICY
1. It is the policy of Jones Wellness Center to have written guidelines on accepting referrals into Jones Wellness Center.
2. All referrals to Jones Wellness Center are processed through the admissions call center.
3. Exceptions to the policy must be approved by the Founder and/or Medical Director.

PROCEDURE
1. Referrals to Jones Wellness Center 's services are processed through Admissions call center;

2. Exceptions to the policy must be approved by the Founder/Medical Director at which time the individual is to be referred for a complete bio-psycho-assessment.

Admission Workflow

1. Complete pre-admission screening
2. Meet with staff and sign consents and does POC
3. Meets with Psychotherapist and does assessments
4. Given a tour of the facility
5. Client is introduced to other clients

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 01.02.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Waiting List

PURPOSE
To establish consistent guidelines for client care, treatment and services.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Medical Director to disseminate this information to all staff under their direction.

POLICY
Jones Wellness Center is a for-profit mental health facility. Due to our small size and low turnover of clients, it is the policy of Jones Wellness Center NOT to maintain a waiting list for services.
If we are at capacity, we will refer any clients in need of services to a facility in our community referral network.

PROCEDURE
1. It is the responsibility of the Founder to determine when Jones Wellness Center can no longer accept individuals for services.
2. If the decision is made to hold off on admissions, the Medical Director is to contact Admissions call center and inform them of the decision to cease admissions.
3. The decision to open admissions is solely the responsibility of the Medical Director based on the criteria utilized to cease admissions.
4. The Medical Director is to notify all parties involved.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 01.03.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Preliminary Plan of Care

PURPOSE
To establish consistent guidelines for client care, treatment and services. To ensure the safety of the individuals served.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Medical Director to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to ensure everyone admitted to Jones Wellness Center has a preliminary screening conducted prior to the completion of the admission screening/assessment process.
2. The pre-admissions screen focuses on the individual's safety and addresses interventions in response to emergency needs, such as an immediate need for placement or danger to self or others.
    a. Individuals determined to be high-risk (recent/continued attempts at self-harm or harm to others) will be reviewed by the Founder for eligibility appropriateness.
3. Individuals with moderate risk, upon admission will be prompted to review a preliminary Safety Plan that is reviewed and signed by the individual upon admission.
    a. The Plan includes contingency plans for care in the case of harm to self or others; elopement; sexual reactiveness or medical instability.

FORMS
See EMR for Pre-Admissions Telephone Intake Sheet/Preliminary Safety Plan

PROCEDURE
1. During the initial phases of the admission process, the designated clinical staff will conduct a Pre-Admission assessment with the individual.
2. Individuals with high risk for violence or self-harm will be reviewed by the Medical Director and referred to an appropriate facility.
3. Individuals with moderate risk will be prompted to enter a Safety Plan.
4. Clients who are either low or moderate risk will still be assessed with the DSM manual upon admission.
5. The Plan is signed and dated by the individual to acknowledge the actions that will be taken if the individual is assessed as not being capable of self-preservation or engaging in harmful behavior.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS.01.03.01, EP1-EP2
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Psychiatric Advance Directives

PURPOSE
To establish consistent guidelines for client care, treatment and services to ensure the safety of the individuals served.

RESPONSIBILITY
It is the responsibility of the Founder or designated staff to implement this policy and procedure. It is the responsibility of the Medical Director to disseminate this information to all staff under their direction.

POLICY
1. Jones Wellness Center does not routinely admit individuals with serious medical diagnoses and/or complications, however it is our priority to explain to each admitting client, the purpose and intent of a Medical Power of Attorney, and give them the opportunity to create one.
2. Jones Wellness Center ensures that all patients will be provided the opportunity to learn about and/or make a valid Medical Power of Attorney/Designation of Healthcare Agent to indicate their decisions about life prolonging treatment, and/or to appoint a proxy to speak for them, should they lose their decision-making capacity or the ability to communicate choices.

PROCEDURE
1. Individuals will be asked if they have a Medical Power of Attorney/Designation of Healthcare Agent at their point of entry into Jones Wellness Center.
2. Admitting staff shall assess and document the existence of a person's Medical Power of Attorney on the initial assessment record.
3. Assistance will be provided to the individual if he/she wants to create a Medical Power of Attorney/Designation of Healthcare Agent.
    a. If a Medical Power of Attorney/Designation of Healthcare Agent exists and is available, staff will acknowledge the document and inquire whether the individual wants it as is.
    b. The patient has the option to review or revise their Medical Power of Attorney/Designation of Healthcare Agent prior to it being placed within the medical record.
4. Staff will communicate pertinent information to the allocated designators based on the directive as it relates to the patient's plan of care and known wishes.
    a. If a copy of the Medical Power of Attorney/Designation of Healthcare Agent is not available for the record, nursing will attempt to document the substance of the document and/or report the name of proxy in the directive (only if the patient can articulate and agrees to provide the information verbally) on the initial assessment section of the Medical Power of Attorney/Designation of Healthcare Agent.
5. Staff will encourage the individual/family to bring the Medical Power of Attorney/Designation of Healthcare Agent as soon as feasible; attempts will also be made to check if the patient has the document in a previous record.
6. The individual will also be offered the ability to create a new Medical Power of Attorney/Designation of Healthcare Agent.
7. If the individual is unaware of the Medical Power of Attorney/Designation of Healthcare Agent, staff will explain to the individual the purpose of the document.

Screening and Assessment

1. The goal of screening and assessment is to determine the care, treatment, or services that will best meet the needs of the individual served initially and over time.

2. Accurately identifying the needs of the individual served is the basis for providing quality care, treatment, or services and depends on three processes:
    a. Collecting data about the individual served current and past emotional and behavioral functioning, needs, strengths, preferences, and goals.
    b. Analyzing data to produce information about the individual's need for care, treatment, or services and to identify the need for additional data.
    c. Making care, treatment, or service decisions based on the information developed about the needs, strengths, preferences, and goals of the individual served and their response to care, treatment, or services.
3. The information to be collected through screening and/or assessment is defined by Jones Wellness Center's policies and procedures and depends on the emergent needs of, and the care, treatment, or services sought by our clientele.
    a. As appropriate, information is collected from the individual's family or significant others.
4. Information collected can indicate the need for more data or a more intensive assessment of the mental health, emotional, behavioral, vocational, educational, and nutritional functioning and legal status of the individual served.
    a. At a minimum, the need for further screening/assessment is determined by the care, treatment, or services sought; the individual's presenting condition(s); and whether the individual agrees to care, treatment or services.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 02.01.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Assessment for Self-Harm

PURPOSE
All individuals will be screened for suicide risk at intake and, if indicated, every subsequent service contact with Jones Wellness Center providers during the course of treatment.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to treat all clients' potential suicide or homicidal ideation with the utmost caution and consideration.
    a. The assessment of potential for self-harm or harm to others is ongoing and begins at the time of screening, continues through the core battery of assessments and is monitored daily based on clinic schedule in group or individual sessions.
    b. When clients/clients evidence moderate at-risk symptoms of expressing suicide ideation and the potential of self-harm or homicidal behavior, Psychotherapist shall conduct an assessment to determine the appropriate levels of treatment for the client.
2. If the client's symptoms or history warrant, the client has expressed through behavior or verbally suicidal ideation or homicidal with current episodes, the client/client is coming to the program as a step-down, or the referral source indicates potential, the treatment team is responsible for:
    a. Conducting complete assessment including discussion with family members
    b. Documentation results of assessment and consulting with attending physician
    c. Developing a safety plan for time between screening and admission (i.e. Safety Contract)
    d. Ensuring the client/client have emergency phone numbers for after-hours emergencies (Outpatient Levels of Care)
    e. Informing clinical staff
    f. Assessing the potential for self-harm through appropriate assessments and documents thoroughly
    g. Placing the potential for self-harm on the Initial and Individual Treatment Plan with appropriate objects for daily monitoring
3. Determination of Risk of Self-Harm through the following criteria:
    a. Assume all verbal expressions of ideation, even if "passive" place at risk
    b. Factors which may increase risk of suicide:
        i. Loss of significant other;
        ii. Loss of economic status;
        iii. Health change;
        iv. Giving away of personal belongings;
        v. Increased isolative behaviors;
        vi. Writings or artwork referring to death;
        vii. Attempted drug overdoses;
        viii. Risky sexual behavior;
        ix. Mood swings; and/or
        x. Depression.
    c. Additionally, protective factors which decrease the risk of self-harm will be reviewed.

4. Evaluation for Appropriate Care:

a. If a qualified behavioral health professional determines the C-SSRS score is high OR that the individual is contemplating suicide, a referral is to be a board-certified psychiatrist for recommendations for continued care or transfer to a more appropriate facility.
b. If it is determined the individual can be safely managed at the facility, a safety contract is to be implemented.
c. If it is determined the individual cannot be safely managed at the facility, the individual is referred and linked to Mobile Crisis Outreach Team: (713) 970-7520; the Emergency Contact is notified; the clinical staff remains in contact with the psychiatric facility to arrange for an evaluation upon discharge and stabilization.

5. Frequency of Follow-up:

Low Risk **0-6.5**	Continue to assess as needed. Monitor for possible need for Treatment Plan problem if ideation (without plan, method, or intent) has taken place within the last year.
Moderate Risk **7-14**	Add a relevant problem area and objectives to the Treatment Plan and create a No-Harm Safety Plan, including specific behaviors and coping strategies for emotional regulation, and provide clients with a copy. Complete and document C - SSRS Since Last Contact assessment at each follow up session until risk level drops to "Low." Notify the clinical staff and schedule with the Medical Director.
High Risk **14.5+**	Immediate evaluation and consultation with the Medical Director are required to assess emergent need for a higher level of care. In units/areas that contain ligature and/or other safety risks, patients determined to be at high risk for suicide must be under observation with the ability to immediately intervene through the use of 1:1 observation until (1) the client is safely transferred / discharged to a higher level of care at an appropriate facility, or (2) the client is reassessed and no longer deemed high risk. If a higher level of care is necessary and the client refuses, the Mobile Crisis Outreach (713) 970-7520 must be called. If the client is deemed appropriate to remain at current level of care (or when client returns from a higher level of care), add a relevant problem area and objectives to the Treatment Plan and create a No-Harm Safety Plan, including specific behaviors and coping strategies for emotional regulation, and provide the client with a copy. At each follow up session until risk level drops to "Low," complete and document C - SSRS Since last contact assessment.

For whose C-SSRS score indicates moderate risk, they are to be seen at a minimum of once weekly for a therapy appointment at which time the C-SSRS is again administered at each contact.

FORM: *See EMR C-SSRS (Suicide Risk Assessment)*

6. STAFF TRAINING & COMPETENCY

a. Staff will receive training on Suicide Awareness, Risks, & Prevention during their probationary period, and annually thereafter. In addition to the training requirements, staff will also be assessed for competency in two manners:
   i. Staff must pass a quiz with at least a 70% passing score on the training received.
   ii. Staff must undergo a face-to-face competency assessment with a representative from the Clinical team, or a designee who has previously shown competency at ‘Instructor Level’.
b. Specific staff from the Operations team will be tasked with understanding ligature risks and mitigation strategies to protect clients and staff.
   i. No training is required, however oversight of the completion of the environmental assessment will be reviewed at least annually.

TITLE: **CARE, TREATMENT AND SERVICES**	**REFERENCE:** **CTS.02.01.03**
REVIEW AND APPROVAL: **09/10/2024**	**SUBJECT:** Screenings and Assessments

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within specific time from the day of admission to Jones Wellness Center.

SCOPE
This protocol applies to all participants served by Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder and/or Medical Director to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to perform screenings and assessments to determine the individual's need for care, treatment, or services and to identify the need for additional data; making care, treatment, or service decisions based on the information developed about the needs, strengths, preferences, and goals for treatment and their response to care, treatment, or services.
2. When relevant to the individual's current care, treatment, or services, as determined by the organization, the organization gathers clinical/case information from both inpatient and outpatient providers who have treated the individual. When it is not possible to obtain this information, the organization documents the reason why it could not be obtained.
3. Assessments and screenings are conducted within specified timeframes, in accordance with all regulatory requirements.
4. For all levels of treatment, Jones Wellness Center's assessment process also includes but is not limited to:
    a. **Telephone Screening**: Determines eligibility and history of mental health/self-harm
    b. **Initial Screening and Intake**: Completed prior to or upon intake
    c. **Assessment of Self Harm**: Completed prior to or upon intake
    d. **Medical History**: Upon admission
    e. **Biopsychosocial Assessment**: Prior to or within 48 hours of admission
    f. **Nutritional Screening**
    g. **Abuse, Neglect, & Exploitation Screen**
    h. GAD-7 - General Anxiety Assessment
    i. PHQ-9 - Depression Assessment
    j. EAT26 - Eating Disorder Assessment: Based on symptomology
    k. PCL-5 Trauma Assessment
    l. MDQ: Mania Assessment: Based on symptomatology

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS.02.01.05; CTS.02.01.06; CTS.02.01.07; CTS.02.01.16; CTS.02.01.17
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Screenings and Assessments

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within a specific time from the day of admission to Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder and/or Medical Director to disseminate this information to all staff under their direction.

POLICY
It is the policy of Jones Wellness Center to require a physical exam for all participants.

POLICY
See Specific Policies and Procedures for:
- Initial Screening and Intake
- Assessment of Self Harm
- Nursing Assessment
- Medical History and Physical Exam
- Bio-psycho-social Assessment

Screenings and Assessments: Physical Health Screening

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within a specific time from the day of admission to Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder and/or Medical Director to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to require physical health screens for all participants.
2. Physical health screens include:

Medical History
The medical history is completed upon intake by the program participant and is to be reviewed by the Medical Director.

PROCEDURE
1. Upon admission, all program participants are to complete the medical history form.
2. The medical history form is to be reviewed by the Medical Director.
3. The medical history forms to be maintained in a clinical record.

Pain Assessment

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within specific time from the day of admission to Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder/Medical Director or designee to implement this policy and procedure. It is the responsibility of the clinical staff to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to ensure each participant has a complete physical health assessment, including a medical history, nursing assessment and physical examination within a specified time frame.
    a. The physical assessment includes a screen for physical pain.
2. All individuals for whom a physical pain assessment is indicated are referred to Jones Wellness Center's Medical Director for an assessment and/or treatment.

PROCEDURE
1. If the physical health assessment indicates a need for specialized treatment for physical pain, the Advanced Practical Nurse is responsible to schedule an appointment with Jones Wellness Center's Medical Director or designated physician; and assist with follow-up of medical recommendations, i.e. appointments for ancillary pain management services, medication, follow-up appointments, etc.
    a. The clinical staff are responsible for ensuring there is a case management note regarding the referral and outcome of the medical appointment.
2. Jones Wellness Center's Medical Director has the sole discretion to determine if a physical pain condition exists which prohibits the individual from participating in the program.
    a. In this case, justification must be documented in the clinical record and alternative placement must be provided.
3. All screenings, assessment, referral, and treatment of pain issues are to be documented in the clinical file.

Nutritional Assessment

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within specific time from the day of admission to Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Registered Dietician to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to ensure all individuals served are assessed for their nutritional needs.
    a. The assessment identifies those individuals who are at moderate or high risk.
2. Individuals for whom a nutritional assessment is indicated are treated by Jones Wellness Center's Medical Director or Dietician.

PROCEDURE
1. Individuals are screened by a nurse upon admission.
    a. An initial weight of the client is obtained upon admission and maintained in the file.
2. The nursing assessment is completed upon admission for intensive outpatient levels of care.
3. The nursing assessment reviews the following dietary aspects of the individual served:
    a. Food allergies
    b. Weight loss or gain of 10 pounds or more in the last 3 months
    c. Decrease in food intake and/or appetite

   d. Dental problems
   e. Eating habits or behaviors that may be indicators of an eating disorder, such as binging or inducing vomiting
4. Nutritional concerns are to be evaluated for inclusion in the individual service plan and discharge recommendations.

Educational Assessment

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within specific time from the day of admission to Jones Wellness Center

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the clinical staff to disseminate this information to all staff under their direction.

POLICY
It is the policy of Jones Wellness Center to screen the educational status of the individual served as relevant to their needs, preferences, interests, and goals.

PROCEDURE
1. Upon admission, all individuals undergo a biopsychosocial assessment within 48 hours of admission.
2. The biopsychosocial assessment includes a screen of the individual's educational status to include:
   a. Educational background
   b. Academic performance and preferred area of study
   c. Attitude towards academic achievement
   d. Possibilities for future education
3. Educational needs and desires are evaluated for inclusion in the individual service plan and/or discharge plan.

Legal Assessment

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within specific time from the day of admission to Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the clinical staff to disseminate this information to all staff under their direction.

POLICY
It is the policy of Jones Wellness Center to screen for legal issues of the individual served.

PROCEDURE
1. Upon admission, all individuals undergo a biopsychosocial assessment within 48 hours of admission.
2. The biopsychosocial assessment includes a screen of the individual's legal status to include:
   a. Legal history;
   b. Preliminary discussion to determine who much the individual's legal situation will influence his or her progress in care, treatment, or services, and the urgency of the legal situation; and
   c. The relationship between the presenting conditions and legal involvement.
3. The legal status/needs are evaluated for inclusion in the individual service plan and/or discharge plan.

Vocational Status

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within specific time from the day of admission to Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the clinical staff to disseminate this information to all staff under their direction.

POLICY
It is the policy of Jones Wellness Center to screen the vocational status of the individual served as relevant to their needs, preferences, interests, and goals.

PROCEDURE
1. Upon admission, all individuals undergo a biopsychosocial assessment within 48 hours of admission.
2. The biopsychosocial assessment includes a screen of the individual's vocational status to include:
    a. Enrollment in school
    b. Employment history (if applicable)
    c. Type of work individual prefers
    d. Type of work individual has received training
3. The vocational status/needs are evaluated for inclusion in the individual service plan and/or discharge plan.

Re-Assessment

PURPOSE
To establish consistent protocols for re-assessing clients/clients throughout their care.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the clinical staff to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to ensure clients/individuals served are reassessed throughout their stay.
2. Although reassessment can occur at any time there is a significant change in status, and/or diagnosis or condition; to evaluate his or her response to treatment or at the request of the payer, Jones Wellness Center has established the following routine reassessment time intervals:
    a. It is the policy of Jones Wellness Center to ensure all individuals are continuously assessed throughout treatment to ensure the care, treatment, or services that will best meet the needs of the individual served.
        i. Individuals are to be reassessed to respond to a significant change in status (relapse) and/or diagnosis or condition.
    b. Assessment tools emotional and behavioral signs and symptoms, and self-report.
        i. Individuals are assessed at a minimum every 30 days (IOP) and every three months (OP), depending on the assessment. (With the exception of the CSSR, the re-assessment will be based off the scoring.)

PROCEDURE
1. Patient Reassessment:
    a. The Psychotherapist is responsible for the ongoing assessment of the individuals served. Assessment tools include attendance in therapeutic interventions, participation in groups, progress regarding assignments, etc.
    b. At a minimum, individuals are assessed weekly at the time of the individual session.

i. The assessment is documented in the clinical record.

2. Communication of Information:
    a. Psychotherapist is to report noted changes in the client's/client's clinical record.
    b. During daily report, clinical staff are to report any noted changes in progress or lack of progress on treatment goals.
    c. Psychotherapists are responsible to work with the treatment team to recommend alternative interventions, etc.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 02.02.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Biopsychosocial

PURPOSE
The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within specific time from the day of admission to Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Medical Director to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to ensure the organization collects assessment data on each individual served.
2. It is the policy of Jones Wellness Center that a biopsychosocial history assessment be completed for all clients within three (3) days of admission to Jones Wellness Center.

Behavioral Health Assessment:
1. A behavioral health assessment is conducted by a Psychotherapist.
    a. If the behavioral health assessment is conducted by an Advanced Practical Nurse, within 24 hours, a certified or licensed behavioral health professional to provide the behavioral health services needed by the client/client will review and sign the behavioral health assessment to ensure that the behavioral health assessment identifies the behavioral health services needed by the individual.
2. The behavioral health assessment is completed before treatment for the individual is initiated.
    a. If a behavioral health assessment that complies with the requirements is received from a behavioral health provider other than Jones Wellness Center and has a medical record for the individual that contains a behavioral health assessment completed within 12 months before the date of the individual's current admission:
        i. The individual's assessment information is reviewed and updated if additional information that affects the individual's assessment is identified.
        ii. The review and update of the individual's assessment information is documented in their medical record within 48 hours after the review is completed.
3. The biopsychosocial assessment includes:
    a. A history of physical problems associated, or possibly associated with mental health or eating disorders.
    b. A report of significant findings from the laboratory screening tests, and an interpretation of the tests by the client's attending physician in relationship to the use of drugs, and any treatment restrictions indicated
    c. Any history of physical abuse
    d. A systematic mental status observation with special emphasis on immediate recall, recent, and remote memory functioning
    e. Special emphasis with comments documented on the cognitive functioning of the client as observed, including any learning disability which might influence treatment
    f. A complete history of family mental health, drug dependence or abuse, treatment received, and present status
    g. The client/client's education level, vocational status, and job performance history (if applicable)
    h. The client/client's social support network, including family and peer relationships
    i. The client's sexual history, including sexual abuse (either as the abused or the abuser, and sexual orientation

j. The client/client's own perception of their strengths and weaknesses
k. The client/client's leisure time, recreational, and vocational interests
l. The client's regular activity patterns, including that which exacerbate mental health or eating disorders;
m. The social and cultural influences on the client/client;
n. The client/clients identify, to include their value system, beliefs, and spiritual orientation;
o. The client's own perception of his/her mental health;
p. An observation of the client/client's ability to participate with peers in the program and social activities;
q. Any criminal or civil legal situations, current or pending;
r. Any military history;
s. A history of the client/client's nutritional intake;

4. An integrated diagnostic summary is completed by the client/client's assigned assessor or Psychotherapist, integrating the information disclosed in the biopsychosocial assessment, the individual's completion of all other screening tools utilized including the DSM-5 criteria, and family members and/or significant others.
    a. A primary, and secondary if applicable, diagnosis in accordance with DSM-5 criteria will be made.

PROCEDURE

1. An initial screening for appropriateness is completed prior to admission.
2. A biological, psychological, and sociological (biopsychosocial) assessment will be completed within the three (2) days of admission no matter what level of care.
3. The biopsychosocial assessment will be reviewed, countersigned, and dated by a qualified professional within five (5) calendar days of admission.
4. The biopsychosocial assessment will serve as the basic document for the formulation of the comprehensive assessment (CTP).
5. In addition to the assessment policies and procedures for Jones Wellness Center, the following specific information is required for clients admitted into the program:
    a. A history of physical problems associated, or possibly associated, with mental health or substance/drug abuse-individual's short and long-term health goals;
    b. A report of significant findings from the laboratory screening tests, and an interpretation of the tests by the client's attending physician and treatment restrictions indicated.
    c. Any history of physical abuse, trauma, neglect or exploitation;
    d. A systematic mental status observation with special emphasis on immediate recall, recent, and remote memory functioning;
    e. Special emphasis with comments documented on the cognitive functioning of the client as observed, including any learning disability which might influence treatment;
    f. A complete history of family mental health, treatment received, and present status;
    g. The client's education level, vocational status, and job performance history;
    h. The client's social support network, including family and peer relationships;
    i. The client's sexual history, including sexual abuse (either as the abused or the abuser), and sexual orientation;
    j. The client's own perception of their strengths and weaknesses;
    k. The client's leisure time, recreational, and vocational interests;
    l. The client's regular activity patterns, including those which are alternatives to substance dependence or abuse;
    m. The social and cultural influences on the client;
    n. The client's identity, to include value system, beliefs, and spiritual orientation;
    o. The client's own perception of their substance dependence or abuse;
    p. An observation of the client's ability to participate with peers in the program and social activities;
    q. Any criminal or civil legal situations, current or pending;

r. Any military history
s. A history of a client's nutritional intake
t. The ability of the individual to manage behavioral and physical health conditions

6. An integrated diagnostic summary will be completed by the client's Psychotherapist, integrating the information disclosed in the biopsychosocial assessment, the client's completion of all other alcohol and/or drug screening tools utilized including the DSM-5 criteria, and family members and/or significant others.
    a. A primary, and secondary if applicable, diagnosis in accordance with DSM-5 criteria will be made.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 02.02.05
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Abuse, Neglect, Trauma, & Exploitation

PURPOSE

1. The purpose of this policy is to ensure consistent assessments will be completed for all clients/clients within a specific time from the day of admission to Jones Wellness Center.
2. Additionally, all staff will be trained on the indicators for Abuse, Neglect, Trauma, & Exploitation (ANTE) and how to respond appropriately when there are those indicators, including if the risk(s) are still present in the client's life.

RESPONSIBILITY

It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Medical Director to disseminate this information to all staff under their direction.

POLICY

1. Jones Wellness Center will train staff on what are the signs of ANTE, how to manage a client with a history of ANTE, and what are the state requirements for ANTE.
    a. This can be found in the training as well as the Employee Acknowledgement that is completed in their new hire orientation.
2. Jones Wellness Center will assess each client during admission for potential or actual Abuse, Neglect, & Exploitation.
    a. Issues around past or current ANTE will be addressed, deferred, or referred out for further evaluation and treatment if necessary.
3. Jones Wellness Center utilizes a validated assessment for trauma, PTSD Symptom Scale Interview (PCL-5).
    a. The PCL-5 is scored by simply summing the individual item scores.
    b. To obtain severity scores for each of the four symptom clusters, sum the items within each cluster.
    c. To obtain total PTSD severity, sum all 20 items for a total PTSD symptom severity score, ranging from 0-80.
4. It is the policy of Jones Wellness Center to ensure the identification of individuals served who may have experienced trauma, abuse, neglect or exploitation.
5. Staff are educated about trauma, abuse, neglect, and exploitation upon hire and educated on the referral process and reporting requirements.
6. Staff will acknowledge the signs of Abuse, Neglect, Trauma, and Exploitation during their probationary period, which includes state reporting guidelines, and thereafter receive training on ANTE.

Identification of Trauma, Abuse, Neglect or Exploitation

1. During Employee Orientation, all staff are educated on the following:
    a. Identification of trauma, abuse, neglect and exploitation
    b. Referral protocols for individuals who are identified as having experienced the trauma, abuse, neglect or exploitation
    c. Reporting requirements for individuals who are identified as having experienced the trauma, abuse, neglect or exploitation (See CTS 02.02.05.1)
2. Upon intake, individuals are screened for trauma, abuse, neglect or exploitation through the biopsychosocial assessment and the PSSI-5 (See CTS 02.02.01)

a. Individuals who are identified as having experienced trauma, abuse, neglect or exploitation are referred to Jones Wellness Center's Psychotherapist for a further assessment and treatment as deemed appropriate (See CTS 02.02.05.2)
b. In cases where the client may need immediate high acuity services to manage the identified issues, the Clinical staff will refer the client to a location who specializes in focused treatment for these cases.

3. Incidents of trauma, abuse, neglect or exploitation which require reporting to the authorities, i.e. Texas Department of Child and Family Services 800-252-5400 (See CTS 02.02.05.3)

Identification of Trauma, Abuse, Neglect and Exportation: Referral for Services

POLICY
Individuals who are assessed as having experienced trauma, abuse, neglect or exploitation are referred for further assessment.

PROCEDURE
1. Individuals who are identified as having experienced trauma, abuse, neglect or exploitation are referred to Jones Wellness Center's Psychotherapist for a further assessment and treatment as deemed appropriate.
2. The assessor is to discuss the need for further evaluation with the individual and the clinical staff; A progress note is to be entered into the clinical record.
3. The clinical staff are to complete a case management note to include the referral and a "Release of Confidential Information" form and schedule an appointment with Jones Wellness Center's Psychotherapist. The information is to document the clinical record.
4. The Clinical staff are to ensure transportation is available as needed.
5. Upon completion of the psychiatric assessment, the Clinical staff are to meet with the individual, review the assessment and recommendations for care.
6. The Clinical staff are responsible to see that all information pertaining to the assessment and treatment recommendations are documented in the clinical record and included on the individual's treatment plan.
7. Services recommended after discharge from Jones Wellness Center are to be included in the Aftercare Plan.

Identification of Trauma, Abuse, Neglect and Exportation: Reporting Requirement

PURPOSE
The purpose of this policy is to identify and describe procedures to follow concerning the abuse, neglect and exploration of individuals served.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Medical Director to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center's employees and contracted employees having reason to suspect abuse or neglect according to state statute and regulations.
2. Duty to report abuse, neglect and exploitation of vulnerable adults; duty to make medical records available; violation; classification
3. By law, everyone in Texas is a mandated reporter. Professionals may not delegate the duty to report to anyone else. The mandatory reporting requirement applies without exception to an individual whose personal communications may otherwise be privileged, including attorneys, clergy, medical professionals, social workers, and mental health professionals.
   a. All the above reports shall be *made immediately in person or by telephone* ***800-252-5400*** *and shall be followed by a written report mailed or delivered within forty-eight hours or on the next working day if the forty-eight hours expire on a weekend or holiday.*
4. Reports shall contain:

   a. The names and addresses of the alleged victim and any persons having control or custody of the alleged victim, if known.
   b. The client's age and the nature and extent of the client's vulnerability.
   c. The nature and extent of the client's injuries or physical neglect or of the exploitation of the client's property.
   d. Any other information that the person reporting believes might be helpful in establishing the cause of the client's injuries or physical neglect or of the exploitation of the client's property.
5. If psychiatric or clinical records maintained at the facility are requested the records shall notify the attending psychiatrist, who may excise from the records, before they are made available:
   a. Personal information about individuals other than the client.
   b. Information regarding specific diagnosis or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the client's health or treatment.
6. If any portion of a psychiatric or clinical record is excised, a court, upon application of a police officer or child protective services worker, may order that the entire record or any portion of such record containing information relevant to the reported abuse or neglect be made available to the peace officer or child protective services worker investigating the abuse or neglect.

PROCEDURE

1. Staff are oriented to the regulatory reporting requirements during New Employee Orientation and through the on-boarding process: A copy of the state statute is included in the Employee Handbook; an acknowledgement form is signed and dated by the staff; the acknowledgment form is maintained in the individual staff's personnel file.
2. Abuse may include, but is not limited to, the physical, psychological, or sexual injury inflicted other than by accident, failure to provide necessary treatment, habitation, care, subsistence, clothing, shelter, supervision, medical services, malnutrition or violation of individual rights.
3. Any staff person participating in client/client abuse will be dismissed immediately.
4. When any staff member witnessed firsthand the violation of client rights due to abuse, neglect, or exploitation of said individual, the employee will immediately contact 911, inform their immediate supervisor, who will report the incident to the Founder and Risk Manager (QA).
5. Staff on duty are to immediately develop an internal incident report.
6. The Founder is to review the internal incident report and report to the Local Law Enforcement and the State's Mandatory Reporter Hotline. (https://www.txabusehotline.org/Login/Default.aspx)
7. The report is to include:
   a. Organization's Name, address, license number
   b. Name of Founder
   c. The client's name and date of birth
   d. Date and time of occurrence
   e. Description of incident
      i. The names and addresses of the adult and any persons having control or custody of the adult, if known;
      ii. The adult's age and the nature and extent of the adult's vulnerability;
      iii. The nature and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property;
      iv. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property;
      v. Actions taken by staff; and
      vi. Notification of Emergency Contact.
   f. Report is to be made to:
      i. Local Police Department:
      ii. Department of Family and Protective Services

8. Incident is to be logged onto Jones Wellness Center's Incident Report Log and included in Jones Wellness Center's Quality Management Activities.
9. Monthly, Quarterly and Annual analysis of incident reports are to be developed and included as part of the performance improvement activities.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS.03.01.01; 03.01.03
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Treatment Planning

PURPOSE
To establish consistent guidelines for the foundation for planning individualized care, treatment, or services.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to ensure the delivery of effective, efficient, client centered care, in accordance with the Joint Commission, to provide each client with an individualized multidisciplinary treatment plan of care.
2. Recommendations for the individualized treatment plan are interdisciplinary; inclusive of medical, psychiatric and behavioral health assessments and interventions.
3. It is the policy of Jones Wellness Center to assess the needs, strengths, preferences, and goals of the individuals served and utilize the findings as the foundation for planning the individual's care, treatment and services.
4. It is the policy of Jones Wellness Center to complete an abbreviated treatment plan for each client upon admission.
    a. The plan is to be signed and dated by the Medical Director, Clinical staff and client.
5. The treatment plan contains the medical plan for stabilization and Withdrawal Management Services, provision for education, therapeutic activities and discharge planning.

Treatment Plan Requirements:
1. Treatment development and decisions should be based on information collected about the client's needs, strengths, preferences, and goals.
2. Treatment decisions are collaborative and interdisciplinary when more than one discipline is involved in the care, treatment, or services of the individual served.
3. Treatment planning includes interventions and services necessary to meet the identified goals.
4. The plan includes:
    a. Goals that are expressed in a manner that captures the individual's words or ideas
5. The plan includes:
    a. Goals that build on the individual's strengths
6. The plan includes:
    a. Factors that support the transition to community integration when identified as a need during assessment
7. The plan includes:
    a. The criteria and process for the individual's expected successful transfer and/or discharge/termination of services, which the organization discusses with the individual
8. The objectives are based on identified goals.
9. The objectives include identified steps to achieve the goal(s).
10. The objectives are sufficiently specific to assess the progress of the individual served.
11. The objectives are expressed in terms that provide indices of progress.
12. The goals and objectives are re-evaluated and/or revised based on change(s) in the individual's needs, preferences, and goals and the individual's response to care, treatment, or services.

   a. If no change(s) occurs, the goals and objectives are reevaluated at a specified time interval established by your policy.
13. Goals and objectives must be either addressed, deferred, or referred out for care, treatment, or services.
14. Reasons for deferring a goal, or the objectives leading toward or related to a goal, are documented.
   a. Remember that every issue should either be:
      i. Addressed
      ii. Deferred
      iii. Referred out
   b. There needs to be documentation for the intent/reason behind each action listed above.
15. Services must be in alignment with the treatment plan's goals and objectives.

PROCEDURE

1. Upon admission to the facility, clients and staff will discuss the initial requirements for services at the facility.
2. Client and staff will agree upon the frequency and timing of tasks noted on the initial treatment plan.
3. The initial treatment plan is to be signed and dated by the Medical Director and client.
4. The initial treatment plan with the original signature is maintained in the electronic medical record of the specific client.
5. A copy of the initial treatment plan is reviewed with the client. The client is provided with a copy upon request.
6. The initial treatment plan is reviewed daily with the individual and Jones Wellness Center staff.
   a. A progress note indicating the initial treatment plan has been reviewed, and progress towards completion is entered into the progress notes.

The Initial Treatment Plan

1. The Clinical staff will screen clients/clients for admission and collect and assess admission data.
2. The Licensed Psychologist will formulate an initial treatment plan.
3. The initial treatment plan is prepared with each client, upon admission, to address treatment from admission to the formulation of the comprehensive assessment.
4. The initial plan documents the date of admission, scheduled attendance and preliminary treatment objectives and goals.
5. The initial plan addresses such issues as the introduction of the client to the symptomatology and progressive nature of the symptomology; introduces the client to the treatment process with emphasis on positive expectations.
6. The initial treatment plan will be signed and dated by the client; signed and dated by the Psychotherapist within 10 days of creation.
7. The initial treatment plan is maintained in the EMR, and a copy is provided to the client.

The Comprehensive Assessment

1. Within 30 days of admission, the Psychotherapist and client will utilize the findings and recommendations from the biopsychosocial and the Diagnostic Summary to develop an individualized treatment plan.
   a. The plan will identify goals and objectives for the client to achieve and the plan that will be utilized to reach those goals and objectives.
2. The perception of the client and the client’s significant other as to the treatment needs will be documented and incorporated into the treatment plan.
3. Identified goals may be added or modified as new information is disclosed during the treatment process.
4. The individualized treatment plan is to indicate target dates for successful completion of the goals established, the type and frequency of services needed and agreed upon, the actual date of successful completion and the need for continuing care after discharge (Discharge Planning).
5. Issues or concerns identified during the assessment process which will not be addressed on the treatment plan or will receive only limited attention, will be documented as such by the Psychotherapist with justification for deferral, and plans for treatment or referral after discharge.
6. The individualized treatment plan will be signed and dated by the client; signed and dated by the Psychotherapist within 10 days of creation.

7. The individual treatment plan is maintained in the EMR and a copy is provided to the client.

Treatment Plan Review:

1. The initial treatment plan will be reviewed upon the development of the individual treatment plan.
2. The individual treatment is reviewed as follows:
    a. Intensive Outpatient:
        i. Every 30 days or as needed
    b. Outpatient:
        i. Every 30 days or as needed
3. The treatment plan review will indicate the progress or lack of progress on the treatment plan goal and objectives and may trigger additional goals and objectives to be added to the treatment plan to meet the needs of the client.
4. The treatment plan review will be signed and dated by the client; signed and dated by the Psychotherapist within 10 days of creation.
5. The treatment plan review is maintained in the EMR, and a copy is provided to the client.

TITLE: **CARE, TREATMENT AND SERVICES**	**REFERENCE:** **CTS. 03.01.05**
REVIEW AND APPROVAL: **09/10/2024**	**SUBJECT:** Family Involvement in Treatment Planning

PURPOSE
To establish consistent protocol to include family involvement in the treatment planning process.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Medical Director to disseminate this information to all staff under their direction.

POLICY
It is the policy of Jones Wellness Center to ensure the plan for care, treatment or services addresses the family's involvement.

PROCEDURE
1. The perception of the client and the client's significant other as to the treatment needs will be documented and incorporated into the treatment plan.
2. Prior to the development of the individual treatment plan, the Psychotherapist is to discuss the involvement of the individual's significant others in the treatment planning process and therapeutic milieu.
3. If the client consents to family or significant other involvement, a Release of Information (ROI) is to be completed to legally allow for contact with the family or significant other.
    a. The ROI is to be signed and dated by the client and maintained in the EMR.
4. With the client's approval, a "family" session will be facilitated with the client's significant other, either through a face-to-face session or phone call to solicit the significant other's perception of the client's treatment needs.
5. The "family" session and the perceptions of treatment needs are to be documented in the clinical record.
6. The family/significant other's involvement is to be reflected on the treatment plan unless otherwise contraindicated by clinical judgment or the client.
7. If family therapy or contact is contraindicated, the Psychotherapist must document why.
    a. For instance, if both parents or the client's spouse or significant other is in active treatment, this would be documented in the client's chart.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 03.01.07
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Referrals

PURPOSE
To ensure individuals have access to additional care, treatment and services not offered by Jones Wellness Center.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder or designee to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to ensure individuals are referred to additional care, treatment and services not offered by Jones Wellness Center.
2. Using a Case Management approach, referrals are to be made and documented in the clinical record.
3. Concurrent care, treatment and services provided by an outside source that are integral to meeting goals and objectives are addressed on the treatment plan and in the medical/clinical record.
4. Staff are to document referrals of individuals served to outside sources in the clinical/case record.

PROCEDURE
1. Upon admission and throughout their stay, clients and staff will continuously assess the client's need for ancillary services such as medical, legal, vocational, employment, mental health, physical health, etc.
2. Identified need for services is to be incorporated into the treatment plan.
3. To acquire ancillary services, staff and clients are to complete a case management note with the information given.
    a. A copy of the referral is to be placed in the client file.
    b. Client is responsible to take the form to the service provider from whom services are requested and ensure the information is completed during the service provision.
        i. The client is to return the form to Jones Wellness Center staff upon return.
    c. Staff is to record the outcome of referral in the client's progress notes.
    d. A Release of Information form is to be completed to allow staff to correspond to the identified service provider.
        i. The signed Release is to be placed in the client file and a copy provided to the client to deliver to the ancillary service provider.
    e. Follow up via phone is to be completed in any instance where the referral is not returned or completed.
        i. Contact to be documented in the client's individual file.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 03.01.09
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Validated Outcomes Assessment Tools

PURPOSE
To establish a systematic assessment of the outcomes of care, treatment and services provided.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder or designated staff to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to assess the outcomes of care, treatment, or services provided to the individuals served.
2. The purpose of doing this is to:
    a. Assess the client's individual progress in achieving his or her goals as well as the overall
    b. Comparatively review the outcomes against increases or decreases in successful outcomes measurements by looking at:
        i. Level of Care
        ii. Adherence to the Treatment Plan & Goals
        iii. Psychotherapist
        iv. Past treatment episodes and length of successful recovery periods
    c. The Leadership Team has established the performance outcome measures for the persons served.
        i. Persons Served Outcome Measures:
            1. % Discharged or transferred with successful completion of services
            2. % who acquired all medical services within the required timeframes
            3. % who were linked with ongoing therapeutic services
            4. % Physical stabilization from mental health symptomology
3. **Clinical**:
    a. The Leadership Team, in accordance with the National Outcome Measurement System from the Substance Abuse and Mental Health Service Administration (SAMHSA) establishes the performance outcome measures for the persons served.
4. **Validated Assessments**
    a. <u>Questions to screen for General Anxiety</u>
        i. GAD-7: Completed on Admission, prior to receiving services (MH), reassess 30 days (IOP) and 3 months (OP)
    b. <u>Questions to screen for Depression</u>
        i. PHQ-9: Completed on Admission, prior to receiving services (MH), reassess 30 days (IOP) and 3 months (OP)
    c. <u>Semi-structured interview providing a categorical diagnosis, as well as a measure of the severity of PTSD symptoms as defined by DSM-5</u>
        i. PCL-5: Completed on Admission, prior to receiving services (MH), and reassess 30 days if clinically indicated (IOP) and 3 months (OP). This may only be addressed in the treatment plan.
    d. <u>Semi-structured interview providing a categorical diagnosis, as well as a measure of the severity of eating disorder symptoms as defined by DSM-5</u>
        i. EAT: As clinically indicated, completed on Admission, prior to receiving services (MH), reassess 30 days (IOP) and 3 months (OP). This may only be addressed in the treatment plan.

Jones Wellness Center has established the following objectives for the program / services seeking accreditation:

1. **Treatment Services:**
    a. **Intensive Outpatient Services:**

i. Maintenance in an environment of support, where each client will gain knowledge of the recovery process, relapse triggers and vocational skills.
1. 95% will have all required assessments within the required time frames.
2. 95% will develop an individualized treatment plan within the required timeframes.
3. 95% will be linked with ongoing therapeutic services.
4. 80% will be employed/schooling upon discharge.

b. Outpatient Services:

i. Maintenance in an environment of support, where each client will gain knowledge of the recovery process, relapse triggers and vocational skills.
1. 95% will have all required assessments within the required time frames.
2. 95% will develop an individualized treatment plan within the required timeframes.
3. 80% will be employed/schooling upon discharge.

PROCEDURE

1. Monitoring of Individual Progress

a. The Psychotherapists are responsible to monitor the individuals' progress in achieving his or her care, treatment and service goals.
   i. The Psychotherapist meets weekly with everyone to review the progress or lack of progress of the individual in meeting their established goals or objectives.
   ii. The assessment of the individual's progress or lack of progress in meeting their established goals or objectives is documented in the clinical records/progress note section.
   iii. Based on the assessment, the treatment plan may be revised to meet the needs of the client.
   iv. Upon transfer or discharge, the Psychotherapist is responsible for completing the Transfer Summary/Discharge Summary which contains the data elements associated with the performance measures.
   v. Reports are available through the EMR, i.e. client specific or organization wide.
   vi. The Compliance Officer will review the data outcomes on a quarterly basis and conduct a comparative analysis on the aggregated data results.

2. Evaluation of Organization-Wide Outcomes of Care, Treatment, or Services.

a. Once per quarter the QA representative is responsible for running the QA reports from the Electronic Medical Record; "PI" and "Client Satisfaction Survey", among other data points.
b. The reports are to be viewed at the Leadership Team Meeting.
c. A Performance Improvement Plan is to be developed to address areas not meeting Jones Wellness Center's standards.
d. A Corrective Action Plan will be developed to address areas of non-compliance.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: 04.01.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Coordination of Care

PURPOSE
To ensure the individuals' needs are addressed in a seamless, synchronized and timely manner.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder or designee to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to coordinate the care, treatment and services provided through internal resources to the individual served.
2. Jones Wellness Center's process for hand-off of communication is in the form of written and oral reports.
3. This allows a discussion between the giver and receiver of information regarding the individuals served by Jones Wellness Center:
    a. For Outpatient Levels of Care: (Partial Hospitalization, Intensive Outpatient and Outpatient)
        i. A **Clinical/Operational Daily Report** is held every morning the Outpatient Center is open;

PROCEDURE
See Specific Procedures:

Outpatient Daily Communication Reports

PROCEDURE

Outpatient Daily Communication Reports

PURPOSE
To ensure the individuals' needs are addressed in a seamless, synchronized and timely manner.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Clinical staff to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to coordinate the care, treatment and services provided through internal resources to the individual served.
2. In the Outpatient Clinic, the Medical Director assigns, supervises, provides, and coordinates care for the individuals served.
3. Jones Wellness Center's process for hand-off of communication is in the form of written and oral reports. This allows a discussion between the giver and receiver of information regarding the individuals served by Jones Wellness Center:
    a. For Outpatient Levels of Care: (Intensive Outpatient and Outpatient)
    b. **Clinical/Operational Daily Report** is held every morning the Outpatient Center is open.

PROCEDURE

1. It is the Medical Director's responsibility to ensure daily written and oral communication is provided to all staff.
2. The Founder is responsible for facilitating the morning Clinical and Operational Update meeting according to the schedule.
3. The staff in attendance at a minimum include the Medical Director, Psychotherapist, Advanced Practical Nurse, and CLinical staff.
4. Information is reviewed in accordance with the **Clinical / Operational Daily Report**
5. **Outpatient Clinical / Operational Daily Report**
    a. The hard copy of the report is to be maintained in a binder, secured under a two-lock system at the Medical Director's office.
    b. The hard copies are maintained on a month-to-month basis.
    c. On the first of the month, the Advanced Practical Nurse is responsible to ensure the three weeks of the previous month the **Outpatient Clinical / Operational Daily Report** are removed from the binder and scanned into a file on Jones Wellness Center's secure server.
        i. The last week of the month is to be maintained in the hard copy format in the binder for reference.
    d. Hard copies of the scanned reports are to be placed in confidential shredding bins for disposal.
6. **Shift Reports/Communication Logs:**
    a. A Business Associate Agreement allows the sharing of information are electronic and forwarded to the Psychotherapist through a secure server.
    b. The reports are reviewed during the meeting with significant events noted in the report.
    c. Reports of significant events are verbally relayed to the Psychotherapist and noted in the individual's clinical record.

TITLE: **CARE, TREATMENT AND SERVICES**	**REFERENCE:** **CTS. 04.01.03**
REVIEW AND APPROVAL: **09/10/2024**	**SUBJECT:** Client Education

PURPOSE
To establish a systematic approach to ensure the individuals served receive education and training specific to the individual's needs and abilities consistent with the care, treatment or services provided.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder or designee to disseminate this information to all staff under their direction.

POLICY
It is the policy of Jones Wellness Center to ensure a systematic approach to ensure individuals served receive education and training specific to the individual's needs and abilities consistent with the care, treatment or services provided.
The individual/family education is an interactive process in which staff impacts knowledge to individuals and families while continuously eliciting feedback. This process ensures that information is understood and that it is applicable in practical terms.

PROCEDURE
1. During the initial assessment, the individual's learning needs are identified utilizing the Intake Assessment.
2. Learning needs may be dependent on several factors, including, but not limited to, the individual's diagnosis, abilities, learning preferences (written, verbal, audio, etc.); and readiness and motivation to learn.
3. Further assessment occurs during the biopsychosocial assessment, when staff address cultural and religious practices, emotional barriers, as well as any physical and cognitive limitations.
4. Resources to aid in the education of individuals, family, significant others, as well as staff are available in the Client Welcome Packet.
    a. The Client Welcome Packet is in the facility and clinical waiting room.
    b. The Client Welcome Packet provides basic education on the following:
        i. History of Organization;
        ii. Organization Mission, Vision, Values, Philosophy, and Goals;
        iii. Admission and Discharge Process;
        iv. Hours of Operation;
        v. Weekly Clinical Schedule; Weekly Clinical Staff Schedule;
        vi. Patient Rights;
        vii. Program Descriptions;
        viii. Rules and Regulations;
        ix. Urinalysis Policy; and
        x. Grievance Procedures.
5. Using an interdisciplinary and collaborative approach the individuals and families are at a minimum educated on the following:
    a. Safe and effective use of medication;
    b. Safe and effective use of any applicable medical equipment;
    c. Advance Directives;
    d. Potential drug/food interactions;
    e. Facility orientation upon admission;
    f. Personal hygiene and grooming; and

   g. Habilitation or Rehabilitation techniques to help him or her reach the maximum level of independence possible.
6. During the educational process, the staff includes feedback to ensure information is effective and understood.
7. Through treatment planning sessions, the individual's ongoing educational needs are reassessed and addressed to meet goals.
8. Individuals are informed via written materials, as well as verbally, about access to resources in the community.
   a. Posted written materials, brochures and pamphlets and other educational materials are approved by the medical and clinical teams prior to use.
9. As part of Jones Wellness Center's discharge planning, individuals are informed on how to obtain further treatment, such as home health referrals, sober housing, continuing therapeutic services, i.e. treatment facilities, etc.
10. Ongoing assessment on individual and family educational needs are assessed by all disciplines.
11. Documentation
12. Outpatient Services: The individual's feedback, unresolved needs or other information pertaining to the results of the teaching process are documented in the Progress Notes.

Client Education on the Biopsychosocial of the Client

PROCEDURE

1. The biopsychosocial aspects of behavioral health participant/family/significant other education is designed to provide the following criteria.
    a. Educate the clients in areas pertaining to the biological, psychological, and the social aspects of mental health diagnosis.
    b. Education classes will integrate human growth and development and child development theories and best practices. Focus on the interruption, the learning/relearning of tasks and skills associated with the stages of adult and child development.
    c. Education classes will be facilitated based on the adult learning theory.
    d. Education class will be implemented in the format of individual session, group session utilizing various methods (group discussions/process, demonstration, audio/visual reinforcement, verbal/written assignments, etc.).

Client Education on Infectious Disease

PURPOSE

To ensure that all clients receive Infectious Disease Education.

RESPONSIBILITY

It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Founder to disseminate this information to all staff under their direction.

POLICY

It is the policy of Jones Wellness Center to provide all clients with education regarding infectious diseases.

PROCEDURE

1. Upon admission, individuals are screened for possible HIV/AIDS, hepatitis, sexually transmitted diseases and tuberculosis.
2. Individuals who are at high risk or who request testing:
    a. Outpatient Services: Individuals will be referred for testing using a case management approach.
3. Jones Wellness Center has an established program schedule inclusive of education pertaining to infectious diseases (Attached).
4. The individual's attendance, participation and confirmation of understanding are documented in the clinical record.
5. Additional education on Infectious Disease may be accessed through a referral to medical staff.
    a. All such referrals are to be facilitated using a Case Management approach with documentation in the clinical record.

TITLE: **CARE, TREATMENT AND SERVICES**	**REFERENCE:** **CTS. 04.03.17**
REVIEW AND APPROVAL: **09/10/2024**	**SUBJECT:** Activities Therapies

PURPOSE
To ensure a coordinated plan for care for all individuals served.

RESPONSIBILITY
It is the responsibility of the Founder or designee to implement this policy and procedure. It is the responsibility of the Clinical staff to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to ensure all individual's plan for care, treatment, or services identifies activity therapies provided to support achievement of a specific goal.
2. Activity therapies provided are to support the achievement of a specific goal and reflect the individual's interest and preferences.

PROCEDURE
1. It is the responsibility of the Psychotherapist to ensure the completion of a biopsychosocial evaluation upon admission, inclusive of the individual's interest and preferences.
2. All activity therapies identified as part of the treatment recommendations are to be reflective of the individual's interest and preferences and included in the individual's plan for care, treatment or services.
3. The activities therapies are to be listed on the treatment plan, with objectives and goals identified.
4. The progress towards the goals is to be reviewed and documentation of the progress or lack of progress towards completion of the goal is to be documented at the time of the treatment plan review or upon completion of the goal.

TITLE: **CARE, TREATMENT AND SERVICES**	**REFERENCE:** **CTS. 04.03.33**
REVIEW AND APPROVAL: **09/10/2024**	**SUBJECT:** Food Service

POLICY

1. It is the policy of Jones Wellness Center that food is not provided.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 04.03.35
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Medical Emergencies

PURPOSE
To establish consistent protocols for responding to medical emergencies.

POLICY
1. It is the policy of Jones Wellness Center to have written policies and procedures for responding to medical emergencies.
2. All facilities are equipped with First Aid kits.
    a. Medical units are equipped with AED Defibrillators.
3. All direct care staff are required to be trained and certified in Cardiopulmonary Resuscitation (CPR).
4. Emergency phone numbers are to be posted throughout the facilities to ease in emergency transfer to an alternative emergency medical facility.
5. Jones Wellness Center's facilities are in areas where 911 is available and is called for all medical emergencies.
    a. In addition to 911 the emergency numbers for fire and police are to be clearly listed throughout the facility's program offices and waiting rooms.

PROCEDURE
1. It is the responsibility of the Medical Director to assist in the development and approve Jones Wellness Center's policy and procedures for handling medical emergencies.
2. Specific policies and procedures address the following:
    a. First Aid
    b. Cardiopulmonary Resuscitation
    c. Suicide / Unresponsive
    d. Seizures
    e. Falls
    f. Psychiatric Emergencies

3. <u>Non-Emergency Situations</u>
    a. In the event of an injury or sudden illness affecting the client or visitor, emergency first aid will be rendered by a nurse.
        i. Patients will be treated in the area the injury occurred, their rooms or the physician's office.
        ii. Visitors will be encouraged to seek treatment from a physician or medical facility of their own choice if additional treatment is required.
        iii. Visitors and clients have the right to refuse first aid services.
        iv. Documentation of this will be made in the Incident Report and in the case of clients, will be documented in the medical record.
    b. The Advance Practical Nurse will call the Physician in case of illness or injury.
        i. If a physician is not available, the nurse will call 911 and EMS will take the client to the nearest Hospital Emergency Room.

4. **<u>Emergency Situations</u>**
    a. Designated nursing staff are responsible to respond immediately to any person on the premises who is injured or ill.
    b. The staff member who observes or discovers the incident will respond to the health, safety, and emotional needs of the injured/ill person by providing support and any required first aid procedures he/she is qualified to perform.
    c. In the event of any potential life-threatening emergency, 911 will be called.

i. When the emergency medical team arrives, they will evaluate the client's needs and take the client to the nearest hospital.

d. When calling Emergency Medical Services (911):
   i. State the location of the facility
   ii. The telephone number of the facility
   iii. Location of the injured/ill person within the facility
   iv. The nature of the incident
   v. The condition of the injured/ill person(s)
   vi. Actions being taken for the injured/ill persons(s)
   vii. Be sure the person you are talking to has all the necessary information.

e. If a new admission's condition requires that they be taken to the emergency room, this is always done by calling 911.

5. Documentation of Injury/Illness

a. In the event of an injury/illness to a client or visitor, an Incident Report will be completed by the staff member who observed or discovered the accident.
b. Patient injuries and illnesses and their treatment will be documented in the client's medical record.
c. All incident reports are tracked to identify trends for improvement through the Performance Improvement Committee.

6. **Patient Medical Treatment Through a Community Based Medical Facility**

a. The nearest hospital will be utilized for all specialized medical services, i.e. diagnostic services, surgical and/or medical treatment which are outside the scope of the facility.

First Aid

POLICY:

1. It is the policy of Jones Wellness Center to require all staff to acquire First Aid Training.
2. Jones Wellness Center utilizes the 2015 American Heart Association Guidelines for First Aid.
   a. The training is provided on-site or off-site and facilitated by a First Aid Trainer certified by the American Health Association.
3. Individuals must acquire training within the first 3 months of employment or prior to working a shift independently.
   a. A staff person trained in First Aid must be on-site at the facility when clients are present.
4. A Certificate of Completion must be presented upon the completion of the training.
   a. A copy of the CPR/First Aid "card" must be maintained in the employee file.

PROCEDURE:

1. It is the ultimate responsibility of the Founder to ensure all staff acquire First Aid training within the specified time frame and evidence of the training is included in the personnel file.
2. The Medical Director or designee is responsible for the day-to-day implementation of First Aid training.
3. A staff training calendar includes routine First Aid training provided by Jones Wellness Center's Medical Director.
4. The Founder is responsible to educate all staff pertaining to the requirement for First Aid Training and schedule the individual to complete the course as necessitated by their job function.
5. The Founder is responsible for tracking the completion of the training, entering the training into Jones Wellness Center Training Log and ensuring a copy of the "certification" is placed and maintained in the employee file.
6. The Founder is responsible for informing supervisors of training needs, i.e. initial training, renewals, etc.

In Case of Event:

1. Efforts to apply first aid are instituted.
2. The staff member who observes or discovers the incident will respond to the health, safety, and emotional needs of the injured/ill person by providing support and any required first aid procedures he/she is qualified to perform.

3. In the event of any potential life-threatening emergency, 911 will be called. When the emergency medical team arrives, they will evaluate the client's needs and take the client to the nearest hospital.
4. When calling Emergency Medical Services (911):
    a. State the location of the facility.
    b. The telephone number of the facility.
    c. Location of the injured/ill person within the facility.
    d. The nature of the incident.
    e. The condition of the injured/ill person(s).
    f. Actions being taken for the injured/ill persons(s).
    g. Be sure the person you are talking to has all the necessary information.

e. The incident is to be documented in the form of an Incident Report and forwarded to the Performance Improvement Committee.
f. If the incident involved individuals receiving services from Jones Wellness Center, the incident is included in the medical record.
g. If the incident involved an employee, the incident is recorded in the personnel file.

CPR

POLICY:

1. It is the policy of Jones Wellness Center to require all staff to acquire CPR Training.
2. While Jones Wellness Center prefers that employees obtain their training through the American Heart Association, we understand that onsite training may be unavailable or difficult to attend onsite.
3. Jones Wellness Center will accept a non-AHA CPR certification in lieu of the AHA.
4. Individuals must acquire training within the first 3 months of employment or prior to working a shift independently.
    a. A staff person trained in CPR and First Aid must be on-site at the facility when clients are present.
    b. A Certificate of Completion must be presented upon the completion of the training.
    c. A copy of the CPR “card” must be maintained in the employee file.

PROCEDURE:

1. It is the ultimate responsibility of the Founder to ensure all staff acquire CPR training within the specified time frame and evidence of the training is included in the personnel file.
2. The Founder or designee is responsible for the day-to-day implementation of CPR training.
3. A staff training calendar includes routine CPR training provided by Jones Wellness Center’s Medical Director.
4. The Founder is responsible to educate all staff pertaining to the requirement for CPR Training and schedule the individual to complete the course as necessitated by their job function.
5. The Founder is responsible for tracking the completion of the training, enter the training into Jones Wellness Center Training Log and ensure a copy of the “certification” is placed and maintained in the employee file.
6. The Founder is responsible for informing supervisors of training needs, i.e. initial training, renewals, etc.

In the case of an event:

1. Efforts to resuscitate are instituted, they will be continued by Jones Wellness Center staff until emergency medical services arrive.
    a. Responsibility for continuation of life support will then be turned over to the emergency Medical Services.

Emergencies involving Self-Harm

PURPOSE

The Purpose of this policy is to identify procedures and policies for dealing with clients having the potential for self-harm.

RESPONSIBILITY
It is the responsibility of the Founder/or designee to implement this policy and procedure. It is the responsibility of the Founder to disseminate this information to all staff under their direction.

POLICY
1. It is the policy of Jones Wellness Center to treat all clients' potential suicide or homicidal ideation with the utmost caution and consideration.
2. The assessment of potential for self-harm or harm to others is ongoing and begins at the time of screening, continues through the core battery of assessments and is monitored daily.
3. When clients/clients evidence at-risk symptoms of expressing suicide ideation and the potential of self-harm or homicidal behavior, Psychotherapist shall conduct an assessment to determine the appropriate of the client for all levels of treatment.
4. If the client's symptoms or history warrant, the client has expressed through behavior or verbally suicide ideation or homicidal with current episodes, the client/client is coming to the program as a step-down, or the referral source indicates potential, the treatment team is responsible for:
    a. Conducting complete assessment including discussion with family members;
    b. Documentation results of assessment and consulting with attending physician;
    c. Developing a safety plan for time between screening and admission (i.e. Safety Contract);
    d. Ensuring the client/client have emergency phone numbers (including 988) for after-hours emergencies (Outpatient Levels of Care);
    e. Informing Case Management;
    f. Assessing the potential for self-harm through appropriate assessments and documents thoroughly;
    g. Placing the potential for self-harm on the Initial and Individual Treatment Plan with appropriate objects for daily monitoring.
5. Determination of Risk of Self-Harm through the following criteria:
    a. Assume all verbal expressions of ideation, even if "passive" place at risk;
    b. Factors which may indicate risk of suicide:
        i. Loss of significant other;
        ii. Loss of economic status;
        iii. Health change;
        iv. Giving away of personal belongings;
        v. Increased isolative behaviors;
        vi. Writings or artwork referring to death;
        vii. Continued intentional drug overdoses;
        viii. Risky sexual behavior;
        ix. Mood swings; and/or
        x. Depression;
    c. Evaluation for Appropriate Care:
        i. If a Qualified Behavioral Health Professional determines the individual is contemplating suicide, a referral is to be a Board-Certified Psychiatrist for recommendations for continued care or transfer to a more appropriate facility.
        ii. If it is determined the individual can be safely managed at the facility, a safety plan is to be implemented.
        iii. If it is determined the individual cannot be safely managed at the facility, the individual is referred and linked to a psychiatric stabilization unit.
            1. The Emergency Contact is notified.
            2. The Psychotherapist remains in contact with the psychiatric facility to arrange for an evaluation upon discharge and stabilization.

FORM
See C-SSRS (Suicide Risk Assessment)

PROCEDURE

1. The treatment team begins assessment of potential for self-harm or harm to others through an interview with the client and referring source.
2. A Suicide Risk Screen / Assessment is completed upon admission.
    a. If the screen score is greater than 8, the individual is referred to a licensed clinician for a comprehensive suicide assessment.
3. Evaluation for Appropriate Care:
    a. If a Qualified Behavioral Health Professional determines the individual is contemplating suicide, a referral is to be a Board-Certified Psychiatrist for recommendations for continued care or transfer to a more appropriate facility.
    b. If it is determined the individual can be safely managed at the facility, a safety contract is to be implemented;
        i. Appropriate interventions to be considered are as follows:
            1. Observation:
            2. Supervised Bathroom
            3. Unit restriction
            4. Restriction to public areas
            5. Placement into hospital clothing (scrubs)
            6. Placement on non-ligature environment
    c. If it is determined the individual cannot be safely managed at the facility, the individual is referred and linked to a psychiatric stabilization unit.
        i. The Emergency Contact is notified.
        ii. The Psychotherapist remains in contact with the psychiatric facility to arrange for an evaluation upon discharge and stabilization.
    d. **In the Case of An Event:**
        i. If a staff member discovers a client/visitor, or staff members who is unresponsive, they are to state over the radio 3 times “Code Blue/Room/Area” and they are to immediately initiate CPR if appropriate.
    e. CPR is initiated and continued until EMS/Paramedics arrive.
    f. As in all medical emergencies, the Medical Director and Founder will be notified immediately. OBJ
    g. Non-responding staff will redirect other clients and visitors out of the area.
    h. The receptionist will give the location and directions as to where in the facility the Code Blue is taking place to EMS Personnel, when EMS Personnel arrives.
        i. After 10 PM, a staff member will be designated to meet the EMS.
    i. The incident will be documented in an incident report and in the progress notes and included in Jones Wellness Center’s Performance Improvement activities.

Seizure Precautions

POLICY:

1. It is the policy of Jones Wellness Center to utilize seizure precautions for program participants who have a history of seizures or a condition which may precipitate seizures, in order to protect the individual from injury and to maintain an obvious airway.
2. The nurse is to note in the EMR an “Urgent Issue” in the client’s medical record stating “Seizure Awareness” and notes in the clinical record.
    a. Status epilepticus shall be considered a life-threatening emergency.
    b. The condition is evidenced by rapid succession of epileptic attacks without the client regaining consciousness during the intervals.
    c. 911 is to be immediately called.

PROCEDURE:

Care During a Seizure:

1. Assume responsibility for the individual's safety.
    a. Assess the environment for sharp furniture edges, protruding objects, etc. moving the individual or furniture to ensure the area is clear and not a danger to the individual.
    b. Ensure all other program participants and visitors are removed from the area.
    c. Protect the individual from injury by cushioning their head before he/she falls against a hard surface.
        i. Continue to cushion the head as the seizure progresses.
    d. If a **medical unit,** the nursing staff will stay with the individual and call for additional assistance if needed.
        i. 911 and physicians are to be contacted.
        ii. Do not attempt to force anything between the client's teeth.
        iii. Always maintain the individual's airway and ensure adequate ventilation. If possible, turn the individual on their side, this will assist the tongue from getting lodged in the throat and block the airway.
        iv. A nurse will stay with the client until the paramedics arrive and will monitor the vital signs and neuro-checks every 5 minutes.
        v. The vitals and neuro checks will be documented in the individual's file.
        vi. Allow the seizure to occur without interference.
        vii. When the seizure is over, check for breathing.
            1. Begin CPR if necessary.
            2. Administer oxygen, if necessary.
        viii. After the seizure, inform the individual that they have had a seizure and that they are all right.
        ix. Keep the client turned on one side until responsive and alert.
        x. Document the vital signs (Blood Pressure, Pulse and Respiration).
        xi. Upon arrival of paramedics, have the client transported to the nearest hospital for medical clearance.

Observation and Documentation

The following procedure is to be adhered to for observing and documenting the events of the individual's seizure. Accurate observation and documentation will assist medical staff in accurately diagnosing the cause of the seizure to prevent further occurrence.

1. Observation: Watch for signs of onset; a change in facial expression such as an expression of fear, or random activity that may represent the individual's aura of an impending seizure;
    a. Observe the initial activity-hand, thumb, mouth, etc. because the first movement is important;
    b. Determine the progression of seizure activity. Note: Muscular movements may change in character during seizure:
        i. Muscular movement may be tonic (steady contractions),
        ii. Clonic (contraction and relaxation),
        iii. Localized (focal) or
        iv. Generalized.
    c. Observe the individual's ability to make voluntary movements, noting the part and extent of the movement - note if the individual was unresponsive during the seizure.
    d. Note changes in color: pallor, pulse changes, respirations, blood pressure, and involuntary micturition (loss of urine contingency), and/or defecation.
    e. Note the presence of thick salivation, vomiting, or bleeding.
    f. Document the type and extent of speech difficulty and client awareness of time, place, person, etc.
    g. Check the time and duration of the seizure and the method of termination.
    h. Document the length of time required to return to normal behavior and response, and assess for possible injuries and other observations.
2. Documentation: Describe the observations in simple terms.
    a. Do not offer opinions, conclusions, or interpretations.
    b. Describe only what is observed.
    c. Describe events in chronological order.

3. Note: Status epilepticus shall be considered a life-threatening emergency. The condition is evidenced by rapid succession of epileptic attacks without the client regaining consciousness during the intervals.
    a. 911 is to be immediately called.

Psychiatric Emergencies

1. If a client experiences a psychiatric emergency/crisis while at a facility, the following procedure will be followed:
    a. If a client is in immediate danger of hurting himself or others:
        i. The Medical Director will make the assessment of whether to call 911/988, or if a staff member can safely get the client to the nearest hospital or psychiatric facility.
        ii. Staff will remove clients from the client community.
        iii. Psychotherapist (or equivalent) is to call and inform the physician of a client's behavior and emotional status.
        iv. Psychotherapist (or equivalent) is to follow doctor's telephone orders for clients.
        v. If a client cannot be stabilized until the police and/or crisis team arrives, call 911/988 for assistance.
        vi. If a client leaves the facility, 911/988 is to be notified of the emergency.
        vii. The Founder is to notify the receiving facility, referral sources, guardian, and family if appropriate.
        viii. The client is to be always supervised by a minimum of one staff member until appropriate transport has arrived.
        ix. Staff will maintain communication with the facility in which the client has entered and update the physician and Operations staff on any changes or updates.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 05.01.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Verbal De-Escalation

PURPOSE
The purpose of this policy is to clarify Jones Wellness Center's protocols for de-escalation without physical force.

RESPONSIBILITY
It is the responsibility of the Founder to implement and disseminate this policy and procedure.

POLICY
It is the policy of Jones Wellness Center to prohibit the use of any procedure that physically harms or is a psychological risk to the individual served. Jones Wellness Center uses verbal de-escalation to address client/staff aggression. Under no circumstances are individuals denied any basic needs, i.e. nutritious food, water, shelter, and essential and safe clothing. The use of corporal punishment, fear-eliciting procedures, intimidation, force or threats, or any violation of the client's rights are strictly prohibited.

PROCEDURE
1. All staff are trained in Verbal De-Escalation Control within 30 days of hire.
2. Evidence of the training and observed competency is maintained in the personnel file.
3. Upon admission and throughout their treatment an explanation of client rights and responsibilities and the facility rules are explained to clients.
4. An emphasis is placed upon being clear, direct and thorough in explaining to clients what we can and can't offer to them and to what degree we can assist them in meeting their needs.
5. Our goal is to prevent untoward behavioral incidents from occurring.
6. **Upon Event:**
    a. It is the responsibility of all staff to ensure the safety and wellbeing of the clients and staff.
    b. Clients who exhibit sudden, intense, or out-of-control behavior are to be separated from the client population and if verbal de-escalation techniques are unsuccessful, either law enforcement is contacted or, depending upon an evaluation of the circumstances, the Medical Director is contacted for possible medical intervention.
    c. During any incident of aggression or disruptive behavior, all available staff will respond quickly as a team and provide a show of support for other staff that may be the focus of a client's inappropriate or escalating behaviors.
    d. Upon resolution of the "incident":
        i. Contact supervisor;
        ii. Write up an incident report and submit to supervisor;
        iii. Document incident and resolution in the client's file; and
        iv. Hand off information regarding the incident in the shift report.
    e. Incidents and Client grievances are tracked and reported quarterly to the Performance Improvement Committee as part of our CQI process and corrective actions taken as needed.

TITLE:	REFERENCE:
CARE, TREATMENT AND SERVICES	**CTS. 05.02.01**
REVIEW AND APPROVAL:	**SUBJECT:**
09/10/2024	Exclusionary Time-Out

PURPOSE
The purpose of this policy and procedure is to clarify Jones Wellness Center's protocols for exclusionary time-outs.

RESPONSIBILITY
It is the responsibility of the Founder to implement and disseminate this policy and procedure.

POLICY
It is the policy of Jones Wellness Center to not utilize time-out as a behavioral management technique.

TITLE: **CARE, TREATMENT AND SERVICES**	**REFERENCE:** **CTS. 05.03.01**
REVIEW AND APPROVAL: **09/10/2024**	**SUBJECT:** Level Systems

PURPOSE
The purpose of this policy and procedure is to clarify Jones Wellness Center's protocols for level systems.

RESPONSIBILITY
It is the responsibility of the Founder to implement and disseminate this policy and procedure.

POLICY
It is the policy of Organization to not utilize a Level System as a behavioral management technique.

TITLE: **CARE, TREATMENT AND SERVICES**	**REFERENCE:** **CTS. 05.04.01-05.04.17**
REVIEW AND APPROVAL: **09/10/2024**	**SUBJECT:** Behavior Contingencies

PURPOSE

The purpose of this policy and procedure is to clarify Jones Wellness Center's protocols for aggression /behavioral control.

RESPONSIBILITY

It is the responsibility of the Founder to implement and disseminate this policy and procedure.

POLICY

It is the policy of Jones Wellness Center to not utilize Behavioral Contingencies as a behavioral management technique.

TITLE: **CARE, TREATMENT AND SERVICES**	**REFERENCE:** **CTS. 05.06.01-05.06.35**
REVIEW AND APPROVAL: **09/10/2024**	**SUBJECT:** Restraint and Seclusion

PURPOSE
The purpose of this policy and procedure is to clarify Jones Wellness Center's protocols for restraints and seclusion.

RESPONSIBILITY
It is the responsibility of the Founder to implement and disseminate this policy and procedure.

POLICY
It is the policy of Jones Wellness Center to not utilize Restraint and Seclusion as a behavioral management technique.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS.06.02.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Transfer of Individuals

PURPOSE
To ensure continuity of care for individuals who are served who are moved across a continuum of care, treatment, or services.

RESPONSIBILITY
1. It is the responsibility of the Founder to ensure this procedure is disseminated to all staff.
2. It is the Founder's responsibility to ensure the protocol is implemented throughout the system.

POLICY
1. It is policy of Jones Wellness Center to ensure when an individual receiving services is transferred or discharged the continuity of care, treatment, or services is maintained.
2. Jones Wellness Center has established protocols address the continuity of care, treatment of services after discharge or transfer that includes the following:
    a. The transfer of responsibility for care, treatment, or services for the individual served from one staff, organization, organizational program, or service to another.
    b. The reason for transfer or discharge when moving from one staff, organization, organizational program, or service to another.
    c. Mechanisms for internal and external transfer.
    d. Identification of the person who has accountability and responsibility for the safety of the individual served during an external transfer.

PROCEDURE

Internal Transfers

POLICY
1. It is policy of Jones Wellness Center to ensure when an individual receiving services is transferred or discharged the continuity of care, treatment, or services is maintained.
2. Jones Wellness Center has established protocols address the continuity of care, treatment of services after transfer that includes the following:
    a. The transfer of responsibility for care, treatment, or services for the individual served from one staff, or service to another.
    b. The reason for transfer or discharge when moving from one staff, organization, organizational program, or service to another.
    c. Mechanisms for internal transfer.

PROCEDURE - For Internal Transfers:
1. It is the responsibility of the Founder to ensure all transfers are completed by this process.
2. Internal transfers are implemented when the level of care is no longer medically or clinically appropriate for the individual in care.
3. **For Non-Medical Units:**
    a. A case staffing completed weekly with the Clinical staff.
    b. When the current level of care is no longer appropriate for the individual served based on ASAM Criteria a transfer is initiated.
    c. A Discharge Summary form is to be completed immediately for individuals who transfer within Jones Wellness Center from one modality to an alternative level of care.

4. The Discharge Summary form is to be completed at the time of transfer and is to be signed and dated by the Psychotherapist. If the Psychotherapist is not an independently licensed individual, then the qualified supervisor is to review and sign off on the transfer.
5. The Discharge Summary is to include the following:
    a. Client Name
    b. Medical Record #
    c. Admission Date to Current Modality
    d. Transfer Date
    e. Reason for Transfer
    f. Services Provided in Current Level of Care
    g. Progress and Summary of Treatment in Current Level of Care
    h. Treatment Recommendations Upon Transfer
    i. Currently Prescribed Medication
6. The Discharge Summary form is to be maintained in the EMR and a copy is provided to the individual served.

External Transfer/Discharge

POLICY

1. It is policy of Jones Wellness Center to ensure when an individual receiving services is transferred or discharged the continuity of care, treatment, or services is maintained.
2. Jones Wellness Center has established protocols address the continuity of care, treatment of services after discharge or transfer that includes the following:
    a. The transfer of responsibility for care, treatment, or services for the individual served from one staff, organization, organizational program, or service to another.
    b. The reason for transfer or discharge when moving from one staff, organization, organizational program, or service to another.
    c. Mechanisms for internal and external transfer.
    d. Identification of the person who has accountability and responsibility for the safety of the individual served during an external transfer.
    e. An External Transfer is limited to less than 24 hours and due to medical necessity.
        i. Timeframes which exceed 24 hours are considered discharges and the individual must be discharged and reassessed upon completion of services at the alternative medical facility.

PROCEDURE

1. All “Transfers” are Emergency or Need Based:
    a. When a medical emergency arises, the staff is responsible for evaluating the individual to determine if the individual’s condition warrants an emergency transport.
    b. If Emergency Transfer is warranted, 911 is called.
    c. The individual’s face sheet from the EMR will be printed and provided to the Emergency Transport staff.
    d. The face sheet includes the following information:
        i. Date of Admission
        ii. Referrer
        iii. Client Name
        iv. Address
        v. Phone No.
        vi. Date of Birth
        vii. Marital Status
        viii. Race
        ix. Ethnicity
        x. Insurance Information
        xi. Emergency Contact
    e. The staff is to verbally provide the reason for transfer to the EMT unit and contact the hospital to speak to the ER nurse for a medical briefing.

f. The nurse is responsible for ensuring the receiving facility has the contact information for the unit to be contacted upon discharge.
g. The staff is responsible for contacting the individual's Emergency Contact to inform him/her of the transport and provide information as to the reason for the transport, location and contact number.
h. The staff is to write a progress note indicating the following information:
    i. Date/Time of Contact
    ii. Name and relationship of whom they contacted
    iii. Contact's reaction to the information
i. The staff is responsible for maintaining contact with the emergency service provider until such a time the individual is discharged from the emergency service.
j. Upon discharge from the emergency service, the individual's discharge orders are to be forwarded to the Medical Director for review; The Medical Director is to evaluate if the individual's needs are within the scope of the facility and staff.
k. If the facility **IS** appropriate to meet the needs of the individual, arrangements are made for the individual to be transferred back to the facility.
l. If the facility **IS NOT** appropriate to meet the needs of the individual, the staff is to coordinate alternative placements for the individual and their significant others.
m. The staff is responsible for documenting the Medical Director's decision to accept or find alternative placement.

TITLE: CARE, TREATMENT AND SERVICES	REFERENCE: CTS. 06.02.03
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: Assessment Driven Transfers and Discharges

PURPOSE
To ensure continuity of care for individuals who are served who are moved across a continuum of care, treatment, or services.

RESPONSIBILITY
It is the responsibility of the Founder to ensure this procedure is disseminated to all staff. It is the Founder's responsibility to ensure the protocol is implemented throughout the system.

POLICY
It is the policy of Jones Wellness Center to ensure the decision to discharge or transfer a client is based on the assessed needs of the individual and the organization's capabilities.

PROCEDURE
1. Decisions to discharge or transfer are based on the criteria.
2. The Psychotherapist may initiate a transfer or discharge based on the assessed needs of the individual and Jones Wellness Center's scope of practice (capabilities);
3. Once there is a determination that a transfer/discharge is in the best interest of the individual, the Psychotherapist is responsible to ensure the individual is notified of the recommendation to transfer/discharge.
    a. Individuals are to be informed on the reason he/she is being transferred or discharged and the alternatives to transfer/discharge if any.
4. The individual and significant others are to be included in the decision-making process.
5. The Psychotherapist is to provide the following information to the individual and their family/support system:
    a. The reason he or she is being discharged;
    b. The anticipated need for continued care, treatment, or services after discharge; and
    c. Illness self-management, i.e. what to do in case of a crisis or health problem.
6. The assessment inclusion of the individual and family in the decision-making process and the recommendations for care after discharge/transfer are to be documented in the EMR by the Psychotherapist or designee.