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**PRIOR AUTHORIZATION**

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**PURPOSE:**
To ensure that all delivered services are eligible for reimbursement according to procedures established by third party payer sources.

**POLICY:**
It is the policy of the Center for staff to adhere to the authorization procedures required by Medicaid Managed Care Organizations to ensure reimbursement of all services rendered.

**MISSION STATEMENT**
To support the recovery of people with mental illnesses.
PROCEDURE:

I. For new admissions, patient payer status is checked against the Medicaid Webtool. Designated UR/UM staff will be notified of patients who are enrolled in a Managed Care Organization in order to update EMR and the Prior Authorization Spreadsheet. Webtool verification pages will be scanned and emailed to Medicaid Accounts Receivable staff who will update CIS.

II. Twenty-four hours prior to the appointment, designated staff members verify Medicaid/Manage Care Organization (MCO) eligibility of all patients who have appointments on the following date. This is accomplished by reviewing appointments report and verifying patient’s payer status in the Medicaid Webtool.
   A. For patients with a change in payer status, print the Webtool verification page, and update EMR and Prior Authorization Spreadsheet to reflect current information.
   B. UR/UM designated staff reviews EMR timeline to determine if patient has had any services between date of eligibility and today, and updates PA Spreadsheet Counter appropriately.
   C. Scan Webtool verification page and email to Medicaid Accounts Receivable staff who will update CIS.

III. Daily, designated staff review Clinical Notes Signed on Previous Day Report and use information to update Prior Authorization (PA) Spreadsheet Counter.

IV. For patients identified in the PA Spreadsheet who have utilized 50% of approved services, designated UR/UM staff notify clinician of record and UR/UM team via email of the need for PA documents to be prepared and submitted for review within 3 business days or staff case for step-down in level of care or discharge.
   A. PA documents may include: a recent (within 12-months) Biopsychosocial Assessment, a current Plan of Care, a Physician’s Medication Order (PMO), and a Treatment Review and Authorization Request form.
   B. Supervisors are to track PAs that are needed from their team members to ensure completion and timeliness of documentation.

V. Designated UR/UM staff review PA documents and confirm accuracy and completeness of information, to include: medical necessity (diagnoses and functioning needs), measurable expectations of patient improvement, PA start and end dates, services requested and frequencies, congruence of clinical data across all PA documents.
   A. If any issues with PA documents, clinician of record is notified of the specific concerns and is instructed to revise/edit, and resubmit.

VI. When PA documents are accurate and complete, designated staff submit, via fax, to the appropriate MCO.
   A. Paper fax confirmation page is maintained until MCO returns Authorization decision.
PRIOR AUTHORIZATION
PAGE 3

B. Once PA has been approved, PA Packet (PA request documents and MCO response) will be scanned into the patient’s record under MCO AUTHORIZATION on the Import Screen, choosing the Record Date as the Authorization Start Date.

VII. UR/UM designated staff enter authorization information into EMR MCO Authorization tab (once functional) and update the PA Spreadsheet.

VIII. UR/UM designated staff will update PA Spreadsheet to reflect patients who have been discharged.

IX. If PA request is denied, designated staff will appeal decision according to the MCO’s appeal process. Denial information is logged in the PA Spreadsheet and forwarded to the DMH Division of Quality Improvement.
PURPOSE: The employees of the Berkeley Community Mental Health Center shall continue to strive to achieve the mission of the Center while being fully compliant with the numerous and complex laws regulating the provision of health care. Berkeley Community Mental Health Center seeks to promote full compliance and to prevent and detect accidental and intentional noncompliance with all applicable legal responsibilities.

POLICY: The purpose of this plan is to fulfill our policy by implementation of a Corporate Compliance Program that is developed in accordance with the Office of Inspector General’s Compliance Program Guidance, the Federal Sentencing Guidelines for Organizations and the SCDMH Corporate Compliance Policy and Plan. Furthermore, this plan:

A. Designates the Organizational Structure, assigns and coordinates the Responsibilities for compliance;
B. Requires the development and provision of minimum Education of employees in the area of corporate compliance as well as ongoing Training;
C. Identifies and ensures compliance with Standards and Procedures;
D. Incorporates the Auditing of the identified Standards and Procedures into the organizational structure and requires that this capacity be supplemented as necessary;
E. Requires employees to immediately Report (1) noncompliance to their supervisor, Corporate Compliance Officer or by means of the Hotline and (2) to their Corporate Compliance Officer any contact with an auditor from outside the agency and to establish a means to Respond, including corrective action, to such reports; and
F. Ensures Enforcement of compliance matters by means of the employment policies and procedures, including, but not limited to, the Employment Performance Management System and the Standards of Disciplinary Actions.
PROCEDURE:

I. **Organizational Structure and Designation of Responsibility** - The Executive Director will ensure that a corporate compliance program is maintained within and throughout the Center. The Executive Director also receives and reviews reports from the Center Corporate Compliance Officer and ensures that the program is effective, as may be evidenced by corrective and preventive actions.

A. **Corporate Compliance Officer** - A Corporate Compliance Officer (CCO) shall be appointed by and report directly to the Executive Director. The CCO will regularly report on the progress of implementation to the Center Executive Director. The CCO shall also have direct access to the Center Board of Directors by means of reporting to the Board no less than once a year. The Executive Director, CCO and the Center’s Corporate Compliance Committee are responsible for the compliance of the Center. The CCO shall oversee and ensure the implementation of all aspects of corporate compliance which are stated in this plan. The CCO shall plan, organize and manage a centerwide program to ensure compliance with the SCDMH Corporate Compliance Directive and Plan. The CCO shall be the primary conduit for communicating and coordinating compliance matters within and outside of the Center. The CCO will ensure that all compliance efforts are in concert with centerwide initiatives and follow the terms of this plan. The CCO may review all documents and other information relevant to compliance activities.

B. **Corporate Compliance Committee** - A Corporate Compliance Committee shall be appointed by the Executive Director and shall be chaired by the CCO. In addition to the CCO, committee membership, at a minimum, will be comprised of individuals who fill the following positions:

- Executive Director
- Director, Access Center Services
- Director, CAF Services
- Director, Adult Services

Other knowledgeable persons who represent quality improvement, accounts receivable, financial, clinical, human resources, utilization review, etc. as determined by the Executive Director may be included in committee activities.

The purpose of the committee is to assist with, advise regarding and implement all aspects of corporate compliance. In addition, the Compliance Committee shall examine existing standards and procedures, assess alternative courses of action, determine a course of action and implement the necessary policies and procedures. The committee will be responsible for designing and implementing a monitoring program consistent with the provisions herein.

The committee shall meet no less than quarterly. The minutes and structure will reflect the separate functions of corporate compliance and the Corporate Compliance Officer shall, at a minimum, maintain the previously stated composition of the committee. The CCO shall organize the minutes and other documents involving corporate compliance following the format of the “ Purposes” listed above.
In addition to the Corporate Compliance Officer and committee, the implementation of the Corporate Compliance Program will be a collaborative effort among staff. Key staff responsible for the following functions and activities will assist in the design and implementation corporate compliance activities:

C. Billing and Accounts Receivable - The Office Manager is responsible for assisting in the review of billing information and practices. This includes identification and implementation of reports designed to prevent noncompliant billing activities.

D. Contracting and Procurement - The Contracts Section of the Department of Mental Health is responsible for assuring the review of contracts to assure that independent contractors and agents who furnish services to the Center are aware of their requirements of DMH Corporate Compliance Plan, particularly the sections of which refer to coding, billing, conflicts of interest, anti-kickback, confidentiality and self-referral. The Business Manager of BCMH will assist in this process.

E. Human Resources - As part of the hiring process, the Human Resources Representative, in coordination with the DMH Employment Section, shall:
   1. Continue the existing requirement that an applicant must disclose any criminal conviction on the application,
   2. Require all applicants to disclose their involvement in any exclusion, which is defined as a determination that Medicare or Medicaid and/or other government programs will not pay the provider (whether it be the applicant or the applicant’s employer) for services performed or for services ordered by the excluded party.
   3. Allow the consideration of employment of applicants who have been officially reinstated into the Medicare and Medicaid programs by the Office of Inspector General, upon proof of such reinstatement;
   4. Make reasonable and prudent efforts to check references;
   5. Prohibit the employment or retention of applicants, current employees, contract employees, volunteers, students and interns who have been recently convicted of a criminal offense related to health care or who have been debarred, excluded or are otherwise ineligible for participation as a provider in Federal Health Care Programs;
   6. Prohibit the employment or retention of applicants, current employees, contract employees, volunteers, students and interns who have defaulted on repayment of scholarship obligations or loans (1) in connection with health professions or (2) as enumerated by Section 59-111-50 of South Carolina Code of Laws;
   7. Prohibit from direct responsibility for or involvement in any federal health care program any current employee who has pending criminal charges related to health care or proposed debarment or exclusion (Please also see the “Off-Duty Misconduct Directive”);

F. Utilization Management - As part of the hiring and credentialing process, the Utilization Review Specialist, in coordination with the Division of Quality Improvement/Outcomes, shall:
1. Ensure that the National Practitioner Data Bank is checked for all physicians and certain other health care practitioners,
2. Check the Cumulative Sanction Report with respect to all applicants under consideration for employment,
3. Check the data bank required by the Health Care Fraud and Abuse Data Collection Act of 1996, once established, with respect to all applicants under consideration for employment,
4. Maintain documentation in the employee’s official personnel file or credentialing file which evidences the fulfillment of these provisions, excepting training which will be documented by the Division of Education, Training and Research.

G. Quality Improvement - The Quality Improvement Coordinator shall coordinate quality improvement activities to assure compliance with the corporate compliance standards and procedures, consult with the CCO regarding inclusion of these standards and procedures, provide training to clinical and management staff regarding delivery and documentation of new services; coordinate the provision of necessary technical assistance training; coordinate the Center’s efforts to ensure billable services are delivered by qualified and well-supervised staff; and coordinate the credentialing process for mental health professionals.

II. Education and Training - All employees are required to participate in initial and annual training which covers the general principles of corporate compliance and the major components of this plan. Employees will be afforded an opportunity to ask questions to ensure understanding of the material. Upon successful completion of the basic/initial training, an acknowledgment form will be signed by participants.

III. Standards and Procedures - It is recognized that standards need to be identified and regularly updated due to modifications of applicable statutes, regulations, federal health care program requirements, and accreditation requirements. Therefore, as part of the statewide corporate compliance initiatives, standards and procedures are being developed which includes a compilation of (a) standards which have been identified as being specific areas of risk to the Department and its subdivisions and (b) mandatory or suggested procedures for compliance, including auditing. Every standard shall be subject to auditing.

IV. Auditing - The Compliance Standards and Procedures which are applicable to the Centers shall be audited as provided by the terms of the “Audit Protocol” which are incorporated into the Community Mental Health Services Operating Manual. Audits shall be conducted in compliance with the minimum criteria set forth in the Standards and Procedures. Centers shall continue to conduct audits as provided by the terms of the Community Mental Health Services Medicaid Contract and associated policies and procedures. As necessary, focused audits may be conducted to audit compliance with the minimum criteria set forth in the Compliance Standards and Procedures.

V. Reporting and Response - Each employee has an obligation to make a good faith report of any activity within the agency that appears to violate compliance policies, regulations or statutes. Matters which do not involve compliance should be dealt with through means other than these
reporting mechanisms. If there is an established procedure to report a matter and it also involves compliance (examples: physical abuse of patients, patient rights and personnel issues), the established reporting system and the appropriate compliance reporting option should be followed by employees.

An employee may seek assistance to resolve and report compliance issues by choosing from the following options. If the matter is not resolved, then the employee may report the issue using another option.

A. Employees are encouraged to resolve issues at a local level whenever possible. Therefore, it is expected that employees will first raise compliance concerns with their supervisor, unless it is inappropriate or uncomfortable due to the nature of the concern. Upon receipt of the report, supervisors are expected to resolve the matter within the chain of command if it is of a local and limited nature that does not reflect a systemic problem. Otherwise, employees and supervisors shall report the concern to the attention of the CCO. The CCO will initiate an investigation within three (3) business days of receipt of the report. All efforts will be made to complete the investigation within thirty (30) calendar days; however, complex issues may require more time in order to fully investigate.

B. Employees may report compliance concerns directly to the CCO.

C. Employees may contact the DMH Compliance Hotline at 803-898-9920 or 866-443-0125.

There will be no retribution for good faith reporting of a possible violation. In addition to this policy, employees who report under the terms of the state's Whistle-blower Act are protected from disciplinary action. Any supervisor or other employee taking retribution due to a good faith report will be subject to discipline. However, employees who negligently and/or willfully make false accusations or otherwise misuse the reporting mechanisms will be subject to discipline.

Reports forwarded or brought to the attention of the CCO will be documented by the CCO, supervisor or employee. When the allegations related to compliance, the report and response will be documented on an approved form (SCDMH Forms CC-1 and CC-2). The original will be maintained by the CCO and copies will be promptly distributed to the DMH Compliance staff and reporting employee. The CCO will follow-up on reports and ascertain whether the appropriate persons have resolved the matter. Additionally, the CCO will provide responsive, non-confidential information to appropriate persons, including the reporting employee. The CCO will maintain copies of the documents, in a secure location, for a period of no less than seven years and will only disclose the contents to persons with a need to know.

Activity by Outside Auditors/Investigators:
There are many federal and state agencies which have legitimate interests in auditing this agency and most are routine and do not relate to criminal activity. In order to ensure involvement of and communication with all appropriate persons, each employee has an
obligation to immediately report to their supervisor and the CCO any activity or contact initiated by outside auditors or investigators. Contact includes a letter requesting medical documentation, direct conversation, a phone call or receipt of a search warrant or subpoena (note: a subpoena seeking confidential patient information regarding a single patient is routinely handled by Medical Records). If none of these persons are available, an employee shall contact the highest ranking individual within their division of the agency. That individual shall then be responsible for notifying the CCO as soon as is practical.

Employees, with the assistance of their CCO if available, will take reasonable efforts to (1) confirm the auditor’s identify, (2) inquire as to the purpose of the contact, (3) obtain copies of the auditor’s identification and any subpoena, court order or search warrant, and (4) ask the auditor to wait while the proper person(s) are notified, although auditors are not under an obligation to do so. Employees may speak with auditors, but are under no obligation to do so unless served with a subpoena or court order naming the employee.

In the case of requests made by an external federal or state auditor or their contractors to review medical documentation, the CCO will contact the DMH CC or DMH QMC and send copies of the documents provided by the external reviewer, if and when available. The DMH CC/QMC will contact the reviewer to verify their identify and clarify the need of the requested information. The DMH CC/QMC will then communicate the information to the Center.

VI. **Enforcement** - Appropriate measures shall be taken to ensure compliance including:

A. **Training of Employees** - Supervisors shall make every reasonable effort to correct noncompliance by first training or retraining employee(s). Supervisors shall seek assistance and resources from their superiors, CCO and Corporate Compliance Committee.

B. **Modification of Systems, Including Policies and Procedures** - If noncompliance occurred due to not having the proper system(s) in place to detect and prevent the activity, supervisors will bring the concerns to the CCO and the Corporate Compliance Committee.

C. **The Employee Performance Management System (EPMS)** - Persons holding a position outlined by this Plan shall, at a minimum, have their responsibilities as stated herein designated as essential job duties. The following persons within the Center shall have compliance listed as an essential job duty.

1. Care providers whose documentation is used as the basis for billing.
2. Staff who have any discretionary responsibilities involving Federal or State health care programs. This includes Office Manager, Business Manager, Quality Improvement Coordinator, Utilization Management Specialist, Accounts Receivable/Billing staff and other designated clinical support services staff. In the event that it cannot be clearly ascertained whether an employee’s job falls into this
category, supervisors shall include compliance as an essential job duty. All other employees shall have “compliance with legal responsibilities” listed as a “Performance Characteristic.”

Reference will be made to Section “E” below and the EPMS Directive when taking action involving an employee’s performance.

D. The Standards of Disciplinary Action - The terms of the Standards of Disciplinary Action Directive are flexible enough to be effective in taking disciplinary action against employees who do not comply with applicable legal responsibilities and reference should be made to its terms and section “E” below.

E. The Role of Compliance in Performance and Disciplinary Actions - When a CCO becomes aware or receives a report of and confirms (1) failure to perform an essential job duty or (2) noncompliance with a legal responsibility, contact will be made with the noncompliant person’s supervisor or other person in authority within the chain of command. The supervisor is expected to follow the terms of the Disciplinary Standards and/or EPMS Directive and advise the CCO of the action taken. All communications regarding a personnel action shall be handled in confidence and on a “need to know” basis. If action is not taken, the CCO will communicate up the chain of command until action is taken to address the noncompliance of the employee. Any supervisor who does not take action will be subject to performance or disciplinary action.

Finally, in the event a supervisor takes retribution against an employee who has reported in good faith, the DMH QMC shall advise the State Director of the circumstances. The State Director will ensure that the Center Director takes appropriate disciplinary and other action including making the reporting employee whole. The retribution must have occurred within one year after having timely (within 60 days of first learning) made the good faith report.
Abuse:
Activity which may result in direct or indirect unnecessary costs to the Medicare or Medicaid program including improper payment or payment for services which fail to meet professionally recognized standards of care, or that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Audit:
Center/Facility Audit: Review or examination within the organization by a person who did not deliver the service.

Departmental Audit: Review or examination by independent, objective persons employed by the Department of Mental Health. This does not include audits conducted by the Department’s Office of Internal Audit.

External Audit: Review or examination by entities outside of the Center, facility and Department.

Corporate Compliance:
A program designed to promote adherence with and keep an organization, oft-times taking a corporate form, in compliance with applicable legal requirements. In health care organizations the primary, initial focus is on the fraud and abuse laws.

CCO:
Corporate Compliance Officer

Federal Health Care Program:
Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or any State Health Care Program including, but not limited to, Medicare, Medicaid, Tricare, VA, Federal Bureau of Prisons and Indian Health Services, but excluding the Federal Employees Health Benefit Program.

Fraud:
Knowingly and willfully executing, or attempting to execute, scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

State Health Care Program:
A State plan approved under subchapter XIX or a program receiving funds or an allotment under subchapters V or XX, each being found in chapter seven (Social Security) of Title 42.
**OPERATION OF CENTER PROGRAMS**

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**PURPOSE:** BCMHC offers comprehensive mental health services on a regular and consistent basis to meet the needs of Berkeley County residents. All Center programs/services will be fully operational unless approval to decrease services is obtained from the Executive Director or designee. The Center does not maintain waiting lists for services.

**POLICY:** All requests to change service delivery rate must be discussed with the Executive Director or designee. This includes requests to terminate a treatment program, to close a program for any length of time, or to alter the frequency of a program.
PROCEDURE: To effect changes in the operation of Center programs, the Program Director will establish the inability to continue service delivery in a clinically appropriate manner which may include inadequate staff numbers (sick leave, vacancies), decline in requests for services or overwhelming demand for services. Supervisor will present the situation and request to Leadership Council.

Leadership Council will help explore resources across the Center, clinical implications and impact of the proposed request.

The decision to accept the request will be the Executive Director’s.

Center Executive Director is responsible for all functions and operations in the Center. When out of the Center, the Executive Director will appoint a program manager/senior leader as covering Executive Director responsibilities as follows:
1. Clinical Program Manager
2. QI Director or Director of A/R
3. Director of Professional Development
4. Program supervisors

CENTER HOURS OF OPERATION

Monday - Friday 8:30am - 5:00pm

Appointments outside established business hours are available based on program needs.

24 hour emergency on-call service is available 7 days a week.
### CULTURAL DIVERSITY PLAN

**Section Number: I - GOVERNANCE AND AGENCY MANAGEMENT**

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**PURPOSE POLICY:**

To demonstrate its commitment to a culturally sensitive and diverse organization, Berkeley Community Mental Health Center’s management, Board of Directors, and staff implement and monitor the following policies and activities.
PROCEDURE:

I. Human Resource Management. Policies and procedures are practiced and monitored to recruit, develop and retain personnel who reflect the cultural diversity of Berkeley County.

A. Berkeley Community Mental Health Center Policy and Procedure for Human Resources Management and Diversity (HR085). The Center is responsible for recruiting, developing and retaining personnel who can deliver the highest quality of services to patients. Ultimate authority for monitoring and evaluating the Center’s performance related to this policy rests with the Executive Director. Mechanisms are in place to monitor adherence to this policy through Berkeley Community Mental Health Center Policies and Procedures listed below (items B through F, inclusive). Staff by virtue of their job duties who support these mechanisms include: Director of Administration, Human Resources Representative, Program Directors, Medical Director and Supervisors.

B. BCMHC Policy and Procedure for Fair Employment Practices (HR068). Center adheres to and is in compliance with the requirements of the amendment to Title VII of the Civil Rights Act now referred to as the Equal Employment Act of 1972, Age Discrimination Act, Equal Pay Act and the South Carolina Human Affairs Law outlined in South Carolina Department of Mental Health Directives. Responsibility for ensuring compliance and continued implementation of this policy is assigned to the Executive Director, Director of Administration, Medical Director, Program Directors and all supervisory personnel.

C. BCMHC Policy and Procedure for Staff Development Plan (SD064). The Center is responsible for ensuring all staff are afforded equal opportunities and support that fosters growth in the area of professionalism, ethical conduct, education, training, supervision and professional development. Policy establishes mechanisms to fulfill this responsibility. Mechanisms for monitoring include, but are not limited to: staff surveys, employee performance management system instruments, mandatory training, strategic planning activities, supervision process, quality improvement system.

D. BCMHC Policy and Procedure for Hiring Employees (HR093). Establishes policies and procedures for hiring of staff that are in compliance with South Carolina Department of Mental Health Division of Human Resources Employment Policies and Procedures Guidelines. Designates staff responsible for executing the hiring process and compliance with Departmental, State and Federal regulations and statutes. Describes Center employment policy as “recruiting, hiring, training and promoting for all job classifications without regard to race, sexual orientation, sex, age, national origin, religion, disability, political affiliations or opinions. All decisions of employment so as to further the principles of equal employment opportunity and affirmative action.” Monitoring is an on-going function of Human Resources Representative, Executive Director, Director of Administration, Medical Director and Program Directors.

E. BCMHC Policy and Procedure for Accessibility (G066). Addresses Center
efforts to recruit and retain a diverse workforce which reflects the communities and patients served as well as activities to include persons of varying disabilities, cultures, etc. in the leadership and staff of the Center. Also includes mechanisms to insure access to Center’s services and facilities (physical, attitudinal and stigma barriers). Annual review of the Accessibility Plan is performed by the Quality Improvement Team, Safety Coordinator, and Board of Directors.

F. BCMHC Policy and Procedure for Affirmative Action Plan (HR097). Defines Center’s commitment to providing equal employment opportunities to all present and perspective employees regardless of race, color, religion, national origin, physical or mental disability, political affiliation, socioeconomic status, language of preference, sex, sexual orientation or age except where sex or age is a bona fide occupational qualification. Designates Center’s Equal Employment Opportunity Officer and responsibilities of this officer. Compliance with the Affirmative Action Plan is monitored by the Equal Employment Opportunity Officer with the support of the Executive Director, Director of Administration, Human Resources Representative, and South Carolina Division of Human Resources.

II Cultural Diversity Committee
A. Membership of this committee reflects diversity in race, gender, religion, and regional character of the communities in Berkeley County. Committee members are selected and assigned by Leadership Council to serve for at least one year.
B. The Committee is responsible for evaluating, enhancing and monitoring sensitivity to and competence in cultural diversity of staff and Center operations and procedures. Cultural Diversity competence includes attention to socioeconomic status and language of preference considerations. Their activities include but are not limited to: evaluation of recruitment efforts, staff training, evaluation of written communications, and evaluation of physical environment. The chairperson or designee orients all new Center employees relative to cultural sensitivity and competence.

III Community Education Activities and Volunteers. The Leadership Council and HR Representative coordinates community education activities by seeking and receiving opportunities for such across the county. A variety of staff participate in these activities as a means of reducing stigma associated with mental health, educating communities, and encouraging persons from all populations in the county to access the Center. The Human Resources Representative is responsible for the recruitment, development and recognition of volunteers. As the Center reaches into communities across the county, persons are presented with the opportunity to participate as volunteers. The scope and nature of community activities is evaluated by the Quality Improvement Team periodically. Monthly and annual statistics related to volunteers are maintained by the Human Resources Representative and reported to the Executive Director and Board of Directors.
PURPOSE: To insure the clinical needs of persons served are handled in a manner which promotes timeliness, safety, and continuity, clinical needs will be addressed prior to the close of business each day. To ensure accountability and tracking standards are met, clinical support services activities will be closed out each working day.

POLICY: Clinical service functions and clinical support service functions will be resolved in a manner that promotes responsiveness, accountability, safety and continuity by the close of each working day.
CLOSING PROCEDURES
PAGE 2

PROCEDURE:

The following procedures will address the close of business at Berkeley Community Mental Health Center:

I. Closing Manager. Clinical members of the Leadership Council will serve on a rotational basis to cover closing responsibilities as defined below. Changes in the schedule must be submitted to Leadership Council via email and indicated on the electronic sign in/out board (Scotland Yard).

II. Office Hours. Office hours are determined by computer and switchboard in the Reception area. The execution of closing procedures is based on the time on computer and switchboard clocks. All staff are expected to know the code for security alarm and to know how to set and turn off the system. This information is provided during orientation. Staff are kept informed of changes in the security code.

III 30 Minutes prior to closing, CSS staff will:
A. Count the money and balance back to yellow receipt tickets.
B. Record the money and collections on the daily payment ledger.
C. Record the money and collections on the monthly balance sheet. All cashiers record their collections and the last one to record adds all collections and records one total.
D. The Patient/Visitor check-in/out ledger and daily schedule copy are dated and stored in the top cabinet drawer according to current work month.

IV Medical Records Room:
A. Any paper medical records will be returned to the medical records room 30 minutes prior to closing, except for records needed for sessions in progress or for emergencies.
B. Any routine faxes needing to be faxed that day will be brought to Medical Records no later than 30 minutes prior to closing.
C. The computer in medical records will be shut down 5 minutes prior to closing.

V. Physician’s Wing. The physician receptionist is responsible for locking the cabinet and locking and closing the office door of the physician’s receptionist area.

VI. 30 Minutes prior to closing:
A. Closing Manager will check with CSS staff to identify any patients remaining in the building or on the decks. Closing Manager will be involved or direct staff in addressing patient’s needs for transportation.

VII 5 Minutes prior to closing:
A. Closing Manager will communicate with CSS for update of clinicians still working
CLOSING PROCEDURES
PAGE 3

with patients in his/her office.

VIII At closing:
A. CSS staff will lock the front and side doors to the lobby, turn out bridge lights, lobby lights and bathroom lights. CSS staff will lock all front desk drawers and filing cabinets.
B. All computers in the front area are turned off, unless clinician has a patient needing subsequent appointments to be scheduled.
C. The copier and shredder in the mail/work room are turned off. The medical records room door is checked to make sure it is locked.
D. Incoming phone lines are forwarded to after hours/on-call Hotline. To check the transfer, use another line to call the 761-8282 number. Once transferred, the phones in reception are not to be used for any calling or call pick-up.
E. Turn off all lights in reception.
F. Closing Manager will remain until it is confirmed that no patients are in the building and CSS functions are completed.

IX. Clinical Services
A. Staff participating in Closing Manager rotation are senior clinical staff or clinical supervisors. They are available to staff for the resolution of clinical issues as needed in addition to closing of the Center.
B. Designees are responsible for covering the dates scheduled in the rotation. For planned absences on days scheduled to close, the designee is responsible for switching with another designee and informing Leadership Council. In cases of unplanned absence, the designee informs the supervisor and supervisor coordinates coverage.
C. Designees will check in as described above with CSS and clinical staff.
D. Designees are to inform clinical staff of patients remaining in the lobby prior to closing. They will assist the clinician with addressing patient’s needs, which may include helping transport or waiting while transportation arrives.
E. 15 minutes before closing, designees will conduct a building walk through checking exterior doors, fans, lights etc.
F. Closing Manager will remain until it is confirmed that no patients are in the building and CSS functions are completed including securing the workroom.
G. Any staff remaining will be encouraged to depart with the others. If they choose to stay, they will be responsible for setting the alarm.

X. Clinicians. Appointments and patient needs are to be handled in a manner that allows the patient to complete scheduling and fee payment with reception prior to the close of business. Clinicians are responsible for structuring sessions to accommodate this need.
A. Any paper medical records are to be returned to the medical records room no later than 30 minutes prior to closing, except for records needed for current sessions or emergencies. If the records room is closed, clinicians are to use the designated spaces in the work room for charts.
B. It is the Closing Manager’s responsibility to ensure their patients have departed before leaving work themselves. The Closing Manager has the discretion and
authority to direct clinical staff members to assist in the coordination of ensuring patients depart the facility. Patients should be discouraged from waiting in the parking lot for their rides after the close of business. CSS will conduct a lobby check 15 minutes prior to closing to aid clinicians in this effort (this does not replace the clinicians checking the lobby themselves). They are to confer with remaining patients and wait with them if necessary until transportation arrives. Supervisors and in-charge supervisors for programs share their staff’s responsibility to see patients have left before departing. If the patient wishes, we can offer to take him/her to a public location nearby and leave a note on the front door for the ride.

C. Staff will use the electronic sign in/out board when leaving for the day if they will not return the following work day.

D. All staff are encouraged to leave the building as coworkers depart for the close of business. Designees will not remain with staff choosing to remain once all patients have departed and CSS functions have been completed.

XI Housekeeping Services. The Center cleaning service crews work after business hours. Cleaning will be coordinated with the Facilities Manager for work spaces in the Center with locked doors (Human Resources, physician offices, medicine rooms).
FEES FOR SERVICES

PURPOSE: To ensure patients are informed and responsive to their obligation to pay for the services they receive, the Center maintains a system for establishing and reviewing fees, receiving payments, crediting accounts, and addressing the therapeutic significance of paying fees. Fee schedules shall be based upon ability to pay.

POLICY: Berkeley Community Mental Health Center charges fees for the services provided to patients. By state law, the Mental Health Commission establishes a service fee schedule for community mental health center services. Fees are evaluated and established when patients initially access services, when re-entering treatment, when financial situation dictates and/or annually during the course of treatment.
PROCEDURE:

Among the behaviors indicative of patient recovery and responsibility for oneself and family is addressing financial obligations in a timely manner. The Center’s approach to patient fee payment is founded on these premises:

- Handling financial responsibilities in a timely manner is a positive skill which promotes self-esteem, independence and recovery.
- Lack of responsibility for Center fees likely represents similar issues in other financial areas of patients’ lives.

Clinical and clinical support staff (CSS) partner to establish accurate financial assessments for patients. Accuracy is vital to establish fees, eligibility of entitlement programs and qualification for pharmaceutical company patient assistance programs. The CSS initiate this process. If at any time in the course of services, a patient’s and/or family’s ability to understand or participate in the fee payment process is in question, clinical staff roles increase.

The Center will be governed by the following procedures for the establishment, review, billing, receipt, and maintenance of patient fee accounts.

I. **Establishing and Reviewing Fees.** Admission Staff will inform individuals requesting services that proof of income is required at the time of the first appointment for the purpose of researching and offering available entitlement benefits for the patient if applicable. Acceptable proof of income includes current paycheck stub(s), annual tax W-2 form, prior year income tax return, public assistance eligibility documentation, alimony/child support documentation, letter of award of retirement income, social security, unemployment compensation, etc. If a patient presents proof of extraordinary (nondiscretionary) expenses, the income may be adjusted. Written documentation must be provided showing that expenses such as medical bills and alimony/child support and confirm payment of these expenses.

During intake, administrative staff will collect the information necessary to do a complete financial assessment to determine ability to pay for all services delivered at the Center. The Ability to Pay Reduction Table will be used to determine the reduced balances based on a financial assessment once a patient is identified as a hardship case. Consistency is necessary in determination of all hardship cases. In utilization of the reduction table, the reduced balances are determined by the gross income to the household and the number in the household in which the income supports. The patient will sign and receive a copy of the fee sheet during the initial visit.

If the patient refuses or fails to present proof of income, he/she will be responsible for and billed the full fee. The patient is told at the time of financial assessment that it is a requirement to submit the proof of income documentation in a timely manner to receive the benefit of a reduced balance based on the ability to pay reduction guidelines. Annually, or as the patient’s income, number of dependents, or other relevant financial
information changes, a new financial assessment is performed. If the patient fails to provide proof of income at the annual due date each year, the patient’s liability is full fees from the expired date of previous year’s documentation. Once new documentation is supplied, another financial assessment will be done to determine the ability to pay and the patient’s account will be adjusted if warranted.

II Payment for Services. Payment for services is expected at the time they are delivered. All efforts are made to collect self pay payment, balances and co-pays at check-in prior to the service being rendered. The receptionist will access patient's fee status and calculate charges for the visit and previous balance, if any. The patient will be informed of the amount due and/or balance and be expected to respond with payment. Total or partial payment will be accepted. The receptionist gives the patient a receipt. Any patient neglecting to show good faith efforts to pay or refuses to make payment for services is referred to the Office Manager/designee to set up a payment plan. If at any time in the course of services, a patient’s and/or family’s ability to understand or participate in the fee payment process is in question, clinical staff roles increase.

CSS responsibilities:
- Collect financial information at the time of admission and provide clear information about fees for services and account balances.
- Evaluate for entitlements and initiate such when indicated.
- Collect payment for services at time they are rendered.
- Provide account information/activity to clinical and medical staff on consistent basis.
- Establish payment plans for account balances when indicated.
- Perform annual re-evaluation of income and fees for services. Perform such re-evaluations if/when patient circumstances change.
- Serve as resource for patients on all issues related to fees, insurances, entitlements, and accounts.

Clinical/Medical Staff Responsibilities:
- Admission clinicians will inform individuals being offered an assessment appointment of the need to bring proof of household income to this appointment. This will be documented on the C-20 Screening Form.
- Read/review all information provided by CSS related to patient incomes, entitlements, and accounts.
- Coordinate patients meeting with CSS when there are changes in income and hardship circumstances.
- Communicate expectation that patients pay for services when rendered and escort patients to reception after appointments.
- Offer and provide clinical interventions to support patient’s goals.

When determining individualized strategies to support patients with payment for services, the following clinical factors must be considered:
ESTABLISHING FEES FOR SERVICES
PAGE 4

- Patient’s abilities and psychiatric symptoms do not indicate any current impairment in handling personal affairs. Refusal to supply information and/or pay for services is not a symptom of mental illness.
- Documentation indicating the patient has been given clear, specific information from Center staff about required information and process for payment for services.
- Logistics involved in obtaining proof of income and/or payment (e.g. transportation, support network).
- Discussion about other financial responsibilities and current status in therapy sessions.

If a patient has the ability to supply proof of income and to pay for services but refuses to do so, clinical staff will address this refusal in an individualized manner. As indicated, the Executive Director will be involved in this process. No patient will be denied services because of an inability to pay fees.

III Billing. The Accounts Receivable Department is scheduled to generate and mail bills on all accounts on at least a bi-monthly basis.

Payments on these balances may be handled by mail or during next visit to the Center. The patient is addressed about payment at each visit to the Center and continues to receive a bill of the outstanding self pay balance. Outstanding self pay balances on discharged patients are billed three additional statements after the discharge date. Discharged outstanding self pay balances after this process will be written off following the SCDMH DOFS procedure 8.3.5

IV Previous Balances. Patients re-admitted to the Center will be informed of any previous outstanding balance and informed of their responsibility to pay in addition to the fees charged for new services. Payments will be applied to any current charges before applying to a previous balance. Payments on a previous balance will be reinstated only for the amount of payment. The total account balance previously written off may be reinstated (transferred to the active accounts receivable) only with the approval of the Executive Director/Director of Administration/Business Manager.

Patients with questions or concerns about this policy will be directed to Accounts Receivable, Director of Administration, Executive Director or Patient Advocate.
PURPOSE: Berkeley Community Mental Health Center establishes this plan for the purpose of ensuring that all newly appointed members of the Center Board of Directors have the opportunity to be oriented to the mission and operations of the Center.

POLICY: It is the policy of the Center to provide pertinent information to all newly appointed Board members.
PROCEDURES:

I. The Executive Director has the ultimate responsibility for the orientation of all members of the Center Board of Directors.
   A. The Board Manual will be given to the Board member to be used during the membership tenure. Materials for review will include but not limited to the following:
      1. BCMHC Brochure
      2. By-laws of the Board of Directors
      3. Center’s Strategic Plan
      4. Board membership
      5. Mental Health Commission membership
      6. Members of Legislative Delegation
      7. Members of County Council
      8. Center mission
      9. Center Goals
      10. Patient’s Rights
      11. Organizational chart
      12. Schedule of meeting dates
      13. Insurance coverage for Board members
      14. Privacy Practices directive
      15. Code of Professional Conduct/Ethics
      16. BCMHC Phone List
   B. Orientation will include an introduction to other Board members.
   C. Board members are encouraged to attend SCDMH agency-wide meetings and other training conferences for the purpose of increasing awareness and understanding of the South Carolina Department of Mental Health.
   D. Opportunities for on-going orientation to services and operations of the Center will be provided at Board meetings, committee meetings, General Staff, visits to Center programs, recognition of Outstanding Employee, etc.
   E. As members request, additional time with the Executive Director is available as well as visits to the Center during business hours.
   F. Documentation of orientation will be filed with records of the Board of Directors.
AUTHORITY OF THE EXECUTIVE DIRECTOR

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PURPOSE: To specify the authority of the Executive Director in the leadership of the Center.

POLICY: The Center Executive Director is designated by the Board of Directors and the South Carolina Department of Mental Health with the authority for operation of the Center which includes establishing policies, maintaining quality, and continuous Center enhancement and development.
PROCEDURE:

I. In accordance with South Carolina State statute 44-15-70, the Board of Directors “will employ personnel necessary to carry out the community mental health program who meet the job specifications as prescribed by the Department of Mental Health”.

II. The By-Laws of the Berkeley Community Mental Health Center Board of Directors Article III, Section 2 (b), Section 2 (e) and Section 2 (c) state the Board will:

   “Assist in employing an Executive Director to carry out the Berkeley Community Mental Health Center programs. Such personnel shall meet the job specifications in accordance with the Department of Mental Health and State guidelines.”

   “Delegate the responsibility for the Berkeley Community Mental Health Center’s daily operation in the area of program planning and evaluation, fiscal management, personnel management, and development of working agreements with other service providers and judicial agencies to the Executive Director who will report to the Board at least nine times per year.”

   “Approve policies governing the Center’s operation.”

III. The authority of the Executive Director for the Center’s operation is established in the above statutes and by-laws. Specific job duties in the Employee Performance Management System Job Description and Planning Stage describe the execution of this authority as it relates to establishing policy, maintaining quality of the organization, and continuous development and enhancement of the organization.

IV. Executive Director’s responsibilities and authority are assumed by the Center’s Director of Clinical Services in her absence from the facility. When the Director of Clinical Services is not available, the Executive Director will appoint a program manager/senior leader (with clinical credentials) as Acting Executive Director.
Purpose: To provide routine mechanism for review of all Center policies and procedures for accuracy and effectiveness.

Policy: All Center policies and procedures will be regularly reviewed and updated annually for accuracy and effectiveness. Policies and procedures will be reviewed, revised, added or deleted as needed to reflect Center practices and operational standards.
PROCEDURE:

Leadership Council and/or Executive Director are responsible for coordinating and executing the review of all Center policies and procedures. The policies/procedures will be delegated to specific staff for review. Recommendations for review, revision, additions, and/or deletions are presented for Leadership Council and/or Executive Director approval. As well as approving the policy and procedure, Leadership Council and/or Executive Director develops action plans for dissemination and education of staff regarding the policy and procedure. Once approved by Leadership Council and/or Executive Director, all new policies are presented to the Board of Directors for approval.
POLICY/
PURPOSE: In accordance with South Carolina Department of Mental Health Directive #624-83 on Key Control, Berkeley Community Mental Health Center controls and monitors access to keys to the building in order to enhance the security of Center patients, staff and facility. It is incumbent upon each staff member receiving keys to handle them in a responsible manner.

The Facility Manager is the designated key control officer. This staff member is responsible for the organization, storage, distribution and monitoring of Center keys.
PROCEDURE:

I. KEY ORGANIZATION AND STORAGE
All master and duplicate keys are labeled according to their function and/or location. Records are maintained in electronic form (e.g. Excel file) as keys are added and deleted from the inventory. Keys included in this inventory are external door keys, internal door keys and office furniture keys.

Keys are stored in a locked cabinet in a locked mechanical room. The following staff have access to the key cabinet: Executive Director, Director of Administration, Center Key Control Officer, Business Manager.

II. KEY DISTRIBUTION
All required keys will be issued to staff during orientation to the Center, to include any or all of the following: exterior doors; interior doors; and keys to assigned office furniture. Employees will acknowledge receipt of assigned keys by completing and signing a Receipt and Control of Center Keys form, which will be maintained by the key control officer.

All keys distributed to an employee are returned to the key control officer at termination of employment. Documentation of the return of keys will be accomplished via the original Receipt and Control of Center Keys form, which will be maintained for an indeterminate time period.

Key control officer receives all requests for keys from staff. If the request appears beyond the scope of the employee's function, the officer consults with the Director of Administration.

Employees are not to give their key(s) to anyone else under any circumstance. The keys are the responsibility of the employee to whom they are issued until the employee terminates employment from the Center.

If an employee loses a key, there is a $5.00 fee for replacing the lost key. New keys are not provided until this fee has been paid. Patterns of losing keys will be addressed by the employee's supervisor.

The key control officer coordinates with the Business Manager to order duplicate keys.
OUT OF OFFICE PROTOCOL

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PURPOSE: To establish guidelines and procedures for staff conducting business outside of the Berkeley Community Mental Health Center. This includes home visits, community visits, school visits, or attendance at meetings at other facilities/agencies.

POLICY: Staff of the Berkeley Community Mental Health Center shall follow the established guidelines set forth in this policy.
PROCEDURE:

Prior to leaving the Berkeley Community Mental Health Center, staff members will complete the following steps:

I. All staff must sign out in Scotland Yard using the appropriate designation for the out of office activity. Clinicians must designate person covering emergency calls in their absence and include the destination if on a home visit.

II. State cars are available for business away from the Center. All home and community visits to patients occur in a state vehicle, unless schedule dictates otherwise. If clinician uses personal vehicle, supervisor will be notified. PATIENTS MAY ONLY BE TRANSPORTED IN A STATE VEHICLE.
   A. Transportation sign out sheet in the Transportation office is used to reserve a vehicle as well as document staff on Center business outside the office.
   B. Staff are to indicate departure and return times by the vehicle reserved. The name of each staff person involved is listed along with destination.
   C. It is the responsibility of each staff member to notify their immediate supervisor or acting supervisor if return to the Center is later than expected. If staff do not call in, attempts may be made to reach staff by cellular phone. In addition, staff members’ supervisor should also contact transportation staff so that any necessary changes may be made if another staff member has reserved that same vehicle for later in the day.

III. In order to assure the safety of staff and patients, the following safety measures will be observed when delivering community based services:
   A. Clinicians will have training on safety in the field when delivering community services.
   B. Clinicians will plan home visit destinations considering all factors which impact safety and accessibility.
   C. Staff shall accompany each other in the community if there are any safety concerns regarding patients or family situations. These concerns should be staffed with a supervisor before making the visit.
   D. Cell phones are available in each vehicle and will be activated at all times while in the community until returning to the Center.
   E. Staff will enter destinations in Scotland Yard.
   F. All staff will call their supervisor (or designee) to report any unplanned home visits or other unusual situations.
   G. Supervisors are responsible for getting messages to clinicians in the field by calling on cell phone or paging if unable to reach by cell phone.
   H. If staff have not returned to the Center by the close of business, supervisors will begin an investigation before leaving the Center.
   I. Patients who are transported in Center vehicles will abide by all safety and emergency procedures applicable to staff. Staff will supervise patients in their care involved in community services. Any incident or accident involving patients will be reported immediately to the supervisor (or designee) as indicated in the Adverse Incident Policy, and follow any emergency procedure deemed necessary.
PURPOSE: To review efficiency, effectiveness and utilization of service delivery as a means of continuing improvement of service delivery and patient satisfaction.

POLICY: Berkeley Community Mental Health Center will advocate for appropriate and efficient utilization of Center services and is committed to the least restrictive environment for its patients.
PROCEDURES:

As outlined in the Quality Assurance/Quality Improvement Plan, Utilization Review/Utilization Management activities will be implemented and coordinated by the Quality Improvement Department. In addition, Utilization Review will provide additional concurrent or retrospective reviews relating to clinical appropriateness and utilization of services. Utilization Management activities will focus on:

1. Effective caseload management
2. Medical necessity for continued stay
3. Cost effectiveness of services
4. Patient satisfaction related to quality of life and service provision
5. Hospitalization rates

Using a form of the SCDMH Audit Tool for Medical Records, a representative sampling of cases will be reviewed at least quarterly by QI. Information from these reviews will be furnished to staff leadership, supervisors and Board of Directors. Results of the reviews will be shared with the Quality Improvement Team and the Department of Mental Health as needed.

Other random reviews of the patient record by Utilization Review/QI Coordinator will occur at request of Center leadership or any Center supervisor.
**PURPOSE:** Berkeley Community Mental Health Center's mission is to provide services that promote the individual's quality of life, focus on the individual's strengths, foster the highest possible degree of independence, and honor the rights, wishes and needs of the individual. To this end, the Center encourages patients to have input into the development of their treatment and in the evaluation of the Center to provide these treatments.

**POLICY:** The Center will seek the input of patients by the mechanisms identified. This input will be directed to the Board of Directors, Leadership Council, Quality Improvement Team and Executive Director for implementation in program evaluation and planning.
PROCEDURES:

Information obtained includes the following: patient satisfaction with services and staff, accessibility of environment, patient/family involvement in treatment planning, community caregiver satisfaction with services (accessibility, quality) and staff, program development/enhancement, community education needs.

I. Patient Survey - As part of the Outcomes Management System, patient surveys will be distributed to persons served at different times during the treatment process to include intake, during treatment and at discharge. Linkages with clinical and/or administrative staff are coordinated.

II Suggestion Box - A suggestion box is available in Center lobby, as well as the prescribers’ waiting area, for comments by patients, families, visitors, etc. Comments are removed monthly and forwarded to the Peer Support Specialist or designee. These comments, along with Patient Survey, are compiled and presented to the Executive Director, Quality Improvement Team, and disseminated to staff as needed. Executive Director informs the Board of Directors of suggestions received. Comments identifying specific clinical and/or administrative interventions are processed by the Peer Support Specialist or designee for timely response.

III Community Survey – During the development of the Strategic Plan, the Center distributes surveys to the numerous community agencies, professionals, care providers, etc. that serve Center patients and their families. The Director of Quality Improvement compiles the mailing list based on feedback from patients, Quality Improvement Team, Utilization Review, and staff. The Directors of large agencies are asked to forward copies of surveys to frontline workers for feedback as well as feedback from management level staff. The Director of Quality Improvement receives all responses, tabulates and records comments. This information is provided to the Executive Director, Quality Improvement Team, Board of Directors, and Staff. Persons identifying specific needs/issues are contacted by the Director of Quality Improvement to link with clinical and/or administrative staff.

IV Peer Support Specialist - The Peer Support Specialist is a person who is or has been treated for a mental illness with the responsibility to represent patient needs and preferences throughout the organization. The Peer Support Specialist serves on the Quality Improvement Team, coordinates the Patient Advisory Board and participates in numerous work groups across the Center. In the absence of a Peer Support Specialist on staff, patient focus groups will be used to elicit input.

VI Patient Advocate - The Center's Patient Advocate is selected by the Executive Director. The responsibilities of this position include receiving, processing, documenting and negotiating resolution of patient complaints. The Center adheres to Department of Mental Health policies and procedures for governing patient complaints. In addition to providing information to the Department of Mental Health's Patient Advocacy office, the
Patient Advocate reports to the Executive Director, who is a permanent member of the Quality Improvement Team. Quarterly reports are generated for consideration and use of the Board of Directors, Quality Improvement Team and Executive Director.

Input from all the mechanisms above is used throughout the Center in planning, evaluation and decision making. Evidence of such is documented in minutes (Quality Improvement Team, Board of Directors), training agendas, and implementation of policies/procedures and programs.
ACCESSIBILITY

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PURPOSE: To promote individuals being treated with dignity and respect, the Center and its Board of Directors supports actions and practices which enhance accessibility for patients, families and the community at large.

POLICY: The Center and Board of Directors promotes involvement in processes to enhance accessibility to our patients in areas which include participation on the Board, service as staff and volunteers, physical environment, addressing attitudes and stigma associated with mental health needs, and participation in programs.
PROCEDURES:

I. Participation as Members of Leadership, Staff and Volunteers - The Center, its Board of Directors and staff value the participation of individuals with disabilities in its operations. To promote the Center’s accessibility to individuals with disabilities, the following policies and practices apply.

A. Board of Directors - The Board supports and monitors the organization’s mission and principles. The Board addresses accessibility through the following mechanisms.

1. Board Membership - Board members are nominated by Berkeley County Council and appointed by the Governor of South Carolina. The Board requests nominations from each county council district to ensure the needs of diverse communities in the county are addressed. The Board’s goal is to have a patient or family member of a patient among its members.

2. Board Meetings - Board meetings are held at least nine times per year. All meetings are open to the public. The annual meeting schedule is published in local newspapers, posted in the Center lobby, and available on Center website. Visitors and guests at meetings are received and are offered opportunities for input and questions.

3. Legislative Delegation - Throughout the year, the Board interacts with the Berkeley County Legislative Delegation to inform legislators of the mental health needs and services of their constituents. Board members may communicate to the legislators about specific issues related to mental health policy, funding, advocacy, etc.

4. Board-Staff Interaction - The Board’s relationship with the Executive Director is established in its by-laws. Employees are welcome to attend Board meetings. Board members participate in the recognition of Center’s Outstanding Employee and may join staff for other recognitions or celebrations and training during the year.

5. Policies - The Board reviews, provides feedback and approves all Center policies. State of South Carolina and South Carolina Department of Mental Health policies, directives or statutes applicable to Center operations are accepted by the Board.

6. Board Agenda - Board agendas include items for the purpose of communication of issues related to accessibility of services to the community. These may include, but are not limited to: building updates, personnel updates, committee/workgroup reports, community contacts, patient affairs report.

B. Personnel - The State of South Carolina and Department of Mental Health (SCDMH) Human Resources policies and procedures govern Center personnel operations. Equal employment opportunity and affirmative action practices are adhered to, as well as the Federal Americans with Disabilities Act.

1. Employee Recruitment - The Center promotes the recruitment of qualified applicants on the State and local level. Employment opportunities are available on the world wide web at [www.jobs.sc.gov](http://www.jobs.sc.gov). SCDMH Division of Human Resources has collaborated with the Center to identify a diverse applicant pool. Locally, positions may be advertised in publications accessible to diverse
2. Mental Health Patients as Employees - The Patient Affairs Coordinator/Peer Support Specialist is a mental health patient with the responsibility to represent patient needs and preferences throughout the organization. The Patient Affairs Coordinator/Peer Support Specialist serves on the Quality Improvement Team, coordinates the Patient Advisory Board and participates in numerous work groups across the Center. In this role, this employee raises issues and provides feedback regarding barriers to persons served. In the absence of a Peer Support Specialist on staff, patient focus groups will be used to elicit input.

3. Patient Volunteers - Opportunities for patients to serve as volunteers within the Center are promoted and encouraged. The Center’s Volunteer Coordinator works collaboratively with the patients, therapists, vocational program supervisor, and co-workers to match the interests, abilities and desires of the patient with volunteer responsibilities in the Center. Accommodations for patients volunteering are made based on individual needs and may include variable work hours or schedule and alternatives for supervision.

4. Accommodations for employees with disabilities are made on an individual basis. Communication with the employee and/or their personal representatives, SCDMH Division of Human Resources, and Center’s Leadership Council promote the best interest of the employee and the organization. The Center’s commitment to serving the community in a responsible manner while fostering the participation of diverse individuals guides accommodations and supports for all employees.

II. Physical Environment - The Center’s physical environment is designed to promote accessibility for the diverse persons it serves. The use of space in the facility is intended to create multiple therapeutic opportunities.

A. Architectural Barriers - The Center’s facility is designed for ready access to persons of all ages, cultures and disabilities. Operational procedures support services to persons with special physical as well as emotional preferences and needs. The Safety Program, through self inspections, supports the on-going attention to architectural barriers, as well as other barriers to accessibility.

B. Transition Plan - Elements of the physical environment identified as impeding accessibility will be evaluated for their impact. Considering the resources available, action plans to rectify such issues will be developed and may include alternative service locations or providers.

III. Community Activities - The Center and Board of Directors seek to reduce stigma associated with mental health needs and services and to decrease attitudes that erect barriers for persons accessing mental health services. Education and awareness of mental health needs in the community enhances patient’s opportunities for social and economic integration and assimilation. The Center has adapted a multifaceted approach to community education to reduce attitudinal barriers and stigma.

A. Patient and Family Education - Patients and their families are offered education about specific issues as well as general mental health topics by: clinicians throughout the
course of service delivery; psychiatrist on the treatment team; group therapies for the patient and family; pamphlets.

B. Community Contacts - Diverse audiences are sought and present themselves for community contacts. The Human Resources Representative identifies and receives opportunities for Center representatives to participate in various capacities. Presentations are tailored to the target audience and their need/request. Staff and volunteers from across the Center are encouraged to participate in such activities. The Human Resources Representative reports to Leadership Council, Quality Improvement Team, and Board of Directors on the nature and scope of community contacts. Staff may represent the Center on community based committees or workgroups. The purpose of these committees may vary from interagency communication to service development to holiday resources for citizens. Roles of staff are two-fold: address specific committee purpose; promote mental health awareness and understanding. The Board of Directors and Executive Director may participate in such activities, as well as be kept informed of community contacts.

C. Community Survey - The Center surveys numerous community agencies, professionals, care givers, organizations, etc. that may also serve Center patients and their families. This survey may be distributed annually, but no less than once every three years. As a tool, it provides input from the community at large as well as identifying groups in need of education and topics to address.

D. Vocational Program - The Center provides services to patients to address individualized vocational goals. One element of this program is developing an array of employment opportunities in the community for patients. In partnership with other agencies and local businesses, the Vocational Program identifies and develops jobs which range from sheltered workshop settings to competitive employment.

IV. Program Eligibility - As a facility of the South Carolina Department of Mental Health, the Center’s priority is to serve adults with severe, persistent mental illnesses and children and adolescents with serious emotional problems and to fulfill its mandated responsibility to provide screening for psychiatric and substance abuse emergencies. The Access Center receives all requests for services and determines eligibility of services for Berkeley County residents based on the following procedures.

Priority Populations
- Adults with severe, persistent mental illnesses
- Children and adolescents with serious emotional problems

The following information is used in evaluating for admission:
- Emergent needs – BCMHC continues to fulfill its responsibility to provide screening for psychiatric and substance abuse emergencies. As gate keeper of the SCDMH inpatient facilities, it is incumbent upon us to maintain a level of screening to offer services which divert admissions from DMH. Persons with multiple admissions to state hospitals are appropriate for the array of Center services. Referrals from DMH inpatient facilities for discharge follow-up will be scheduled an assessment.
- Symptoms – Contacts with persons requesting services, beginning with telephone calls, will gather information on the ways they are feeling, thinking and behaving that have led
them to seek mental health services. To use language familiar to mental health professionals, what symptoms are these individuals describing that tell us something about their level of distress, functioning and potentially, the presence/absence of serious persistent mental illness or serious emotional problems?

- Role functioning – To what degree has the individual’s ability to carry out his/her usual roles and responsibilities been impaired by the ways he/she is feeling, thinking, and behaving? Impairments which substantially interfere with or limit role functioning in one or more areas, including basic living skills, independent living skills, and functioning in social, family and education or vocational contexts, are identified through contacts with the individual and other informants, as appropriate.

- History of mental illness/emotional disorders and/or treatment – Persons are asked to identify other times when difficulty with their feelings, thoughts, behaviors or symptoms may have impaired their role functioning. Have other contacts with mental health providers/systems resulted in specific interventions, treatments, or diagnoses?

- Substance use/abuse – The individual requesting services will be asked about his/her use of alcohol and other drugs, to include the last episode of use and the longest period of time without use. History of participation in any substance abuse treatment/recovery programs will be gathered. Should a history of substance abuse without periods of abstinence (6 months) be presented in individuals not describing any other symptoms of co-occurring serious or persistent mental illness, a referral to the local alcohol/drug abuse agency may be made.

- Medical emergencies – Persons in need of immediate medical intervention due to physical illness, injury, suicide attempts (e.g. overdose, self-inflicted wounds) or alcohol intoxication will be directed to primary medical care.

- Court orders to services – Persons seeking treatment as the result of a court order will be asked to provide specific documentation from the referring court. Probate Court, as a standard practice, forwards copies of its orders for outpatient mental health treatment to the Center. Family Court, Magistrates Court and General Sessions Court, as a practice, simply tell individuals to contact the Center for services. It will be the individuals’ and families’ responsibility to provide documentation of the court’s expectations regarding type of mental health services. It has been an established practice that referrals of children/adolescents from DJJ are accompanied by DJJ paperwork. Assessments to determine the Center’s capability to fulfill the court mandates will be offered.

- Evaluation/Report Generation – If the request for services is solely an evaluation for the purpose of generating a report for an attorney or court, the individual will be referred elsewhere. Center assessment and evaluations are associated with the intent to engage in treatment services.

- Pastoral Counseling – Persons specifically requesting pastoral counseling or counseling based on a specific religious/belief system are referred to other resources. The Center provides services in a manner that respects individual belief systems, but does not offer services founded on schools of thought based in such belief systems.

- Financial resources (i.e. private insurances) – The persons for whom the Center has the capability to serve are not denied services because of an inability to pay for services. As a DMH facility, the Center’s mission is to address the mental health needs of indigent citizens. Individuals requesting services covered by an insurance plan the does not
reimburse the Center because of provider network limitations or level of provider credentialing are educated about their option to seek an in-network provider or be assessed self pay fees at the Center.

Participants in access process (includes telephone and face-to-face contacts):
- Individual requesting services
- Family/support system of individuals requesting services
- Referral source such as agency, pastor, primary care doctor, school, etc.
- Center staff

Admissions Process
All requests for services are directed to the Access Center. Requests are received by telephone and walk-in. All requests are documented on Screening and Referral Form (SCDMH C-20 as mandated). The documentation of information to determine eligibility begins with the initial contact in the Access Center. The individual requesting services, family/support systems, and referral source are potential resources to provide information related to the requests for services. More than one call/contact may be involved in getting pertinent information.

Based on information gathered, the Access Center counselor will schedule an assessment appointment or make referral(s) to other resources. When making these decisions, clinicians will err on the side of caution. Assessments will be scheduled for individuals if their eligibility for services cannot be readily determined.

Assessment appointments (up to 3 non-emergency visits in Access Center) are available to determine the Center’s capability to meet the needs of individuals requesting services, as many sources of information as appropriate/available will be accessed in this process. If the assessment determines the individual is not eligible for services, referral to indicated resources will be initiated.

Records will be maintained for all persons deemed ineligible for services at the time of request and as the result of assessment. The Medical Director and Access Center supervisor are available throughout the day for consultation. Review and staffing will provide oversight of the admission criteria to insure clinical appropriateness and objective application of criteria. Data will be monitored for trends for the purpose of training and program planning.

To increase accessibility of programs, the Center is open 37.5 hours a week. After office hours, crisis intervention services are accessible in local emergency rooms to accommodate persons traveling to the emergency room nearest their homes.

V. Plan Review - The Accessibility Plan will be reviewed by the Quality Improvement Team, Leadership Council, Safety Coordinator and Board of Directors. With reporting mechanisms and information available, revisions and enhancements will be developed and incorporated into Center operations.
PURPOSE/
POLICY/
PROCEDURE: Berkeley Community Mental Health Center, in conjunction with the South Carolina Department of Mental Health, provides insurance coverage for employees, volunteers and board members in amounts which responsibly protect such individuals and the organization. Berkeley Community Mental Health Center adopts and practices South Carolina Department of Mental Health Directive #845-04 (1-040) “Insurance Coverage”.

MISSION STATEMENT
To support the recovery of people with mental illnesses.
PURPOSE: To establish the mission and function of Berkeley Community Mental Health Center in support of South Carolina Department of Mental Health Directive #782-94.

POLICY: Berkeley Community Mental Health Center, along with the South Carolina Department of Mental Health Office of Quality Improvement/Advocacy, will advocate for the continuous improvement of the quality, appropriateness and continuity of services provided for people eligible for its services - services which build on strengths of each person, provide them with an opportunity to improve their quality of life and attain a comfortable level of independence in the setting best suited to their needs.

Activities will focus on:
1. Patient outcomes related to quality of life
2. Family outcomes related to effects of mental illness on the family
3. Employee satisfaction and productivity
4. Risk management and prevention of adverse outcomes
5. Promulgation of clinical and program standards
6. Cost effectiveness of services
7. Patient satisfaction related to quality of life and service provision
PROCEDURES:

The Berkeley Community Mental Health Center will develop and implement a Quality Assurance and Quality Improvement Plan outlining the organization and mechanisms for implementing the scope of activities listed. The plan will also include a team designated as the Quality Improvement Team which will include clinicians representative of Center programs. The membership and purpose of this team and other committees will be outlined in the Quality Assurance and Quality Improvement Plan.

In addition, a Patient Advocate is selected by the Executive Director in order to receive, process, document, negotiate, and resolve patient and family complaints. The Patient Advocate reports to the Executive Director, a permanent member of the Quality Improvement Team. Quarterly reports are generated for consideration and use of the Board of Directors, Quality Improvement Team and the Executive Director.

A Patient Affairs Coordinator/Peer Support Specialist, along with Patient Advisory Board, shall exist to ensure that patients are involved in specific program planning and/or evaluation of needs for programs to meet their needs at Berkeley Community Mental Health Center and to improve quality of life. The Patient Affairs Coordinator/Peer Support Specialist reports to the Executive Director, Quality Improvement Team and Board of Directors. In the absence of a Peer Support Specialist on staff, patient focus groups will be used to elicit input.

Input from all mechanisms above is used throughout Berkeley Community Mental Health Center in planning, evaluation and decision making to improve quality of life and satisfaction for patients and employees. Evidence of such is documented in minutes, staff in-service trainings, implementation of policies/procedures and programs.
LEGAL REQUIREMENTS

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<tr>
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<tr>
<td>Policy Number: G084</td>
<td>Date of Origin: September 1997</td>
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<tr>
<td>Revision Number: 01</td>
<td>Revision Date: 12/02</td>
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<td>Approved by:</td>
<td>Date Approved by Board: 9/97</td>
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PURPOSE/POLICY/PROCEDURE:
Berkeley Community Mental Health Center conforms with all State of South Carolina and federal statutes and laws pertaining to its existence, operations, mandates and governance as a community mental health center.

These documents include:
1. South Carolina Laws Pertaining to Mental Health
2. South Carolina Department of Mental Health Context Statement defining relationship between SCDMH and BCMHC
3. South Carolina Department of Mental Health Division of Financial Services Policies and Procedures
4. South Carolina Department of Mental Health Division of Human Resources Employment Policies and Procedures
5. South Carolina State Board of Pharmacy License/Drug Outlet Permit
6. South Carolina Department of Mental Health Policies and Procedures (Directives)
7. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
**ETHICS**

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<tr>
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<td>Revision Date: 10/00, 3/01, 9/01, 10/01, 7/04, 3/08, 5/13</td>
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<td>Approved by:  [Deborah Calcote]</td>
<td>Date Approved by Board: 11/09/00</td>
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**POLICY:** To uphold the highest ethical and professional standards for conduct as employees of Berkeley Community Mental Health Center and the State of South Carolina, all employees will abide by the Berkeley Community Mental Health Center Code of Professional Conduct and the State Ethics, Government Accountability, Campaign Reform Act of 1991 and its Ethical Principles of South Carolina State Government Service, SCDMH Directive #786-94, Off-Duty Misconduct, and SCDMH Directive #875-06, Public Information Procedures. The Code of Professional Conduct is given to every employee as part of employee orientation and it is the responsibility of the professional staff member to adhere to this Code of Professional Conduct and to communicate this code to patients as appropriate.

This policy, as applicable, applies to all Center employees and members of the Board of Directors.
PROCEDURE:

Each employee receives a copy of the Code of Professional Conduct, which is to be posted at
their work station readily visible to patients and visitors. The Code of Professional Conduct is
posted in the Center lobby. The Patient Orientation packet makes reference to Center staff
abiding by a Code of Professional Ethics. It is the employees’ responsibility to review and
discuss issues related to Code of Professional Conduct with patients and families when indicated
during the course of service. This includes the selling/promoting of business and/or goods to
patients and/or their families by clinical or administrative staff (ex: selling Avon, church raffles,
fund raiser items, etc.).

Communications
Berkeley Community Mental Health Center will be guided by SCDMH Directive #875-06,
Public Information Procedures, for media relations procedures.

The following are guidelines for employees who participate in social media. Social media
includes, but is not limited to, personal blogs and other websites, including Facebook, LinkedIn,
MySpace, Twitter, YouTube or others. These guidelines apply whether employees are posting to
their own sites or commenting on other sites:

- Follow all applicable BCMHC and SCDMH policies (i.e., patient confidentiality, patient
  rights, internet use, etc.).
- Do not use your official email to establish a private social media presence.
- Employees should be sensitive to the fact that social networks and other online forums
  blur the distinction between an individual’s official and personal identities.
- “Friending” of patients on social media websites is strongly discouraged. Staff in patient
care roles generally should not initiate or accept friend requests except in unusual
circumstances such as the situation where an in-person friendship pre-dates the treatment
relationship.
- BCMHC strongly discourages staff in management/supervisory roles from initiating
  “friend” requests with employees they manage. Managers/ supervisors may accept friend
  requests if initiated by the employee, and if the manager/ supervisor does not believe it
  will negatively impact the work relationship.
- BCMHC does not endorse people, products, services and organizations. On social media
  websites such as LinkedIn, where your affiliation to BCMHC is known, personal
  recommendations or endorsements should not be given or requested.

Violations of Procedures
Employees failing to uphold the principles of these policies are subject to disciplinary actions.
Reports of violations received from any source will be forwarded to the Center Executive
Director. The Director, in consultation with the South Carolina Department of Mental Health
Offices of General Counsel and Human Resources, will coordinate investigation of the
allegation.
Allegations of patient abuse or neglect will be investigated according to BCMHC Policy and Procedure CS069, Abuse, Neglect And Exploitation Of Patients Prohibited.

Allegations of ethical misconduct and/or violations of policies on part of the Center Executive Director will be directed to the Chairperson of the Board of Directors. The Chairperson, in consultation with the South Carolina Department of Mental Health Offices of General Counsel and Human Resources, will coordinate the investigation.

Should the investigation of violations of ethical and/or abuse or neglect be founded, consequences for the employee will be administered in accordance with South Carolina Department of Mental Health Human Resources Policies and Procedures. Additionally, such violations by all licensed employees will be reported to the appropriate State licensing board. Members of the Board of Directors abide by Center and State of South Carolina policies regarding ethical behavior. During the nomination process to serve on the Board, prospective members will be given applicable policies. Particular attention will be given to the review of any potential conflicts of interest resulting from the members’ personal and/or professional business and Board participation. During the course of their appointment, violations of ethics and conflicts of interest will be reported to Berkeley County Council, as the appointing body for the Board of Directors.

This policy will be reviewed with staff annually.
**OUTCOME EVALUATION**

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<td>Revision Number: 03</td>
<td>Revision Date: 9/98, 4/04, 3/08</td>
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<td>Approved by: <strong>Debbie Calcote</strong></td>
<td>Date Approved by Board: 10/08/98</td>
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**PURPOSE/POLICY:** This policy establishes a system of measuring outcomes of treatment that includes: efficiency, effectiveness, satisfaction and access to services of persons served and annual evaluation of the relationship between the needs of the persons served and the services provided. This system will include, at a minimum, a representative sample of the persons served and measure outcomes during treatment and post discharge. The results of the outcome evaluation system will be available at all levels within the Center to be used for decision making, program planning and evaluation. The outcome evaluation systems will be reviewed annually based on input from patients, staff and Board of Directors to determine the efficiency of the system and assess its impact on enhancing the Center’s performance.
PROCEDURES:

An outcome management system will be implemented which includes, at a minimum, the following dimensions of performance. This system and data sources and measurements will be detailed in the Center’s Outcome Management Plan.

I. SATISFACTION: Satisfaction will be evaluated using Patient Satisfaction Survey among adults, children and the elderly. Community Surveys will also be distributed to key informants in the community as part of the assessment and identification of mental health needs among the community.

II. EFFICIENCY: Outcome evaluation will provide information on how efficiently the Center is utilizing its resources to meet the needs of patients, their families and community.

III. EFFECTIVENESS: In keeping with the Center’s mission to assist individuals improve the quality of their lives, data will be generated and evaluated to measure the impact of services provided to patients, their families and community.

IV. ACCESS TO SERVICE: The Center will continuously monitor patient’s access to service through the survey and patient advocacy programs.

V. POST DISCHARGE: Post discharge information will be obtained to follow patients after discharge from services to generate data concerning effectiveness of treatment and how the patient is utilizing his/her discharge plan.

VI. APPLICATION OF OUTCOME EVALUATION MEASUREMENTS: The data collected to measure satisfaction, efficiency, effectiveness and access to services will be outlined in an Outcome Management Report, which will be available to all staff through the following mechanisms: group inservice sessions, committee meetings, email. The Outcomes Management Report will outline identified satisfaction, efficiency, effectiveness and access measures, data collection, measurement tools and outcome results. Staff are expected to consider this information as they provide services and participate in structured and informal program planning.

The Quality Improvement Team and Board of Directors will use outcome evaluation results as they make decisions about program changes and improvements, utilization of financial and human resources, and in Center long range planning.

It is expected that results of initial outcome measurements will generate new evaluation questions. This system will be reviewed annually by the Quality Improvement Team, Board of Directors and designated staff and patients.
MEDICAL STAFF BY-LAWS

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<td>Approved by: [Signature]</td>
<td>Date Approved by Board: 2/12/98</td>
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PURPOSE/POLICY: To provide organizational structure, span of control, authority and a clinical framework to facilitate the Center’s physicians in executing their responsibility for quality clinical care, the attached Medical By-Laws are adopted by the Board of Directors.
PROCEDURES:

All physicians working in the Center will have knowledge of and operate in adherence to these Medical By-Laws.

These By-Laws will be reviewed once every two years and revised or amended as needed to reflect clinical and/or administrative changes affecting patient care.
THE MEDICAL STAFF BYLAWS
OF
BERKELEY COMMUNITY MENTAL HEALTH CENTER

PREAMBLE

These Bylaws are adopted by the Berkeley Community Mental Health Center Board of Directors in order to provide an organizational structure, span of control, authority, and a clinical framework to facilitate the Medical Staff in discharging its responsibilities in matters involving the quality of clinical care provided to the Center’s clients.

The Medical Staff of this Center is dedicated to the principle that psychiatric care in community mental health centers is delivered through the combined expertise of multi-disciplinary teams which include, among others, psychiatrists, nurse practitioners, nurses, psychologists, and clinicians. The multi-disciplinary approach is vital to the provision of comprehensive care within these settings. The effective delivery of this care requires both mutual appreciation of each discipline’s special expertise and full interdisciplinary cooperation.

The Medical Staff is committed to the principle that the provision of quality medical services should be the overriding goal in the delivery of care and treatment to all clients suffering from a mental illness.

ARTICLE I – RESPONSIBILITY

Section 1. The Medical Staff accepts the responsibility of assuring effective involvement in center-wide mechanisms which monitor and evaluate the quality and appropriateness of client care and the clinical performance of all mental health professionals. The Medical Staff also accepts the responsibility of serving on Quality Care/Peer Review Committees which assess and evaluate adverse incidents and quality of care or situations which may adversely impact upon patient care, safety, rights or dignity.

MISSION STATEMENT
To support the recovery of people with mental illnesses.
Section 2. Unless the Center Director (Chief Executive Officer) is properly trained and qualified to serve this purpose, the Medical Director (Chief Medical Officer) has the responsibility for the medical/psychiatric services of the Center. Specifically, this includes responsibility for:

1. Assuring that Center clients receive appropriate evaluation, diagnosis, treatment, medical screening and medical/psychiatric evaluation whenever indicated.

2. Assisting the Center Director in assuring the clinical staff receive appropriate clinical supervision.

3. Overseeing the work of all physicians and nurse practitioners.

4. Participating in a multi-disciplinary process that assures the appropriate privileging and regular performance review of all clinical staff.

5. Providing direct psychiatric services.

6. Advising the Center Director regarding the development and review of the Center’s programs, positions and budgets that impact clinical services.

7. Participating, in cooperation with the Center Director, in regular and direct communications with the Director of Clinical Services or the State Director of Mental Health’s office, where appropriate, regarding psychiatric issues.

8. Providing liaison for the CMHC with community physicians, hospital staff and other professionals and agencies with regard to psychiatric services.

9. Assisting the Center Director in assuring the quality of the professional services provided by individuals with clinical privileges is acceptable and accounting therefore to the governing body. As part of the quality improvement program, the Medical Staff shall be actively involved in effective center-wide mechanisms to monitor and evaluate the quality and appropriateness of client care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms shall enable quality assurance/peer review committees at the Center level and at the Department of Mental Health level to conduct boards of inquiry and quality care review boards to assess and evaluate adverse incidents, questions of quality of care or situations which adversely impact upon client care, safety, rights, or dignity involving any Department of Mental Health client. Appointments to a board shall be made by the Director of Quality Improvement or by responsible Medical Staff of the Center pursuant to the bylaws, rules and regulations of the South Carolina Department of Mental Health and the Center.
ARTICLE II - MEDICAL STAFF MEMBERSHIP

Section 1. Only physicians/nurse practitioners licensed and legally authorized to practice in the State of South Carolina, who can document their background, experience, training and demonstrated competence, adherence to the ethics of their profession, good reputation, and ability to work with others with sufficient adequacy to assure the Center Director and the Center Medical Director that any client treated by them will be given a high quality of medical care, shall be qualified for membership in the Medical Staff.

Acceptance of membership in the Medical Staff shall constitute, by the staff member's agreement, that he/she will strictly abide by the Principles of Medical Ethics of the American Medical Association, the standards of the State Board of Medical Examiners, and the standards of behavior as promulgated by the South Carolina Department of Mental Health and Berkeley Community Mental Health Center.

Section 2. For appointment to the Medical Staff, the physician/nurse practitioner must first complete all requirements and conditions of the State Department of Mental Health's personnel employment system as a state employee or contractual physician. The Center Director, usually with the advice and consent of the Board of Directors, shall appoint the Medical Director (Chief Medical Officer). The Medical Director shall be a fully trained psychiatrist. If a fully trained psychiatrist is not available, an otherwise qualified physician may be appointed as Acting Medical Director until a psychiatrist can be recruited. Other appointments to the Medical Staff are to be a joint decision of the Center Director and the Medical Director. Should the Center Director (CEO) be a psychiatrist, then it shall be his/her option to serve as the Medical Director.

Section 3. Annual performance evaluation of all Medical Staff shall be as described by the Department of Mental Health directives. Continuation of clinical privileges should be based upon the staff member's professional competence and clinical judgement in the care of his/her patients, his/her ethics and conduct, his/her health status, results of Quality Assurance activities, results of Utilization Review activities, his/her attendance at Medical Staff meetings, participation in staff affairs, his/her compliance with Medical Staff Bylaws, Rules and Regulations, Center and departmental policies and procedures, his/her cooperation with Center personnel, his/her relationship with other staff members and his/her general attitude towards clients, the hospital and the public.

Section 4. Removal from employment or cancellation of contractual services shall be according to the State Department of Mental Health's personnel and contractual procedures, policies and rules.

The Center Director and/or Medical Director shall have the authority whenever action must be taken immediately in the best interest of client care, to summarily and temporarily suspend all or any portion of the clinical privileges of any practitioner of the Center and such a summary suspension shall become effective immediately upon imposition. In such cases, the aggrieved party shall have recourse to a timely and fair hearing.
ARTICLE III – REVIEW AND REVISION

These bylaws shall be reviewed at least every two years and shall be revised or amended as necessary, to reflect clinical and/or administrative changes that affect client care.

ARTICLE IV – ADOPTION

These bylaws shall be considered adopted and approved upon the affixation of signatures as listed below and shall be equally binding on the Medical Staff, Center Director, and Center Board of Directors.

Previously issued Medical Staff Bylaws are hereby rescinded.

Approved:  
Margaret Rittenbury, MD, Medical Director  
Date

Approved:  
Deborah T. Calcote, MA, Executive Director  
Date

Approved:  
Vicki J. Ellis, Chair, Board of Directors  
Date
SECURITY OFFICER

PURPOSE: To identify a Security Officer to manage the security of Electronic Protected Health information

POLICY: It is the policy of the Berkeley Community Mental Health Center to follow the HIPAA Security Rule by assigning a Security Officer for management of the Center’s Electronic Health Information. This policy is consistent with those enforced by South Carolina Department of Mental Health Networking Services and Information Technologies.
SCOPE/APPLICABILITY: This policy is applicable to all departments that use or disclose electronic protected health information for any purposes. This policy’s scope includes all electronic protected health information, as described in Definitions below.

A. The HIPAA Security Rule is organized in two types of provisions: standards, which are general requirements, and implementation specifications. Implementation specifications are either required or addressable. (The organization must implement required specifications. However, the organization has flexibility in how it will implement the addressable implementation specifications).

B. The organization’s Executive Director or designee must assign a specific person to be responsible for managing the security of electronic protected health information (EPHI). This assignment is designed to promote security. Responsibilities would include managing and supervising the use of security measures, protecting EPHI specifically, and monitoring personnel in relation to data protection.

C. The Security Official is responsible for EPHI confidentiality, integrity, and availability. He/she may also be responsible for all Privacy Act matters relating to electronic, written and oral protected health information (PHI).

D. The security responsibility must reside in one individual and not in a group. More than one individual may be given specific security responsibilities, but a single individual must be designated as having the overall final responsibility for EPHI security. This is consistent with and analogous to the policy in the Privacy Rule, and the same considerations apply. (The same person could fill the role for both security and privacy. [45 C.F.R. , 164.530(a) & 65 Federal Register, pages 82744 through 87445]).

E. The appointment of Security Official may be a current employee or a new hire.

F. The HIPAA Security Rule requires the documentation of actions and activities for assigning a Security Officer, such as board minutes, personnel action forms, or organizational chart designations.

Duties:
1. Ensure the confidentiality, integrity, and availability of all electronic protected health information the organization creates, receives, maintains, or transmits.
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.
3. Protect against any reasonably anticipated uses or disclosures of such information.
4. Ensure compliance by all assigned employees.
5. The Security Officer may use any security measures that are reasonable and appropriate when implementing the standards and implementation specifications.
In deciding which security measures to use, the Security Officer must take into account the following factors:

a. The hardware and software security capabilities.
b. The costs of security measures.
c. The probability of potential risks to electrical protected health information.

(Standards must comply with the standards as provided in this section and in Sec. 164.308, Sec. 164.310, Sec. 164.312, Sec. 164.314, and Sec. 164.316 with respect to all electronic protected health information).

Implementation specifications are required or addressable. If an implementation specification is required, the word “Required” appears in parentheses after the title of the implementation specification. If an implementation specification is addressable, the word “Addressable” appears in parentheses after the title of the implementation specification.
HIPAA VIOLATION SANCTION POLICY

**PURPOSE:** To define HIPAA security violations and establish/implement sanctions for HIPAA security violations.

**POLICY:** It is the policy of the Berkeley Community Mental Health Center to follow the HIPAA Security Violations Policy and apply sanction guidelines toward policy offenses. This policy is consistent with those enforced by South Carolina Department of Mental Health Networking Services and Information Technologies.
In the event that you as an employee of South Carolina Department of Mental Health are responsible for a Violation of the States Privacy Practices and/or violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the following sanction guideline would apply:

**DEFINITION OF OFFENSE:**

**Class I offences:**
1. Accessing information that you do not need to know to do your job;
2. Sharing your computer access codes (user name & password);
3. Leaving your computer unattended while you are logged into a PHI program;
4. Sharing PHI with another employee without authorization;
5. Copying PHI without authorization;
6. Changing PHI without authorization;
7. Discussing confidential information in a public area or in an area where the public could overhear the conversation;
8. Discussing confidential information with an unauthorized person; or
9. Failure to cooperate with privacy and/or security officer.

**Class II offences:**
1. Second offence of any class I offence (does not have to be the same offence);
2. Unauthorized use or disclosure of PHI;
3. Using another person’s computer access codes (user name & password); or
4. Failure to comply with a resolution team resolution or recommendation.

**Class III offences:**
1. Third offence of any class I offence (does not have to be the same offence);
2. Second offence of any class II offence (does not have to be the same offence);
3. Obtaining PHI under false pretences; or
4. Using and/or disclosing PHI for commercial advantage, personal gain or malicious harm.

**SANCTIONS:**

**Class I offences** shall include, but are not limited to:
(a) Verbal reprimand and resigning the Internet **Acceptable Use Policy**;
(b) Written reprimand in employee’s personnel file;
(c) Retraining on HIPAA Awareness;
(d) Retraining on Agency’s Privacy Policy and how it impacts the said employee and said employee’s department; or
(e) Retraining on the proper use of internal forms and HIPAA required forms.

**Class II offences** shall include, but are not limited to:
(a) Written reprimand in employee’s personnel file;
(b) Retraining on HIPAA Awareness;
(c) Retraining on County’s Privacy Policy and how it impacts the said employee and said employee’s department;
(d) Retraining on the proper use of internal forms and HIPAA required forms; or
(e) Suspension of employee (In reference to suspension period: minimum of one (1) day/maximum of three (3) days).

Class III offences shall include, but are not limited to:
(a) Termination of employment;
(b) Civil penalties as provided under HIPAA or other applicable Federal/State/Local law; or
(c) Criminal penalties as provided under HIPAA or other applicable Federal/State/Local law.
ACKNOWLEDGMENT:

I, the undersigned employee, hereby acknowledge receipt of a copy of the HIPAA Violation Sanction Policy for Berkeley Community Mental Health Center.

Dated this ________ day of _________________, 20____.

____________________________________________
Signature of Employee BCMHC Office
# OVERTIME

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<th>Section Number: II - HUMAN RESOURCES</th>
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<td>Revision Number: 05</td>
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<td>Date Approved by Board: 10/10/96</td>
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**PURPOSE:** To establish overtime policy and procedure in compliance with South Carolina Department of Mental Health Directive 814-99 (3-050).

**POLICY:** In compliance with the Fair Labor Standards Act and SCDMH Directives, the Berkeley Community Mental Health Center will compensate exempt and non-exempt employees for hours worked in excess of 40 in each 7 day work period.

Exempt employees are defined as any employee in a bona fide executive, administrative or professional capacity and are not eligible for overtime pay. Compensatory time will be given to exempt employees on an hour-for-hour basis for hours worked in excess of 40 in a 7 day work period.

Non-exempt employees (those not qualifying for exempt status) shall be given compensatory time for hours worked in excess of 40 in each 7 day work period. For hours worked in excess of 40 in a 7 day work period, the accrual of compensatory time shall be at a rate of time & one-half (1 1/2) hours for every hour over 40 worked. In computing the 40-hour base, time charged as annual leave, sick leave, dependent sick leave, holiday compensatory time, compensatory time, LWOP, or a holiday shall not be included.
PROCEDURE:

1. Approval to work overtime must be obtained in advance from appropriate supervisor using Form F-162, Request for Overtime/Compensatory Time. Tasks completed outside normal Center work hours which constitute overtime include face-to-face contact with patients, travel time for directed training/meetings and administrative functions that cannot be completed during the day’s routine. Employees cannot routinely work through lunch periods to accumulate overtime.

2. Employees must submit, to supervisor, a leave request through MySCEmployee to use compensatory time. Upon termination of employment, non-exempt employees shall be paid for unused compensatory time, and exempt employees forfeit any compensatory time accumulated.

3. Supervisors must route all completed Request for Overtime/Compensatory Time forms to timekeeper for filing. All accrual and use of overtime is subject to audit.
LICENSED PROFESSIONAL COUNSELORS (LPC) AND LICENSED MARITAL AND FAMILY THERAPISTS (LMFT)

| Section Number: II – HUMAN RESOURCES | DMH Reference: 
|--------------------------------------|-------------------------------------------------
| Policy Number: HR007                 | Date of Origin: 8/98                             |
| Revision Number: 10                  | Revision Date: 8/00, 10/01, 12/02, 3/06, 10/07, 3/08, 3/09, 3/10, 10/14, 8/15 |
| Approved by:                         | Date Approved by Board: 9/14/00                   |

PURPOSE: Berkeley Community Mental Health Center offers avenues for growth and development to employees in order to provide the most qualified service providers for patients and families.

POLICY: To promote the development of clinical staff, the Center has established procedures for offering supervision to qualified staff seeking licensure as Licensed Professional Counselors and/or Licensed Marital and Family Therapists.
PROCEDURE:

I. Eligibility for Participation - Clinicians interested in participating in the Center’s system or providing LPC/LMFT supervision hours must:
   A. Employee must have been employed by BCMHC for at least six (6) months prior to beginning supervision and must be performing at a “Successful” level or above on all essential job duties and objectives.
   B. Employee must be in good standing. “In good standing” means no involvement in the disciplinary process.
   C. Employee must meet the SC Department of Labor, Licensing and Regulation/Board of Examiners for the Licensure of Professional Counselors and Marital and Family Therapists minimum qualifications for LPC/LMFT applicants.
   D. Provide status in licensing process to include examination and hours of supervision. LPC/LMFT examination must be passed prior to accumulating supervision hours. Employee is responsible for contacting licensing board for clarification of their status. Documentation to verify that the LPC/LMFT examination has been passed and/or Board statement of employee’s status must be provided at the time of BCMHC application for supervision.

II Approval Process – The employee meets with the LPC/LMFT Supervisor to review the “SCDMH Employee Supervision for Clinical Licensure Program Agreement”. If employee agrees to the terms of the Payback Agreement (with individualized information noted in an Addendum if warranted), the full Participation Request, Acceptance, and Approval Agreement is forwarded to the Executive Director for final approval/required signatures.

   There must be mutual agreement between the LPC/LMFT Supervisor and employee that no barriers to an effective working relationship exist before entering into supervision.

   If more than one LPC/LMFT Supervisor, employee may work to accumulate hours with each supervisor (not concurrently).

III Ineligible for Participation - If at any time during LPC/LMFT supervision, the employee’s job performance on essential job duties falls below a “Successful”, participation in the Center sponsored process will terminate. If the disciplinary process is implemented, Executive Director will review the employee’s status with regard to Center sponsored supervision and make a decision to continue, suspend or terminate participation based on the nature of the disciplinary action.

IV Employee Supervision for Clinical Licensure Payback Agreement – Once an employee completes licensure supervision, the licensure supervisor will notify Human Resources and provide a copy of the employee’s log of hours for supervision received.
   A. HR will calculate the employee’s work payback time and track when the employee has completed their commitment. The work payback schedule will be put on hold in the event the employee takes more than two (2) weeks of consecutive leave and resume the work payback schedule once the employee returns to work.
   B. If an employee resigns prior to the completion of the work payback, Human Resources will follow Work Payback Agreement, items 6-11.
PURPOSE: To maximize efficient and effective utilization of staffing resources as part of our commitment to meet the mental health needs of the patients and families of Berkeley County.

POLICY: The attached staff utilization guidelines will be used as a tool in establishing productivity standards for staff based on each respective staff member’s job functions and responsibilities assigned.
PROCEDURES:

I. Standards will be established for each direct service staff member and integrated into the staff members job description as part of their essential job functions. Staff utilization and productivity data will be part of the consideration at the time of the annual EPMS review.

II Equally, staff utilization/productivity standards will also be established for administrative staff based on their respective job functions. Indicators of productivity and efficient staff utilization will be integrated into the staff members job description as part of their essential job functions and part of the performance evaluation at the time of the annual EPMS review.

III Staff Utilization Goals
   A. To maximize staff utilization and time management strategies.
   B. To maximize revenue potential.
   C. To standardize expectations across like positions.
   D. To develop and maintain an ongoing system for monitoring staff utilization as well as resource needs.
PURPOSE: To facilitate the planning of personnel actions on a Centerwide level, all EPMS planning stages and evaluations will be reviewed by the Executive Director.

POLICY: In addition to EPMS policies outlined in SCDMH Directive No. 855-06, all planning stages and evaluations will be reviewed and signed by the Executive Director prior to discussing with the employee.
PROCEDURE: Supervisors are to follow procedures detailed in SCDMH Directive No. 855-06 (Employee Performance Management System). In addition, Quality Improvement staff will be notified of upcoming reviews for clinical staff so that QI reports may be provided to supervisors to assist in this process. The supervisor will not discuss the planning stage or evaluation with the employee until the reviewer and Executive Director have signed off on the form.
EMPLOYEE TRANSFER WITHIN CENTER

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<td>Date of Origin: 3/88</td>
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<td>Revision Number: 04</td>
<td>Revision Date: 1/97, 9/00, 4/04, 3/08</td>
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<td>Approved by: Debbié Calhoun</td>
<td>Date Approved by Board: 9/14/00</td>
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PURPOSE/POLICY: To outline procedures in the event an employee of the Center is interested in transferring to a vacant position within the Center.
PROCEDURES:

I. The employee will respond to a posted vacancy requesting he/she be considered as an applicant by completing an application at www.jobs.sc.gov.

II. Interviewing supervisor will consider employee as well as other applicants from outside the Center.

III. Should an interview be scheduled, employee's current BCMHC supervisor will be contacted as a reference by interviewing supervisor. If the employee refuses to give permission to contact current supervisor, the interviewing supervisor has the option to refuse to consider the employee for the vacancy.

IV. If the employee is offered the vacant position, he/she will give current supervisor a two week notice before the transfer is effective. Under circumstances where a transferring employee's absence in their current position would jeopardize program continuity, the Executive Director, both supervisors and employee will negotiate an effective transfer date considering all needs. If the internal transfer results in a position upgrade, Human Resources will be involved in setting transfer date.
AFTER HOURS EMERGENCY SCREENING STAFF

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<td>Date of Origin: 4/88</td>
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<td>Revision Number: 07</td>
<td>Revision Date: 1/97, 9/00, 12/02, 2/07, 3/08, 2/12, 5/16</td>
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<td>Approved by:</td>
<td>Date Approved by Board: 6/14/00</td>
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PURPOSE/POLICY: Berkeley Community Mental Health Center has a system of dually employed staff that work in conjunction with local emergency rooms to provide emergency consultations. These on-call staff members rotate after hours coverage on a daily and weekend basis. The opportunity to participate in this rotation is available to all clinical staff qualified as mental health professionals who have met certain criteria and training procedures.
PROCEDURES:

The following criteria and training are required to participate as a mental health professional in the after hours program:

1. Employed at the Center for at least six months. Based on related experiences in the Center and/or other jobs, Executive Director may grant exceptions to the six (6) month requirement.

2. Approved for training by the Program Director.

3. Completed training with Coordinator of After-Hours Emergency Services covering procedures and resources.

4. Approved for addition to on-call rotation by Leadership Council. Feedback from Coordinator of After-Hours Emergency Services and on-call staff will be considered in the approval process.

5. Complete all forms for Dual Employment and sign BCMHC’s contract for on-call staff after receiving position description for on-call staff. Apply for Notary status in their county of residence.

Staff interested in participating in Center’s after hours coverage should submit their request to Coordinator of After-Hours Emergency Services on the Application for On-Call Status form.
PURPOSE: To keep all Center operations and programs available to patients on all weekdays, except official holidays.

POLICY: Each area of the Center will be staffed and operational during all routine office hours. Supervisors are responsible for insuring adequate coverage by managing requests for training, annual and sick leave, in adherence with SCDMH Directive 902-11, “Leave Policies”.

LEAVE POLICY

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<td>Approved by: <del>Debree Calcutt</del></td>
<td>Date Approved by Board: 2/13/97</td>
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PROCEDURES:

All anticipated requests for leave (annual, sick, other) are to be submitted to supervisor in advance through MySCEmployee.

I. Training Leave - Requests for training leave must be made based on employees’ need to enhance skills in order to perform job duties in a more competent manner. The supervisor and employee will refer to the staff development plan to prioritize training leave requests. The availability of other staff to perform necessary job duties, the distribution of resources designated for training, and the credentialing requirements of the employee will be considered when granting leave requests for training. Training leave requests are to be submitted to supervisor in advance on SCDMH Form P-14, Application for Leave.

II. Sick Leave - Requests for anticipated sick leave must be made as far in advance as possible. The employee is responsible for completing leave request through MySCEmployee.

When an employee has a need for unscheduled sick leave, it is required that he/she speak with his/her supervisor to provide information related to the job responsibilities that need to be addressed in the employee’s absence.

If the immediate supervisor is not available, the employee is to speak to another supervisor to relay job responsibilities that need to be addressed.

Coverage of appointments and calls becomes the responsibility of the supervisor or acting supervisor. Supervisor may enlist assistance of co-workers. Reception will be informed in writing of who is covering duties of sick employee.

The leave request is completed through MySCEmployee by the employee and forwarded to the supervisor immediately after returning to work. Additional requirements regarding sick leave are documented in SCDMH Directive 902-11, Leave Policies.

III Annual Leave - Requests for annual leave must be made as far in advance as possible through MySCEmployee. Supervisors will consider the pending job responsibilities, previous time away from duties, and employee’s plan for coverage prior to granting leave. When multiple requests are made for the same dates, the supervisor will consider seniority, family conditions (i.e., children in school, mandatory vacation period of another family member), previously granted requests, and other conditions which contribute to a reasonable decision. The supervisor is responsible for maintaining fairness and an equal distribution of annual leave.
IV Overtime/Compensatory Time - If approved, non-exempt employees will receive compensatory time at time and one-half for all hours worked in excess of 40 in a 7 day work period. Exempt employees may earn compensatory time for hours worked in excess of 40 hours in a 7 day work period. The completion of SCDMH form F-162 is required.

Requests to use accrued compensatory time are to be made by completing leave request through MySCEmployee.

V Other Leave - Military, court, leave without pay, leave for death in immediate family, and voting leave are governed by SCDMH Directive 902-11, and this policy where appropriate.

VI Adjusted Leave - When the needs of patients and/or Center operations dictate, employees may work an adjusted schedule within the 7 day work week. Completion of BCMHC adjusted leave form is required, and this adjustment must be approved by the supervisor.

VII Family and Medical Leave - An eligible employee shall be granted up to a total of 12 weeks of FMLA in each calendar year for any of the following reasons:
A. For the birth of a son or daughter and to care for that child;
B. For placement of a son or daughter for adoption or foster care with the employee;
C. To care for the employee’s spouse, son, daughter or parent with a serious health condition;
D. Because of serious health condition that makes the employee unable to perform the functions of the employee’s job.

VIII Coverage for Absent Employees – At the time leave is requested, requesting employee identifies co-worker providing coverage of duties during absence in the “Notes for Approver” section of leave request. In addition, the electronic In/Out Board (Scotland Yard) indicates absence period and coverage plan. Employees covering for absent co-workers receive calls directed by Reception. They also are to check co-workers voice mail at least twice daily.

Reference is made to SCDMH Directive 902-11 for additional guidelines.
PERSONAL APPEARANCE OF EMPLOYEES

Section Number: II - HUMAN RESOURCES

DMH Reference: #826-01

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<td>Approved by: [Signature]</td>
<td>Date Approved by Board: 11/09/00</td>
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PURPOSE: To establish minimum standards of general appearance for all BCMHC employees, volunteers, students and contract employees.

POLICY: Employees are reminded that the personal appearance of staff reflects an image of our agency to the public and the persons we serve. It is the intent of BCMHC to assure as much as possible that the image projected is one of professionalism. As representatives of BCMHC, employees, volunteers, students and contract employees will maintain dress, grooming and personal hygiene in a manner suitable for a public health service agency. Interactions with patients, families, other professionals and one another require attention to behaviors, verbal communication and appearances.

Perceptions of individuals experiencing emotional distress and/or mental illness may prevent them from maintaining therapeutic relationships when employee's dress/appearance is inappropriate. Staff are expected to be mindful of personal appearance and hygiene so as not to offend those we serve or the public we encounter in the work setting.
PERSONAL APPEARANCE OF EMPLOYEES
PAGE 2

PROCEDURE:

The following guidelines will serve as the Center's dress code for employees, volunteers, students and contract employees.

1. In all instances it is expected that grooming and personal hygiene will be appropriate to the performance of professional duties. Clothing, make-up and personal ornamentation are not to create barriers to establishing therapeutic relationships.

2. Shoes must be worn at all times.

3. All clothing, including footwear, shall be clean, neat and in good repair.

4. Revealing attire is prohibited. This includes, but is not limited to: tank tops or tops with spaghetti straps without a second shirt/blouse over such, excessively low necklines, excessively tight or short clothing, bare midriffs, transparent garments. Men will not leave shirts unbuttoned beyond what is reasonable.

5. All garments must conceal underclothing as employees conduct job duties.

6. Overly casual attire is prohibited. Sweatshirts, sweat pants, leggings, spandex, etc. are not accepted dress.

7. Monday through Thursday, blue jeans may be worn when the day's activities warrant casual dress.

8. Fridays are designated as Mental Health Awareness days when employees can wear T-shirts with mental health theme/logo and blue jeans. Whenever worn, blue jeans must be in good condition, free of tears, holes, etc.

Exceptions to the guidelines above are permitted according to work function and unusual job duties requiring casual wear.

Non-compliance with these guidelines will be addressed individually by supervisors using established means for disciplinary actions. In addition, an employee in violation of the dress code may be required to leave the workplace and return appropriately dressed, taking annual leave for the time away.
**PRIVATE PRACTICE**

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<th>Section Number: II - HUMAN RESOURCES</th>
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**POLICY:** Berkeley Community Mental Health Center adheres to South Carolina Department of Mental Health’s policy and procedure on private practice, Directive #808-98, Private Off-Duty Employment (“Moonlighting”) and the South Carolina Ethics Reform Act. There is no additional Center policy.
FAIR EMPLOYMENT PRACTICES

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<th>Section Number: II - HUMAN RESOURCES</th>
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<td>Approved by:</td>
<td>Date Approved by Board: September 1997</td>
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PURPOSE/ POLICY:
It is the policy of Berkeley Community Mental Health Center to adhere to and be in compliance with the requirements of the amendment to Title VII of the Civil Rights Act now referred to as the Equal Employment Act of 1972, Age Discrimination Act, Equal Pay Act and The South Carolina Human Affairs Law outlined in South Carolina Department of Mental Health Directive #817-99.
PROCEDURES:

Berkeley Community Mental Health Center will be in compliance with all requirements including:

1. Employment, upgrading, transfer or demotion
2. Recruitment, advertising, or solicitation for employment
3. Treatment during employment
4. Rates of pay or other forms of compensation
5. Selection for training
6. Layoff or termination

Berkeley Community Mental Health Center shall provide equal opportunity to all qualified employees and applicants for employment without regard to race, creed, color, sex, age, sexual orientation, national origin, religion, physical or mental handicap, or political affiliation.
HARASSMENT FREE WORKPLACE

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<th>Section Number: II - HUMAN RESOURCES</th>
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<td>Date Approved by Board: September 1997</td>
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PURPOSE/ POLICY: Berkeley Community Mental Health Center adopts and practices South Carolina Department of Mental Health Directive #842-03, “Harassment-Free Workplace”.

MISSION STATEMENT
To support the recovery of people with mental illnesses.
PROCEDURES:

It is the policy of Berkeley Community Mental Health Center to provide all of its employees with a work environment free from harassment and intimidation. Certain forms of conduct based on sex, race, religion, color, or other legally protected categories, which have the effect of substantially interfering with a person’s work performance, or creating an intimidating, hostile or offensive work environment, may be illegal and are prohibited by this policy. In addition, even conduct which is not deemed to be illegal is nevertheless improper if it has the effect of substantially interfering with an employee’s performance of his/her duties or creates an intimidating, hostile or offensive work environment.

It shall be the policy of BCMHC to take immediate and appropriate action when it learns of an employee being subjected to unwelcome sexual advances, disparaging or insulting remarks, verbal or physical conduct of an improper nature, or any other conduct that might be construed as racial, sexual, ethnic, religious or any other type of harassment in the workplace.

Any behavior prohibited by this policy will be treated as misconduct and will be subject to immediate review when reported. Appropriate disciplinary action, up to and including dismissal, will be taken in accordance with DMH’s progressive discipline policy if an employee is determined to have engaged in improper, prohibited conduct.

Harassment is defined as any conduct that is unwanted by the recipient or affects the dignity of any individual or groups of individuals at work. Key feature: repetitive nature of the behavior.

Managers and supervisors have as one of their responsibilities the promotion of a harassment-free environment. It is their responsibility to adhere to, implement and support the DMH policies designed to prevent harassment. In this regard, managers and supervisors are expected to intervene appropriately whenever they become aware of conduct by their employees which manifests any illegal or otherwise improper discriminatory behavior or which creates an intimidating and/or hostile work environment. Managers and supervisors are expected to take actions that are in the best interest of DMH.
PURPOSE/
POLICY/
PROCEDURE: Berkeley Community Mental Health Center adopts South Carolina Department of Mental Health Directive 727-89 (3-40) “Employee Assistance Program”. This policy reflects the Center’s concern for the well-being of its employees as well as our dedication to quality service for our patients. Its purposes and concepts are supported by the Center.
PURPOSE/
POLICY/
LABORATORY TESTING FOR ALCOHOL AND/OR DRUG CONTENT OF EMPLOYEE

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<th>Section Number: II - HUMAN RESOURCES</th>
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<td>Approved by:</td>
<td>Date Approved by Board: September 1997</td>
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PURPOSE: To develop a procedure to be used with South Carolina Department of Mental Health directives regarding employee drug testing. This procedure will be followed when indicated to obtain alcohol and/or drug laboratory testing to assist in the evaluation of an employee’s condition while at work. All candidates for employment will be required to pass a mandatory pre-employment drug test as described in SCDMH Directive #893-09 and #899-10.

POLICY: In order to provide a drug-free workplace, laboratory testing will be utilized to determine whether an employee or candidate for employment has consumed alcohol, drugs, or other substances. This testing process will be confidential.
PROCEDURES:

Pre-Employment
All prospective employees will be required to pass a mandatory pre-employment drug test. Testing shall occur when the prospective employee is offered a position and employment will be conditional upon the prospective employee taking and passing the test.

Reasonable Suspicion Testing
When a supervisor has reasonable cause to suspect that an employee is under the influence of alcohol or drugs while at work, he/she will report this to the Executive Director or designee. After consultation, which may include contact with the South Carolina Department of Mental Health Human Resources Director and General Counsel, the outcome may be to request laboratory testing for alcohol/drug content.

The Executive Director or designee shall explain the need for testing to the employee and request his/her signature to submit to the alcohol and/or drug testing. Refusal to submit to testing will constitute admission by the employee that he/she is under the influence of alcohol and/or drugs and disciplinary action will be taken in accordance with the current disciplinary directive.

When the consent form is properly completed, the supervisor will accompany the employee to Doctor’s Care in Moncks Corner for testing.

The employee will be suspended until completion of the investigation, including testing of all specimens collected. Results of those tests will be sent to the Executive Director. Based on the findings of the tests and investigation, the supervisor will follow the current standards of disciplinary action and/or referral to Employee Assistance Program.

Random Testing
Employees may be selected at random for drug testing at an interval and sample as determined by SCDMH. An employee may be selected more than once in a twelve (12) month period. The names of all employees will be placed in a random selection pool and subjected to mandatory random drug testing. Implementation of the above will be consistent with all SCDMH Directives and policies and applicable law.

Doctor’s Care will be responsible for the collection of specimens, all procedures to test specimens and legal protocol for said collections. Berkeley Community Mental Health Center will be responsible for all charges for testing.
REQUEST FOR EMPLOYEE LABORATORY TESTING
FOR ALCOHOL AND/OR DRUGS

I, ________________________________, agree to submit to laboratory testing for alcohol and/or other substances. I understand that failure to do so constitutes admission of use.

The results of my testing shall be forwarded to the Executive Director of Berkeley Community Mental Health Center.

I understand that all information received shall be treated in a confidential manner in accordance with applicable laws.

Date _________________________________________________________

Employee Signature _____________________________________________

Director Signature ______________________________________________

Supervisor Signature ____________________________________________
# NEPOTISM

**Section Number: II - HUMAN RESOURCES**

**Policy Number:** HR080

**Revision Number:** 00

**DMH Reference:** Directive #770-92

**Date of Origin:** September 1997

**Revision Date:**

**Date Approved By Board:** September 1997

**Approved by:** [Signature]

**PURPOSE/ POLICY/ PROCEDURE:**

## HUMAN RESOURCES MANAGEMENT AND DIVERSITY

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<tr>
<th>Section Number: II - HUMAN RESOURCES</th>
<th>DMH Reference:</th>
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<tr>
<td>Policy Number: HR085</td>
<td>Date of Origin: September 1997</td>
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<tr>
<td>Revision Number: 04</td>
<td>Revision Date: 10/01, 2/03, 6/04, 2/07</td>
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<td>Approved by:</td>
<td>Date Approved By Board: September 1997</td>
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**PURPOSE/ POLICY:** Berkeley Community Mental Health Center recruits, develops, and retains personnel who can deliver the highest quality of services to patients.
PROCEDURES:

I. Recruitment
Through mechanisms available in the Human Resource Divisions of the State of South Carolina and the South Carolina Department of Mental Health, the Center recruits applicants who meet minimum position qualifications. Local, regional, state-wide and national recruitment options may be considered to generate potential employees with education, experience, and abilities to enhance the organization’s performance. From these qualified applicants, the Center is responsible for providing a workforce which reflects the cultural diversity of the persons it serves and the community. The following Center policies and procedures pertain to the recruitment of a qualified and diverse applicant pool:

A. BCMHC Policy and Procedure for Fair Employment Practices, HR068
B. BCMHC Policy and Procedure for Hiring Employees, HR093
C. BCMHC Policy and Procedure for Accessibility, G066
D. BCMHC Policy and Procedure for Affirmative Action, HR097
E. BCMHC Policy and Procedure for Employee Transfer Within the Center, HR017
F. BCMHC Cultural Diversity Plan, G013
G. BCMHC Policy and Procedure for Consultation, Education and Prevention, SD096

II. Development
The Center promotes professional growth for all staff. Opportunities are available through training and supervision for employees to enhance their skills/abilities. Employees are encouraged to consider promotional opportunities within the Center when qualified. The following Center policies and procedures pertain to developing staff who can deliver the highest quality of service to patients:

A. BCMHC Policy and Procedure for Employee Transfer Within the Center, HR017
B. BCMHC Policy and Procedure S067, which includes Behavioral Emergency Stabilization Training
C. BCMHC Policy and Procedure for Private Practice, HR056
D. BCMHC Policy and Procedure for Licensing of Clinical Staff as Licensed Professional Counselors/Licensed Marital And Family Therapists, HR007
E. BCMHC Policy and Procedure for Red Cross First Aid and CPR Training, S060
F. BCMHC Policy and Procedure for Review of EPMS Evaluations, HR012
G. BCMHC Policy and Procedure for Body Fluid and Bloodborne Pathogen Infection Control Policy, S047
H. BCMHC Policy and Procedure for Staff Development Plan, SD064
I. BCMHC Quality Improvement Plan

III. Retention
To promote satisfaction and tenure in the Center, mechanisms listed below are among those in place for employees to participate in program planning and evaluation, express satisfaction, and on-going recognition of performance and contributions:

A. Participation in Program Planning and Evaluation
   1. BCMHC Quality Improvement Plan and process
   2. BCMHC Strategic Plan and process
   3. BCMHC Policy and Procedure for General Staff Meeting, SD014
4. BCMHC Policy and Procedure for Quality of Care Review Boards, S057

B. Employee Satisfaction
   1. Suggestion Box

C. Recognition
   1. “You Helped Me Do My Job” at General Staff
   2. “Thank-you” bulletin board
   3. Quarterly and Annual Outstanding Employee selection and recognition
   4. State Employee Recognition Week

D. Policies and Procedures pertaining to employee retention
   1. BCMHC Policy and Procedure for Affirmative Action, HR097
   2. BCMHC Policy and Procedure for Employee Transfer Within the Center, HR017
   3. BCMHC Policy and Procedure for Private Practice, HR056
   4. BCMHC Policy and Procedure for Licensing of Clinical Staff as Licensed
      Professional Counselors/Licensed Marital And Family Therapists, HR007
   5. BCMHC Policy and Procedure for Red Cross First Aid and CPR Training, S060
   6. BCMHC Policy and Procedure for Review of EPMS Evaluations, HR012
   7. BCMHC Policy and Procedure for Body Fluid and Bloodborne Pathogen
      Infection Control Policy, S047
   8. BCMHC Policy and Procedure for Staff Development Plan, SD064
   9. BCMHC Policy and Procedure for Criminal Sexual Assault, S005
  10. BCMHC Policy and Procedure for Cultural Diversity Plan, G013
  11. BCMHC Policy and Procedure for Drug Free Workplace, HR077
  12. BCMHC Policy and Procedure for Employee Assistance, HR072
  13. BCMHC Policy and Procedure for Ethics, G087
  14. BCMHC Policy and Procedure for Insurance Coverage, G071
  15. BCMHC Policy and Procedure for Laboratory Testing for Alcohol/Drug Content
      of Employee, HR079
  16. BCMHC Policy and Procedure for Leave, HR028
  17. BCMHC Policy and Procedure for Nepotism, HR080
  18. BCMHC Policy and Procedure for Personnel Records, HR090
  19. BCMHC Policy and Procedure for Tobacco Use in the Center, S050
  20. BCMHC Policy and Procedure for Staff Development Plan, SD064

Berkeley Community Mental Health Center follows all South Carolina Department of Mental Health (SCDMH) Division of Human Resources Policies and Procedures (Section 3-200).
PERSONNEL RECORDS

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<tr>
<th>Section Number: II - HUMAN RESOURCES</th>
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<tr>
<td>Policy Number: HR090</td>
<td>Date of Origin: September 1997</td>
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<tr>
<td>Revision Number: 03</td>
<td>Revision Date: 4/04, 2/07, 3/08</td>
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<td>Approved by: [Signature]</td>
<td>Date Approved By Board: September 1997</td>
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PURPOSE

POLICY: The purpose of this policy is to establish procedures of the Berkeley Community Mental Health Center (BCMHC) regarding the maintenance and confidentiality of records maintained at the facility level in compliance with Department of Mental Health Directive #722-88.
PROCEDURES:

I. The South Carolina Department of Mental Health (SCDMH), Division of Human Resources, maintains the official personnel record of all employees of the department. Employees of the Division of Human Resources are the only persons authorized to remove a personnel record from the files for any reason.

The Berkeley Community Mental Health Center (BCMHC), Human Resources Office, maintains field folders on all BCMHC employees. These records are intended for information purposes and are not considered the official personnel record. The field records are used by the facility personnel representative for all business related to personnel issues. The facility level field folder includes all information maintained in the official personnel record as well as all oral/written reprimands/counselings given to the employee.

II. An employee, his/her supervisor, Program Director, Center’s personnel representative, Director of Administration and Executive Director are also authorized to review the employee’s field folder. A review of the record will be conducted within the confines of the personnel office.

Employees authorized to access personnel field folders and personnel office employees are not authorized to discuss or release any information contained in the facility level field folders except to those individuals authorized to review such files.

In the event an employee requests a transfer to an area under another supervisor, information will not be released to the hiring supervisor, nor will the hiring supervisor be allowed to review the employee’s field folder, unless a written statement signed by employee granting permission to review the file is provided to the personnel representative.

III. The field folder is maintained on file for a period of two years following an employee’s termination, at which time the contents of the folder are destroyed.

The official personnel record is maintained on file for a period of two years following an employee’s termination, at which time the contents of the folder are microfilmed and the original is destroyed.

IV. All employees are entitled to a copy of any information maintained in the facility level field folder. Copies of personnel information should be requested through the employee’s supervisor or the personnel representative. Copies of the facility level field folder shall only be made available to the employee or in accordance with the Freedom of Information Act as stated in SCDMH Directive #722-88. Copies of the official personnel record will be provided to the employee at the employee’s request or at the request of other authorized sources for an administrative fee of $5.00 for the initial copy and .15
cents per copy thereafter.

V All requests for computer access to personnel related information must be submitted in writing through the SCDMH Director, Division of Human Resources and the BCMHC Executive Director.

VI All requests for any employment or wage verifications will be forwarded to the SCDMH, Division of Human Resources Department. BCMHC employees are not authorized to release any information to outside sources regarding any information contained in the facility field folders or any information regarding employee job performance while employed at BCMHC. Verification requests are submitted in writing to the SCDMH Division of Human Resources.
PURPOSE/
POLICY: To establish policy and procedures relating to the hiring of staff at Berkeley Community Mental Health Center (BCMHC) in accordance with South Carolina Department of Mental Health (SCDMH) Division of Human Resources Employment Policies and Procedures Guidelines. It is the responsibility of the Executive Director to assure that a primary and secondary person is designated and trained in these procedures. These employees should be identified as having duties and responsibilities in Human Resources Management.
PROCEDURES:

I. In compliance with EEO and Affirmative action, to avoid discrimination against any employee or applicant for employment, the Employment Policy for BCMHC is to:
   A. Recruit, hire, train, and promote for all job classifications without regard to race, sexual orientation, age, gender, color, national origin, religion, disability, political affiliations or opinions.
   B. Base all decisions of employment so as to further the principles of equal employment opportunity and affirmative action. Decisions will be based solely on individual skills and abilities, and fitness of applicants and employees related to the specific job without regard to non-job related factors.

II. Primary Persons Responsible for Human Resources Management
   A. The Center Human Resources Representative is designated as the primary person responsible for ensuring that BCMHC meets the Fair Labor Standards Act (FLSA), EEO, and Affirmative Action guidelines in all hiring practices. The Director of Administration is designated and trained as the secondary person responsible for meeting these guidelines. The Executive Director and Director of Administration are also charged with ensuring that BCMHC meets established laws and regulations.
   B. Supervisory and management staff are required within (30) days of employment to have Employee Performance Management Systems (EPMS) training. This training also provides information to managers and supervisors as to employee rights in the work place.
AFFIRMATIVE ACTION PLAN

Section Number: II - HUMAN RESOURCES  
DMH Reference: #817-99

Policy Number: HR097  
Date of Origin: September 1997

Revision Number: 05  
Revision Date: 12/00, 10/01, 12/02, 3/06, 3/08

Approved by: [Signature]  
Date Approved by Board: January 11, 2001

PURPOSE/POLICY: As an embodiment of the Center’s commitment to equitable treatment of employees and effective management, the following policy and procedures are in place. Equal employment opportunity will be provided to all present and potential employees regardless of race, color, religion, national origin, sexual orientation, physical or mental disability, political affiliation, sex, or age except where sex or age is a bona fide occupational qualification. This policy applies to all personnel actions including, but not limited to, recruiting, hiring, compensation, benefits, promotions, transfers, layoffs, recall from layoffs, social or recreational programs of this organization.

MISSION STATEMENT
To support the recovery of people with mental illnesses.
PROCEDURES:

I. Responsibilities for Implementation
Debbie Calcote, Executive Director, serves in the capacity as Berkeley Community Mental Health Center’s Equal Employment Opportunity Officer. She has the authority to implement every facet of the Center’s plan and reports directly to the Board of Directors. Specific responsibilities of the Equal Employment Opportunity Officer may include, but are not limited to:

A. Developing policy statements, programs and internal communication techniques.
B. Assisting in the identification of problem areas.
C. Assist managerial personnel in finding solutions to problems.
D. In conjunction with the South Carolina Department of Mental Health Human Resources Division, complete audit and reporting systems that will measure the Center’s Affirmative Action Plan and indicate needs for remedial actions.
E. Holding periodic discussions with managerial personnel, supervisors, and employees to be certain Center policies are being followed.

II. Recruitment
The Center works to enhance the cultural diversity of the applicant pool for vacant positions through the following mechanisms:

A. Available jobs are listed online at www.jobs.sc.gov.
B. Employment opportunities are forwarded to manpower development and placement agencies through the Employment Manager of the Department of Mental Health’s Human Resources Division as an equal opportunity employer.
C. Newspaper, which may include local, regional and state papers, and periodical advertisements.
D. Word of mouth dissemination of vacancies by current employees.
E. Recruitment efforts on minority campuses and advertisements in minority media are accomplished through the Department of Mental Health Human Resources Division.

III. Employment
The Center has established policies and procedures and adheres to all Department of Mental Health policies and procedures governing the employment process and defining responsibility of the organization to promote and ensure equal employment opportunity.

Supervisors understand their work performance will be evaluated on their promoting equal opportunity for their area of responsibility. In the interviewing and hiring process, supervisors will give consideration to persons of diverse cultures who can contribute to the Center’s goal of reflecting the diversity of persons served.
IV Retention
All employees are encouraged and afforded opportunities to participate in Center and/or Departmental training, educational, recreational and social activities. All employees are encouraged to seek consideration for promotional opportunities for which they are qualified.

V Evaluation of Affirmative Action Plan
The Equal Employment Opportunity Officer collects and provides data to the Board of Directors which illustrates the recruitment, hiring, and retention of culturally diverse employees. Enhancements in the Center plan will be considered and implemented as needed.
**PURPOSE:** Diverse job responsibilities at the Berkeley Community Mental Health Center impede communication and interaction among staff on a professional and personal level. Providing a forum within which staff can address job-related issues applicable to all and interact in a supportive manner is vital to the function of the Center.

**POLICY:** Berkeley Community Mental Health Center will hold General Staff Meetings on a semi-annual basis to address issues essential to the functioning of the Center to include administrative, operational and inservice education issues, and to enhance communication among staff in a supportive manner.
PROCEDURE: General Staff Meetings will be held semi-annually. Since this is the only opportunity for the entire staff to meet, attendance is mandatory. Therefore, no scheduled sick leave or single day of annual leave will be granted for this day. Exceptions requested will be discussed with supervisors. Coverage of reception areas, emergency services and medical services will be rotated allowing all staff to attend General Staff Meetings.

An agenda will be distributed prior to General Staff Meeting. Items to be included should be routed to the Executive Director at least one week prior to the General Staff Meeting.

All staff are welcomed and encouraged to express ideas, comments and concerns during this meeting.
PATIENT AND FAMILY EDUCATION

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<tr>
<th>Section Number: III - STAFF DEVELOPMENT/COMMUNITY RESOURCES</th>
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<td>Revision Number: 10</td>
<td>Revision Date: 12/96, 2/98, 8/01, 3/06, 2/10, 2/11, 2/12, 5/13, 8/15, 7/16</td>
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<td>Approved by: [Signature]</td>
<td>Date Approved by Board: March 1998</td>
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PURPOSE: To establish a documented, efficient system for the education of patients and their families regarding mental illness, medications, and healthy lifestyle.

POLICY: Berkeley Community Mental Health Center will offer education to patients and their families regarding mental illness, treatments, and prognosis. To insure patients and families have access to this education, the following procedures were adopted.
PROCEDURE:

PHYSICIANS/APRNs:
Physicians/APRNs in the Center will provide personnel providing direct service to the patient, patients and their families with education about medications on an on-going basis. Evidence of this process will be documented in Physician’s Service Notes. This education and information will include but is not limited to:

- How the medication works
- Intended benefits and rationale as related to the behavior or symptoms targeted by this medication, along with biological principles for each medication
- Side effects, unusual effects and contraindications
- Potential implications between medications and diet/exercise
- Alternative medications – use and potential drug interactions
- Potential reactions and dangers associated with combining prescription and non-prescription medications, alcohol, tobacco, caffeine, alternative medications, and illegal drugs.
- Proper storage of medication
- Risks associated with each medication, including metabolic risks such as weight gain, diabetes, increased cholesterol levels, etc.
- Alternative treatments instead of medication
- Early signs of relapses associated with medication efficacy and/or non-adherence
- Instructions on how to self administer medications
- Need for any laboratory monitoring
- Use and risks of medications with women of childbearing age or pregnant women
- Importance of taking medication as prescribed and any barriers to adherence
- Resources available for financial assistance with medication
- Wellness and recovery management to include diet, and exercise with medication dietary restrictions

THERAPISTS:
As a fundamental element of service, therapists will provide individualized education about recovery concepts, mental illnesses and treatments. Throughout the course of services, patients and families will have opportunities to discuss their specific issues related to recovery, signs and symptoms of illness, relapse and responses to treatments.
STAFF DEVELOPMENT PLAN

Section Number: III – STAFF DEVELOPMENT/COMMUNITY RESOURCES

DMH Reference: Directive #913-12

Policy Number: SD064

Date of Origin: September 1997

Revision Number: 12

Revision Date: 4/03, 6/04, 10/05, 5/06, 2/07, 4/08, 2/10, 2/12, 5/12, 4/13, 5/14, 7/16

Approved by: [Signature]

Date Approved by Board: September 1997

PURPOSE: Berkeley Community Mental Health Center establishes this Staff Development Plan for the overall purpose of ensuring that all staff are afforded equal opportunities and support that fosters growth in the areas of professionalism, ethical conduct, education, training, supervision and professional development.

POLICY: The purpose of this plan is to provide staff development guidance in the areas of new employee orientation, staff training (both external and internal to the Center) and individual development plans between staff and supervisors.
PROCEDURES:

I. AUTHORITY

Staff Development activities are coordinated through the Director of Professional Training and Development in collaboration with the personnel office under the direction of the Executive Director, who has the ultimate responsibility for the training compliance among all staff. Supervisory staff are responsible for establishing development expectations and enforcing inservice requirements that facilitate implementing the purpose of this plan. This will be accomplished in a way that is consistent with the Center's mission and philosophy.

A. Clinical Supervisors - The clinical supervisors are responsible for overseeing the following staff development areas as it pertains to all clinical staff:
   1. Developing and implementing clinical supervisory activities for each clinical staff dependent upon individual staff needs.
   2. Coordinating, monitoring and evaluating various facets of clinical supervision needs on an individual and programmatic basis.
   3. Working in conjunction with QI office to ensure clinical staff members are appropriately credentialed and/or licensed in terms of agency and programmatic requirements.
   4. Assign, facilitate and conduct necessary training events as deemed needed.
   5. Supervisors will ensure the consistent and timely application of this plan and all associated policies and procedures relating to staff development activities.
   6. Supervisors will ensure that written staff development goals and objectives are reviewed and monitored on a routine basis. These goals and objectives are incorporated into the EPMS (Employee Performance Management System) at the time the Planning Stage/Objectives are developed.
   7. Annual performance appraisals will include a supervisor's review of the individual’s staff development goals and objectives.

B. Clinical Support Supervisors – The clinical support supervisors are responsible for overseeing the following staff development areas as it pertains to all clinical support staff:
   1. Developing and implementing supervisory activities for each clinical support employee dependent upon individual staff needs.
   2. Coordinating, monitoring and evaluating various facets of supervision needs on an individual and programmatic basis.
   3. Assign, facilitate and conduct necessary training events as needed.
   4. Supervisors will ensure the consistent and timely application of this plan and all associated policies and procedures relating to staff development activities.
   5. Supervisors will ensure that written staff development goals and objectives are reviewed and monitored on a routine basis. These goals and objectives are incorporated into the EPMS (Employee Performance Management System) at the time the Planning Stage/Objectives are developed.
   6. Annual performance appraisals will include a supervisor's review of the individual’s staff development goals and objectives.

C. The Director of Professional Training and Development works closely with staff and supervisors to identify training needs and coordinating inservice training activity
designed to meet those needs.
1. Compile employees’ staff development goals/objectives into master list for planning, delivering and coordinating training/development activities.
2. Implement and maintain file on employee professional licensure status.
3. In collaboration with Director of Clinical Services, identifies evidenced based practices for implementation. Provides and/or coordinates EBP training for clinicians to include documentation of EBP in medical records. Develops and provides consultation teams for adherence to EBP fidelity.

D. All Staff Members - All individual staff members are responsible for the initiation and maintenance of their overall professional development needs within their respective areas, including application for, and maintaining of, appropriate licensure and training opportunities which enhance the performance of their duties.

II ORIENTATION
All new employees will receive a thorough, comprehensive orientation to the agency, as well as their specific areas of responsibility. Upon completion of orientation, the immediate supervisor will forward the orientation checklist to the Human Resources Representative for placement in the individual credentialing file.

A. Clinical Staff - All new professional staff will participate and complete appropriate areas of the Orientation Checklist.
   1. The Human Resources Representative and immediate supervisor of the new employee will be responsible for coordinating and monitoring all aspects of the orientation process.
      a. Establishing dates and times for the new employee to receive required information from appropriate personnel.
      b. Coordinating dates and times for the new employee to observe and then demonstrate various aspects of their duties and responsibilities.
      c. Provide thorough and adequate feedback to the new employee on a routine and timely basis.
   2. The clinical supervisor will provide adequate clinical information, supervision, observation and training to the new clinical employee to facilitate appropriate clinical privileging, to include individualized peer support in the form of “shadowing” a mentor in the clinician’s service area. The area supervisor will determine the mentor and length of time for each new employee to be mentored.

B. Clinical Support Staff - All new clinical support staff will participate and complete appropriate areas of the Orientation Checklist.
   1. The Human Resources Representative and immediate supervisor of the new employee will be responsible for coordinating and monitoring all aspects of the orientation process.
      a. Establishing dates and times for the new employee to receive required information from appropriate personnel.
      b. Coordinating appropriate dates and times for the new employee to observe and then demonstrate various aspects of their duties and responsibilities.
      c. Provide thorough and adequate feedback to the new employee on a routine and timely basis.

C. Interns/Students/Volunteers/Part-time Staff - All new interns/students/volunteers/
part-time staff will participate and complete appropriate orientation activities.
1. The Human Resources Representative and the immediate supervisor of the
   employee/volunteer/trainee will be responsible for coordinating and monitoring all
   aspects of the orientation process.
   a. Establishing dates and times for the new employee to receive required
      information from appropriate personnel.
   b. Coordinating dates and times for the new employee to observe and then
demonstrate various aspects of their duties and responsibilities.
   c. Provide thorough and adequate feedback to the employee/volunteer/
      trainee on a routine and timely basis.
2. If the employee/volunteer/trainee is acting in a clinical capacity, the clinical
   supervisor will provide appropriate and adequate clinical information, supervision,
   and training to them on a routine, timely basis to facilitate appropriate clinical
   privileging.
D. Temporary Staff - Orientation and training for temporary staff hired into a clinical
   position will follow guidelines as outlined in Section A above and temporary staff hired
   into a clinical support position will follow section B above.

III MANDATORY AND ONGOING TRAINING
The agency will make every reasonable effort to facilitate maximum opportunities for training
and continuing education as it relates to duties and responsibilities.
A. Mandatory Training - Mandatory training will be provided and scheduled for all staff in
   accordance with current standards and practices. This includes, but is not limited to:
   1. Blood Borne Pathogens/PPE/Infection Control/Tuberculosis Exposure Training
   2. Hazard Communication Training
   3. Fire Safety Training, Bomb Threat and Utility Emergency to include evacuation
      procedures.
   4. The Behavioral Emergency Stabilization Training Program (BEST)
   5. CPR
   6. Patient Rights and Rights of Staff Members
   7. Confidentiality/Privacy/HIPAA
   8. Cultural Sensitivity
   9. Corporate Compliance
   10. Workplace Violence
   11. Medical and Behavioral Emergencies
   12. Safety in the Field
   13. Ethics and Code of Conduct
   14. Customer Service
   15. Promoting Wellness of the Person Served
   16. Person-Centered Practice
   17. Unique Needs of the Person Served
   18. Reporting and Documenting Adverse Incidents
   19. Medication Management, if appropriate
   20. Transportation Procedures for staff who transport patients
   21. Reporting Abuse and Neglect
Mandatory training may be provided within the scope of General Staff meetings (which are
held bi-annually), online training modules, QI Inservice time (which is scheduled monthly),
or at special training times and events scheduled throughout the year (such as the case with CPR and Cultural Sensitivity training). At the discretion of the Executive Director, staff may be exempted from their scheduled training if job duties dictate and fulfill mandatory training through Pathlore online modules.

B. Quality Improvement In-Service Training - Supervisors are responsible for ensuring that individual staff receive feedback and training within their respective areas of duties and responsibilities on an ongoing basis. The Quality Improvement Program Coordinator implements in-service training events in accordance with this plan and associated agency guidelines and practices. Identified training shall be scheduled and carried out in the following manner:

1. Supervisors and/or staff, many times within the scope of Leadership Council or Quality Improvement Team meetings, will help identify training needs and be responsible for suggesting a presenter. The Quality Improvement Program Coordinator will ensure no conflicts exist with prior scheduled training.
2. Supervisors will ensure that affected staff follow through in attending the training event.
3. The presenter/trainer will ensure that the Training Sign-in Sheet is completed prior to completion of the training event along with the agenda/curriculum for the training. These documents are maintained by the Human Resources Representative.
4. Mandatory blocks of time will be scheduled monthly for appropriate in-service training aimed at specific staff and subject matter. This may include, but is not limited to:
   a. Clinical Practices
   b. Clinical Policies/Procedural Issues/Updates
   c. Administrative Policies/Procedural Issues/Updates
   d. Quality Improvement Training
   e. Organizational Issues/Updates
   f. Mandatory training topics
5. Depending on relevancy of training content, clinical support staff will be requested to participate in QI Inservice training. Training topics and target audience is routinely posted to keep staff well informed of upcoming training activities.
6. Attendance reports are provided to supervisory staff as needed. “Make-ups” are required unless exception is determined by supervisor relating to relevancy of training content with job functions.

C. Workshop Training Events - The Center will make every effort to provide adequate opportunities for formal training apart from in-service events.

1. The Human Resources representative will make information concerning workshops, seminars and formal training/educational events readily available to appropriate staff.
   a. Verbal dissemination in General Staff meetings, Leadership Council, and Quality Improvement Team.
   b. Training notebook maintained in mailroom which contains workshop brochures.
   c. E-mail notification
2. Staff members are responsible for keeping track of their individual formal training hours and submitting written proof of attendance to the Human Resources Representative for submission to his/her credentialing folder and Pathlore staff transcripts.
3. The following procedures will be followed when requesting to attend formal training events outside of the Center:
   a. Complete and submit the Workshop/Training Attendance Request form to the immediate supervisor for review with attachments of registration form and brochure containing information on training event.
   b. If overnight stay and/or travel is required, the staff member requesting will also submit a Travel Voucher/Request with the request.
   c. Submit application for leave (P-14) requesting training leave.
   d. The immediate supervisor is responsible for ensuring the adequacy and appropriateness of the requested training.
   e. Approval of the requested training is granted by the Executive Director.
   f. Upon notification of approval, staff members are responsible for ensuring continuity of service delivery and patient care.
      (1) Clinical staff will ensure that scheduled patients and groups are covered during training attendance. Clinical support staff will coordinate coverage of their responsibilities with supervisor.
      (2) Clinical staff will ensure that training events are properly blocked off their schedules.
      (3) All staff will be responsible for mailing their registration forms.
   g. Upon completion of the training event, staff members are responsible for:
      (1) Sharing information learned with supervisors and co-workers as indicated.
      (2) Forwarding certificates acquired from the training, leave slips (Form P-14), Training Request Form indicating training was attended, and Travel Support Forms to the Human Resources Representative, who will forward needed information to the Business Manager.
      (3) Workshops not attended - staff will forward Training Request Form, indicating training not attended to Human Resources Representative. Employee will destroy SCDMH P-14 Application for Leave and Travel Support Form.

IV. CLINICAL SUPERVISION

Supervisors are responsible for assuring that clinical and work supervision occurs on a regular basis and is properly documented.

A. Each clinical supervisor and clinical staff member should have clinical training to ensure that they are able to carry out their clinical job duties. Clinical supervisors should have, at a minimum, two (2) years of experience providing clinical services.

B. Supervisors shall establish training plans for their clinical staff members based on their level of skill and indicated need.

C. Supervisors shall establish and maintain scheduled supervision for clinical staff members they rate under the Employee Performance Management System or directly supervise.
   1. The schedule shall include, at a minimum, one (1) supervisory conference per month. Supervisory conferences may be scheduled more often based on the individual needs of the clinical staff member. Supervision may be in an individual or group setting. Disciplinary issues with individual supervisees will not be discussed in the group setting.
      a. Each supervisory conference shall be of sufficient duration to assure support, feedback, and direction for all clinical staff.
      b. The supervisor shall tailor the content of the conference to meet the needs of each clinical staff member, intern, or volunteer.
      c. Supervisory conferences must be documented and maintained by the supervisor for a minimum of three (3) years or the duration of the supervisees’ employment.
   2. Clinical supervision shall annually include at least one (1) direct (live) observation, live supervision, or co-therapy.
3. Supervision of evidenced-based practices (EBP) should be congruent with the standards established by the practice and occur as frequently as essential to maintain fidelity of the EBP.

D. Clinical supervision shall focus on the use and provision of services to patients as outlined in each patient’s individual plan of care (IPOC).

1. Supervisors shall choose at least one random medical record per month for review, in addition to the patients/records presented by the supervisee for supervision.
   a. Each clinical staff member shall have no less than one medical record audited by his/her supervisor each month for discussion during supervision. Supervisors should ensure that treatment being rendered is directly related to the patient’s IPOC.
   b. Additional medical records shall be audited by the supervisor as necessary.
   c. The supervisor will ensure that entry of documentation is in compliance by reviewing any outstanding documentation under the audit tab of the electronic medical record (EMR).

2. Supervision of clinical staff must be ongoing, documented, and maintained. When applicable, the supervision should address the following and be documented on the clinical supervision form:
   a. Accuracy of assessment and referral skills.
   b. The appropriateness and medical necessity of the treatment or service intervention selected relative to the specific needs of each person served.
   c. Treatment/service effectiveness as reflected by the person served meeting his or her individual goals per the IPOC.
   d. The provision of feedback that enhances the skills of clinical staff.
   e. Issues of ethics, legal aspects of clinical practice, and professional standards.
   f. Clinical documentation issues identified through ongoing compliance review.
   g. Cultural diversity issues.
   h. Competencies of Clinical Practice, including the specific needs of the person served, person-centered plan development, interviewing skills, evidence-based treatments, the role of the Peer Support Specialist, wellness and recovery, and educational opportunities for families.

V. STAFF DEVELOPMENT FILES/DOCUMENTATION

Documentation of all training events is maintained by the Human Resources Representative and filed in individual staff members credentialing files.
DONATIONS AND CONTRIBUTIONS

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<th>Section Number: III - STAFF DEVELOPMENT/COMMUNITY RESOURCES</th>
<th>DMH Reference: DoFS Directive #5.3.4</th>
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<td>Date of Origin: September 1997</td>
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<td>Revision Number: 03</td>
<td>Revision Date: 2/03, 5/06, 3/13</td>
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<td>Date Approved by Board: September 1997</td>
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PURPOSE: To establish donation and contribution procedures in compliance with South Carolina Department of Mental Health (SCDMH) Division of Financial Services (DoFS) Directive #5.3.4.

POLICY: In compliance with SCDMH Division of Financial Services Directive #5.3.4, the Berkeley Community Mental Health Center (BCMHC) will ensure donations and contributions are properly accounted for and used according to law.

Provisions of the Appropriation Act
The General Appropriation Act requires that, “Donations or Contributions from sources other than the Federal Government, for use by any state agency, shall be deposited in the State Treasury, but in special accounts, and shall be withdrawn from the treasury as needed to fulfill the purposes and conditions of the said donations, or contributions, if specified, and if not specified, as may be directed by the proper authorities of the department.”

“The expenditure of funds by agencies of the State Government from sources other than General Fund appropriations shall be subject to the same limitations and provisions of law applicable to the expenditure of appropriated funds with respect to salaries, wages or other compensation, travel expense, or other allowances or benefits for employees.”
PROCEDURES:

I. The receipting of all donations/contributions must conform to applicable policies and procedures contained in Section 5.3 of the SCDMH DoFS Manual, COLLECTION OF CASH FUNDS. Cash is receipted using SCDMH Form V-7. Any cash donations or contributions received at BCMHC must be directed to the Business Manager, or in her absence, the Director of Administration. The Business Manager, or in her absence, the Director of Administration, is responsible for reporting the receipt of donations or contributions to the BCMHC Human Resources Representative, who is responsible for reporting to the SCDMH Community Resource Developer.

II. Solicitation from the community shall be coordinated with the Executive Director to prevent duplication of solicitation. SCDMH for V-8, “Community Contacts”, must be completed indicating community contacts. The guidelines for solicitation are included with the exhibit.

III. It is the policy of BCMHC to send an acknowledgment letter to the donor/contributor. The BCMHC Human Resources Representative is responsible for the coordination of these letters and maintaining copies of these letters and notes.

IV. Cash donations/contributions must be deposited into the Center depository account. Cash donations/contributions received for specified purposes must be clearly identified on the BCMHC cash collection records. Cash donations/contributions without a specified purpose must also be recorded on the BCMHC cash collection records.

V. Expenditures are processed through the SCDMH SCEIS system or the Procurement Card Program. The Center Business Manager, or in her absence, the Director of Administration, is responsible for providing the appropriate documentation supporting the disbursement of donated funds designated for a specific purpose. Expenditures of donations without a specified purpose may be used as determined by the Executive Director. Detailed records are maintained by the Business Manager showing the purposes for all expenditures of both types of donated funds.

VI. Donations of material goods may be used in the appropriate programs as specified by donor restrictions or for the general good of BCMHC as determined by the Executive Director.

VII. The Center Human Resources Representative is responsible for maintaining accurate records of all donations/contributions. A Volunteer Report, SCDMH Form V-12A, is completed monthly by the BCMHC Human Resources Representative and submitted to the Director, SCDMH Office of Community Resource Development. This report indicates the total of cash and material donations received by BCMHC and is used to compile an annual report by SCDMH that provides totals of all donations of cash and material goods received for the fiscal year. All records pertaining to donated cash or material goods are subject to audit by appropriate authorities.
# COMMUNITY RESOURCE DEVELOPMENT

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<th>Section Number: III - STAFF DEVELOPMENT/COMMUNITY RESOURCES</th>
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<td>Approved by: [Signature]</td>
<td>Date Approved by Board: January 11, 2001</td>
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**PURPOSE:** The purpose of Community Resource Development is to utilize volunteers and other community resources to promote mental health and to help limit the effects of mental illness. By providing positive and necessary contributions to total patient care and treatment, community resources and volunteers serve as liaisons between the patients and the community. They help to promote an understanding of Berkeley Community Mental Health Center, its services and needs; foster the development of additional community resources for the benefit of the patients and Center; and provide the community with an opportunity to contribute services, material goods and monetary donations to help meet the needs of the patients.

**POLICY:** Berkeley Community Mental Health Center encourages, promotes and administers a community resource program that will provide a wide range of services to the patients and staff. The program will include such components as helping to determine the needs of patients and staff members; recruiting, interviewing, screening, orienting, placing, supervising, training, evaluating and recognizing volunteers and donors; accepting and processing monetary and material donations; record keeping; and enhancing community awareness and involvement through coordinated consultation, education and prevention activities.
PROCEDURES:

I Volunteers
A. Under the supervision of the Executive Director, the Human Resources Representative administers, coordinates and directs the volunteer program.
B. Staff members are to be supportive of developing unique ways to utilize services of volunteers and other community resources in meeting the needs of patients and in making the services of the facility more effective.
C. Potential volunteers will be referred to the Human Resources Representative before their services are accepted. Volunteers selected for service will be screened to ensure they have the necessary capabilities to properly perform a particular job or have the capability to engage in a training program. Placements of volunteers must be approved by Program Director of the area of service.
D. Services of volunteers are an integral part of the overall Center program. Care will be taken to ensure that volunteers and staff understand their respective duties and responsibilities, their relationship to one another, and their respective roles in fulfilling the objectives of the Center.
E. All volunteer functions will be performed under employee supervision, the level and grade of such supervision being in the proper relationship to the complexity of the job.
F. Berkeley Community Mental Health Center will recognize its volunteers, donors and staff members who are supportive of the volunteer program.
G. A monthly report, including information relating to the total number, hours and duties of all volunteers, as well as the monetary value and general description of all donations, will be provided by the Human Resources Representative. A fiscal year report will also be compiled by SCDMH with copies being forwarded to the Center’s Executive Director.
H. No person will be denied the opportunity to serve as a volunteer in any facility or program of the SCDMH on the basis of a physical disability, gender, age, race, sexual orientation, religion, color, nation of origin or having received treatment for mental illness. All persons applying to serve as volunteers will be interviewed, screened and their qualifications assessed. Final selection will be based on the ability of the person to perform specific volunteer assignments. If no appropriate placement is available at the time a person is determined to be qualified for volunteer service in the Department of Mental Health, they should be encouraged and assisted in locating an appropriate volunteer assignment in another community setting.
I. The services of volunteers are very much appreciated by Berkeley Community Mental Health Center. However, when deemed appropriate, it may be necessary at any time to terminate the services of any individual volunteer or group volunteers. The acceptance of the services of a volunteer or group of volunteers does not guarantee the continued availability of a position slot or time for such services to be accepted.

II Assessment of Needs
A. Need for volunteer service is determined by consultation, cooperation and coordination between the Human Resources Representative and staff from other disciplines.
B. Staff members who wish assistance from volunteers will forward request to the Human Resources Representative stating type of work, duties, qualifications, number of persons needed, days and hours preferred.

III Interviewing and Screening  
A. Persons or groups applying to serve as volunteers will:  
   1. Complete a Volunteer Application if planning to serve as a regular volunteer or complete a One Time Activity Form if serving as a one time volunteer.  
   2. Be interviewed and screened by the Human Resources Representative.  
   3. Read and adhere to SCDMH Directives #837-03, Privacy Practices; #885-07, Abuse, Neglect or Exploitation of Patients Prohibited; #775-93, Searches for Contraband/Stolen Property; #842-03, Harassment-Free Workplace; and #730-89, Drug Free Work Place.  
   4. Read and be aware of the information contained in Patient Rights.  
   5. Read and adhere to BCMHC Tuberculosis Infection Control Policy, S051.  
   6. Provide written or verbal references from at least two individuals or sources if required by the interviewing staff member.  
   7. Show evidence of ability to learn required functions and to perform satisfactorily.  
   8. Minors (less than 18 years of age) must have written consent of a parent or guardian prior to volunteering. The assigned service will be performed in a nonhazardous environment and will comply with appropriate requirements of child labor laws.  
   9. A staff psychiatrist will review the medical records of current patients/former patients to assist in determining areas in which the individual’s volunteer services can be most suitably utilized.

V Orientation and Training  
A. All regular volunteers will receive a general orientation from his/her appointed supervisor. The orientation will include the following components:  
   1. Mission, philosophy and history of the Center  
   2. Organizational structure of the Center  
   3. Relationship of Center to the other SCDMH facilities  
   4. Types of patients and their needs  
   5. Tour of building  
   6. Roles of volunteers and staff members  
   7. Privacy (confidentiality) and Patient Rights  
   8. Orientation to their work area and explanation of job assignments

B. Ongoing training will be provided as needed.

C. One time service volunteers will be given a briefing before being allowed to provide any service. The orientation briefing will include elements in Section V.A, “Orientation and Training”, that are necessary for successful and safe conduct of the activity. Acknowledgement of receipt of SCDMH Directive #837-03, Privacy Practices, will be signed and a One Time Activity Form will be completed at this time. Both forms will be forwarded to the Human Resources Representative immediately following the event.
VI Placement and Supervision
   A. Scheduling of volunteers for programs and services will be coordinated by the Human Resources Representative and the person supervising the volunteer.
   B. Volunteers will be placed as needed and/or when staff request them for service. Placement will be made based on volunteer availability and appropriateness.
   C. All volunteers must have a clearly identified supervisor who is responsible for direct management of the volunteer. A volunteer may act as a supervisor of other volunteers provided the supervising volunteer is under direct supervision of a paid staff member.
   D. Staff members will be responsible for training and supervision of volunteers who work within their jurisdiction.
   E. Staff members supervising volunteers are responsible for maintaining communication with the Human Resources Representative on the status of the volunteer and for the timely reporting of the assigned volunteer’s monthly work hours. This information is due to the Human Resources Representative by the 7th day of each month. The Human Resources Representative will be informed immediately of any substantial change in the work or status of a volunteer.

VII Evaluation
   A. Individual or group volunteers will be evaluated by the supervisory staff to whom they are assigned.
   B. Periodic volunteer satisfaction surveys may be conducted by the Human Resources Representative.

VIII Recognition
   A. Recognition of volunteers may be made in any of the following ways:
      1. Written letters of appreciation may be given to volunteers and their families.
      2. Presentation of certificates for service.
      3. Nominations for outstanding service made to SCDMH Volunteer Services by staff.
      4. Receptions or luncheons held to honor volunteers.
      5. Articles and pictures submitted to the departmental newsletter.
      6. News releases to radio, TV and local newspapers.
   B. Copies of letters, news articles or notes in reference to the recognition will be filed in the volunteer’s personnel folder.

IX Resignation and Termination of Assignments
   A. Written notice of resignations would be preferred; however, notice may be given in person or by phone. Exit interviews are helpful for evaluation purposes and are an opportunity to thank the volunteer. Exit interviews will be conducted whenever possible by the supervisor.
   B. Termination of an assignment may take place and the volunteer released if the volunteer:
      1. Is not productive
      2. Violates regulations
      3. Unsatisfactory evaluation by supervisor
      4. The following procedures have been followed:
a. A conference should be held between the volunteer and supervisor to clearly outline the problem and explore possible solutions. The results of this conference, including timeframes for future meetings and review of volunteer performance and satisfaction, should be documented.

b. If the problem continues, the supervisor should discuss the situation with the Human Resources Representative.

c. The Human Resources Representative should meet with the volunteer and the supervisor to carefully consider all the information. At this point options available include:
   (1) Additional training or more individualized instruction for the volunteer
   (2) Transfer of the volunteer to another assignment within the agency
   (3) Volunteer may choose to withdraw from participation in the program
   (4) Human Resources Representative may ask the volunteer to withdraw from participation in the program.

d. A personal conference with the volunteer and the Human Resources Representative will be offered and the Center Director will be notified of the results.

X Insurance
The Department of Mental health provides general liability insurance (tort) and professional liability insurance for all volunteers during the time that they are providing services for the Department for Mental Health.

XI Donations
A Donations (other than fund-raising activities)
   1. All material and in-kind donations are to be receipted and coordinated through the Human Resources Representative.
   2. All gifts of cash must be directed to the Business Manager, or, in her absence, the Director of Administration. The Business Manager is responsible for reporting the receipt of donations or contributions to the Human Resources Representative, who is responsible for reporting to the SCDMH Community Resource Developer.
   3. Monetary donations are receipted by the business office and deposited into the Center depository account.
   4. The Human Resources Representative receives material donations which will be distributed upon request for direct patient care subject to need of the individual patient and availability of the donated items.
   5. Material donations will be given to the appropriate program or where needed.
   6. Appropriate receipts will be maintained by the Human Resources Representative to reflect accountability for all items and monies received and spent.
   7. It is the policy of BCMHC to send an acknowledgment letter to the donor/contributor.

XII Record Keeping
The Human Resources Representative maintains records of all volunteer activities, direct or
indirect, and includes material, monetary and in-kind contributions. The records will include:

A. Personnel files of all volunteers
B. Monthly reports
C. Annual reports (Fiscal Year)
D. Records of contributions/donations

XIII Students/Interns
The Berkeley Community Mental Health Center maintains agreements with local programs of higher education to provide field placement for students. Students applying will:

A. Adhere to all terms and conditions as outlined in their school’s Memorandum of Agreement.
B. Be interviewed and screened by the Program Director/supervisor.
C. For any student/intern acting in a clinical capacity, the clinical supervisor will provide appropriate and adequate clinical information, supervision, and training to them on a routine, timely basis to facilitate appropriate clinical privileging.
CONSULTATION, EDUCATION AND PREVENTION

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PURPOSE: Consultation, Education and Prevention is a service provided by employees of the Berkeley Community Mental Health Center to promote mental health for all citizens.

POLICY: The employees of the Berkeley Community Mental Health Center will provide information that promotes mental health by:

A. Coordination and collaboration with other agencies and activities necessary to meet community mental health needs.

B. Education of citizens, including patients, their families and significant others, academic facilities, and service providers about the nature of mental illness, its prevention, treatment, management and prognosis.

C. Education to reduce the stigma associated with mental illness.

D. Promotion of the development of behaviors and habits that enhance good mental health.
CONSULTATION, EDUCATION AND PREVENTION
PAGE 2

PROCEDURES:

I. The Human Resources office coordinates Consultation, Education and Prevention services at the Berkeley Community Mental Health Center. The Human Resources representative:
   A. Functions as a liaison between the community and the Berkeley Community Mental Health Center and is responsible for program management and documentation of Consultation, Education and Prevention services.
   B. Keeps Center staff informed about Consultation Education and Prevention efforts. The means for this communication include, but are not limited to:
      1. Reporting to QI Team community contacts
      2. Reporting to Center Board of Director community contacts
      3. Coordination with Executive Director
      4. Posting/distributing information

II Definitions
   A. Consultation: Subcomponent designed to supplement clinical efforts aimed at the community, including clinical programming, strategies for making the best use of funds, orientation, training, coordination, collaboration and the exchange of information and resources within and outside of the agency.
   B. Education: Subcomponent which conducts activities designed to:
      1. Inform citizens, patients, families, friends, academic facilities and other service providers about the nature of mental illness, its treatment and prognosis.
      2. Increase public awareness of DMH services, the nature of mental illness, its treatment and prognosis.
      3. Promote good mental health.
      4. Decrease stigma associated with mental illness.
   C. Prevention: Activities designed to provide individuals and systems (i.e. families, schools, work place) with knowledge and skills, as well as resources, necessary to deal with stressful life conditions and to prevent or reduce the impact of serious and debilitating psychiatric illness.

III Needs Assessment: An ongoing needs assessment for CE&P services includes:
   A. Asking members of the QI Team to require staff to report CE&P offerings provided to the community.
   B. Receiving feedback from patients and families via Patient Advisory Boards, SHARE groups, suggestions and satisfaction surveys.
   C. Evaluating and responding to requests for Consultation, Education and Prevention services, most effective educational methods and the most current information available.
   D. Incorporating emerging information and needs into program development and appropriate management of consultation and education resources.
IV Consultation, Education and Prevention Services Delivery - Consultation, Education and Prevention Program services are implemented according to demand and available resources. Service delivery includes:

A. Responding, within limits of resources, to requests for offerings from any elements of the county attentive to providing programs to culturally diverse communities/groups.

B. Providing educational materials regularly for patients and their families in facility lobbies, on bulletin boards and within limits of resources providing educational materials in response to specific request.

C. Participating in SCMDH committees regarding Consultation, Education and Prevention.

D. Documenting services provided, requests not filled and evaluations of services.

V Staff Involvement in Consultation, Education and Prevention activities.

A. Any Center employee who either receives a request or initiates an outreach activity for Consultation, Education and Prevention should forward information to the Human Resources office. When the request comes directly to the Human Resources office, an attempt to recruit staff for the activity will be made.

B. Staff must receive prior approval from their supervisor before committing to participating in the activity.

C. Staff should make requests for materials (i.e. brochures, tri-fold board, etc.) needed for the activity to the Human Resources office as far in advance as possible to ensure availability and readiness.

D. The “Community Education and Prevention” form is completed by the employee who participates in the activity and forwards the form to the Human Resources office, where it is retained.

VI Documentation of Consultation, Education and Prevention Services - Consultation and education activities are documented by:

A. The completed “Community Education and Prevention Report” form is forwarded to and retained on file in the Human Resources office.

B. Records are maintained that document all information including the staff member conducting the activity.

VII Evaluation of Consultation, Education and Prevention activities may include:

A. Evaluation by attendees

B. Evaluation by persons requesting services

C. Incorporation of feedback into program development

D. Other methods deemed effective by Office of Human Resources.
TRANSPORTATION SERVICES

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PURPOSE/ POLICY:

The Berkeley Community Mental Health Center operates a transportation system to support center objectives. The operation of this system is consistent with South Carolina Department of Mental Health Directive #870-06. The system provides for limited patient transportation and the availability of state-owned vehicles for staff to use for official travel. The transportation coordinator is responsible for managing this system.
PROCEDURES:

I. Staffing Pattern - This service is managed by the vehicle operator, and Facilities Manager as his supervisor.

II Driver Selection and Screening - Center vehicles are available to staff who possess a South Carolina driver's license to perform official duties. Employees will provide a copy of their driver’s license upon employment with the Center. Employees are required to inform the Center Executive Director in the event of license revocation or suspension. Driver’s license revocation or suspension will result in the loss of the use of Center vehicles.

Prior to employment in a job which may include the operation of a state-owned motor vehicle, potential employees will provide a copy of his/her motor vehicle record obtained at the applicant’s expense from the Department of Motor Vehicles, to the Human Resources office. If the motor vehicle record shows involvement in more than two accidents in the last three years or more than six current violation points, the applicant (employee) must attend the eight-hour driver training course within six months of date of employment at own expense and on own time.

Employees are required to secure their motor vehicle record from the Department of Motor Vehicles on a triennial basis. If an employee’s motor vehicle record shows more than two accidents in last three years or more than six current violation points, the employee must attend the eight-hour driver training course within six months at own expense and on own time.

If the motor vehicle record shows involvement in more than three accidents in the last three years or more than eight current violation points, applicants will be unqualified for employment in jobs which may involve the use of state vehicles. Such employees will not be allowed to transport patients.

III Patient Transportation - The Center transportation service is available on a limited basis to patients with psychiatric symptoms so acute that public transportation is not feasible or usual means of transportation is not available or safe. Routine, recurring transportation of other patients is not provided. Transportation appointments for patients are emailed to vehicle operator. Appointments can be scheduled no more than 7 working days in advance and at least 24 hour notice given. If an emergency transportation situation arises during a workday, the vehicle operator and/or transportation supervisor must be called for scheduling.

Routinely, patients travel in Center vehicles. Exceptions are made for parents of children who are patients, or for responsible adults accompanying adult patients not able to perform independent travel. Adolescent patients, if arranged and approved beforehand, may ride without parental/adult supervision. Compliance with all state motor vehicle laws is required of all passengers transported in Center vehicles.

Final destination for patients is the Center. Drivers do not pick up patients for appointments or business other than at the Center. Drivers do not stop en route to or from the Center for the convenience of the patients (i.e. no stops at the pharmacy, grocery, etc.). Patients are returned to the same point from which they were picked up.
Employees do not transport patients in personal vehicles. The vehicle operator and/or Facility Manager is available and responsible for accessing vehicles across the Center to meet transportation needs.

Transportation of patients to local hospitals must be approved by a supervisor. A minimum of two staff must accompany the patient. One staff person must be a clinician.

Patients are not transported to initial appointments or to first appointments following hospitalization except in approved cases. These situations must be staffed with supervisor, case manager and transportation coordinator.

IV Transportation of Patients with Special Needs - Transportation of patients with special needs will be provided by center. If center transportation is not available, transportation will be coordinated with TriCounty Link or other appropriate transportation providers at center’s expense.

V Patient Scheduling - In order to arrange transportation schedules, all requests for patient transportation as described in paragraph III should be documented and received by the vehicle operator by 2:00 pm the day before the appointment whenever possible.

Verbal direct communication or transportation request forms are completed by the clinician requesting transportation service.

VI Patient Behavior - Clinicians and transportation staff work together to facilitate a safe and effective transportation system for patients. Unusual behavior will be addressed in a timely manner to avoid loss of transportation privileges. Unusual behavior is verbally reported to the clinician. The clinician will discuss this concern with the patient.

VII Evacuation - In the event of an extended emergency evacuation of the facility, available Center vehicles will be used to transport staff, patients and visitors to our temporary shelter site at Roper Berkeley Hospital.

VIII Reserving a Vehicle - All employee requests for a vehicle are made by using the vehicle log book. Reservations are made as far in advance as possible.

Center vehicles may be used to conduct any agency official business.

If a car is needed for unplanned travel and the transportation coordinator is not available, staff will consult the Vehicle Request Book for vehicle availability. Vehicles not already reserved by other staff may be used.

IX Keys - Keys and credit cards for purchase of gasoline are picked up from the designated cabinet. Vehicles, credit cards, or keys are not to be taken home overnight. Keys are returned to the designated cabinet.

X Fuel - Employees using state vehicles will refuel the vehicle upon return if there is less than one half tank of gasoline. Fuel is purchased by using SCDMH credit card, which is accepted at all major fuel stations. Only regular unleaded fuel is to be purchased.
XI Mileage Log - Each vehicle has a mileage log to be completed upon departure and return from every trip.

XII General Regulations
A. Safety: All drivers will operate vehicles in accordance with all traffic rules and regulations. Each person riding in a Center vehicle will wear a seat belt. Safety procedures are located in each vehicle manual.

B. Handling of Emergencies: Fire extinguishers, flares, first aid supplies, OSHA clean-up kit and mobile telephones are located in Center vehicles. Depending on the nature of the emergency, assistance can be obtained by calling 911 and/or the Center. Written procedures for handling emergencies are kept in all vehicles.

C. Roadside Assistance: Employees may use available equipment (fire extinguishers and mobile telephones) to assist other motorists in emergency situations. Employees at no time will put the safety of the Center’s patients in jeopardy.

D. Clean-up: All trash is removed by the employee and/or patients after each trip. Routine interior and exterior cleaning is scheduled by the transportation coordinator.

E. Preventive Maintenance: The transportation coordinator is responsible for arranging preventive maintenance and repairs on Center vehicles (i.e. check fluid levels and general vehicle conditions weekly, serviced every 5,000 miles). The transportation coordinator maintains records that document preventive and required maintenance.

F. Problem Reporting: Any problems with the operation of a vehicle are reported as soon as possible to the coordinator. Damage to vehicles is reported as soon as possible to the coordinator and the Executive Director or designee.

G. Traffic Violations/Accidents: Staff incurring a fine as a result of a traffic violation are personally responsible for paying the fine. All traffic accidents are reported immediately to the SC Highway Patrol/local law enforcement and Executive Director or designee. Staff must obtain a copy of the accident report (FR-10) from law enforcement, compose a written statement and provide both to Director of Administration for claim processing with SC Fleet Management and complete an Adverse Incident Report.

H. Proof of Insurance and Registration: Proof of insurance and registration are kept in all vehicles.

I. OSHA Clean-up Kits: OSHA required clean-up kits for use in blood and/or body fluid spills are located in each Center vehicle. Any incident of this nature will be reported to the infection control coordinator and the transportation coordinator.

J. Cell Phones or Other Handheld Devices: Employees are not permitted to use cell phones or any other handheld device, pagers, digital assistants, laptops, or any other electronic communicative devices while operating a moving vehicle. Exceptions apply in emergency situations only.
ADVERSE DRUG REACTION

Section Number: V – MEDICATION MANAGEMENT

DMH Reference:

Policy Number: MM002

Date of Origin: February 1998

Revision Number: 04

Revision Date: 12/02, 9/06, 2/12, 5/13

Approved by: 

Date Approved by Board: March 1998

PURPOSE: Increase safety in patient care and prescribing by monitoring, reporting and preventing adverse drug reactions in the patients of BCMHC.

POLICY: It is the responsibility and obligation of Center staff responsible for patient care to communicate in an expedient and coordinated manner in all issues related to medications. Clinical staff will keep treating prescribers aware of information reported by patients and families and of observations related to medications. All prescribers and nurses in the Center will educate patients and families about the benefits and potential side effects of medications. Physicians and nurse practitioners will monitor for, evaluate, and treat as needed adverse drug reactions.
ADVERSE DRUG REACTIONS
PAGE 2

PROCEDURE:

ADVERSE DRUG REACTIONS

1. Definition - Adverse Drug Reaction (ADR) is defined as “an effect produced by an FDA approved medication that is undesired, unintended, or unexpected in doses recognized in accepted medical practice.” This adverse drug reaction may result in one or a combination of the following: hospital admission, changes in drug therapy, complications of diagnosed disease state(s), fatality or personal injury. This definition emphasizes that the reaction is seen in association with a given drug or drugs. It is not incumbent upon the physician to prove cause and effect beyond a shadow of doubt before reporting it. The definition states that minor adverse drug reactions need not be reported, but only ones which necessitate a change in therapy or initiation of a hospital stay. Any adverse drug reaction involving personal injury or death must always be reported as described in the Center’s adverse incident policy.

2. Types of Reactions - Adverse Drug Reactions can either be severe or minor. Each of these types of ADRs need to be reported if trends and major problems are to be monitored. These different types of ADRs can be categorized as follows:

   Type A Reactions: Those reactions resulting from exaggerated, but otherwise known, pharmacologic actions of the drug when given in typical therapeutic doses, or reaction resulting from an interaction between a combination of medications given at proper doses. Such reactions are usually dose-dependent and common, yet produce significant disability to the patient.

   Type B Reactions: Those reactions which are idiosyncratic and totally unexpected from the known pharmacologic actions of the drug, when administered in typical therapeutic doses to patients with no known metabolic abnormalities. This would include immunologically-mediated hypersensitivity reactions. Examples would be agranulocytosis associated with carbamazepine or hepatitis resulting from phenothiazine therapy.

3. Responsibilities and Reporting Mechanisms for Monitoring

   Non-physician staff: Mental health professionals and nurses will immediately communicate to the prescriber and/or Medical Director all information related to patients’ unusual or exaggerated reactions to medications. This information can be in written form and given to the physician’s receptionist or can be verbally communicated directly to the physician. The mental health professional and nurse will document information in the EMR.
ADVERSE DRUG REACTIONS

PAGE 3

Physicians: All physicians and nurse practitioners in the Center will evaluate, treat as necessary, and collaborate with outside entities (i.e. ER when needed) to address adverse drug reactions in a manner that reflects the standards of care. Documentation of ADRs will be as follows:

Physician’s Service Note. The Physician’s Service Note will document upon verification the ADR and recommendations.

Adverse Incident Report. Physician will follow the Center policy for the reporting of Adverse Incidents. These are directed to the Quality Improvement/Risk Management process and Center’s Medical Director.

FDA MedWatch Form (FDA Form 3500). Physician will determine need for completion of the form. This form will then be forwarded to MedWatch via mail service or fax (address and fax number on form).

4. Utilization Review - The Center’s Medical Director will review each Adverse Drug Reaction Report to identify opportunities to improve patient care and to determine the need for completion of the FDA MedWatch form, FDA form 3500. The Center’s Medical Director will review each Medication Error Adverse/Unusual Incident Report to identify opportunities to improve patient care and physician performance. The Quality Improvement Coordinator will submit quarterly summaries to the Division of Clinical Services at SCDMH. As an element of the Risk Management process, information will be provided to the Medical Director and Executive Director.
REACTION TO INJECTABLE MEDICATIONS
(PROLIXIN, HALDOL DECANOATE, RISPERDAL CONSTA,
INVEGA SUSTENNA, ABILIFY MAINTENA)

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PURPOSE: To provide guidelines to ensure that patients receive the best possible standards of care when administering long-acting injectable antipsychotics.

POLICY: For this policy, hypotensive crisis is defined as an extreme fall in blood pressure leading to loss of consciousness and shock requiring immediate medical treatment.
PROCEDURE:

I. Prior to administration of any intramuscular long-action antipsychotic to patient their blood pressure is taken. The patient is required to wait for a period of 15 minutes after injection, at which time a second blood pressure is taken before patient leaves the Center.

II. In the case of an emergency, CODE BLUE is called to activate emergency medical response protocol which includes EMS responding and Center staff administering support until EMS arrives.
DOCUMENTATION AND FOLLOW-UP OF MEDICATION ERRORS

Section Number:  V – MEDICATION MANAGEMENT  
DMH Reference: 

Policy Number:  MM031  
Date of Origin:  February 1998 (separated from policy #002 11/98) 

Revision Number:  03  
Revision Date:  12/02, 3/03, 5/13 

Approved by:  

Date Approved by Board:  11/09/00 

PURPOSE:  To establish a uniform protocol for review, reporting and documentation of medication errors. 

POLICY:  Center staff responsible for patient care will communicate in an expedient and coordinated manner in all issues related to medications. Clinical staff will keep treating prescriber informed of information/adverse effects reported by patients and families and of observations by clinicians related to medications. All physicians and nurses in the Center will educate patients and families about the benefits and potential side effects of medications. Physicians will evaluate (and treat as needed) medication errors.
PROCEDURE:

I. Definition
Medication Error is defined as any preventable medication related event occurring as a result of actions by a healthcare professional that may cause or lead to patient harm.

II. Responsibilities and Reporting Mechanisms for Monitoring
Non-physician staff: All mental health professionals and nurses will immediately communicate to the attending physician all information related to medication errors. This information can be in written form and given to the physician’s receptionist or can be verbally communicated directly to the physician or nurse practitioner.

Physicians: All physicians in the Center will evaluate, and treat as necessary, medication errors in a manner that reflects standards of care and evidence-based practice.

Nursing: In the case that nursing staff is involved in the medication error, the nursing supervisor will be notified immediately.

Medical Director: Physicians/APRNs will notify the Medical Director in a timely manner.

III. Documentation of medication errors will be as follows:
A. Medical Record. Medical Record documentation will be completed by the staff member who discovered the medication error on a Clinical Service Note (Nurse or Case Manager) or Physician Medical Assessment (Physician). The note will document that the physician was notified and will address any action that was taken as a result of the medication error.

B. Adverse Incident Report. Physician or nurse will follow the Center policy for the reporting of Adverse Incidents. These are directed to the Medical Director for review and then to Quality Improvement/Risk Management for processing.

IV. Incident Review
The Center’s Medical Director will review each Adverse Incident Report related to medication errors to identify opportunities to improve patient care and physician performance. These reports will be reviewed and processed by Quality Improvement/Risk Management guidelines and reviewed by the Medical Staff as appropriate.
MEDICATION MANAGEMENT
including
STORAGE AND CONTROL

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PURPOSE: To establish procedures for procurement, storage, distribution and administration of medications in compliance with all Departmental, State and Federal regulations and in consultation with a SCDMH registered pharmacist.

POLICY: BCMHC will offer to its patients receiving pharmacotherapy a full range of services including evaluation, ongoing assessment, medication procurement, storage, distribution and administration.
PROCEDURES: All center staff will adhere to the following procedures.

I. Pharmacotherapy

The initial assessment done at time of first appointment will provide the physician with important information regarding history and present use of medicines: prescription, alternative, and over the counter. Use of medications will be integrated into the person’s overall treatment plan. New generation medications will be considered and prescribed to patients at the discretion of the physician with the patient’s informed consent. The Center maintains an emergency stock supply of medication and injectable neuroleptics. All other medications must be obtained through other referrals. Medication may be supplied by direct referral to the patient’s pharmacy of choice or if needs of the person dictate, referral to patient assistance medication programs, or other community resources may be indicated. A physician is available twenty four hours a day, seven days per week for consultation regarding medication either at the Center or through the on-call staff at a local emergency room. The Center adheres, to the extent possible, the use of treatment guidelines and protocols to ensure patient safety and to promote state-of-the-art prescribing.

The physician’s initial review and evaluation shall include, but is not limited to, the following:

- Review of past and present medication use, both prescription and over the counter medication, to include effectiveness and who it is prescribed by
- Coordination with any medical/primary care giver prescribing medications
- Evaluation/identification of co-existing medical conditions
- Use of medication by women who are pregnant or of child bearing age
- Identification of any allergic or adverse reaction to medications in the past
- Identification of use of alcohol and tobacco products, and illegal substances
- Special dietary needs and/or restrictions associated with medication use
- Necessary laboratory studies, tests, or other procedures, when indicated, including screening for common medical co-morbidities
- Education regarding medications (see policy on patient and family education)
- Offer and document, when possible, informed consent, including alternatives to medication
- Evaluation of abnormal movements if neuroleptic medication is indicated (AIMS), along with an informed consent form from the person served
- Continuing a prescribed medication if a generic medication is not available
- Continuity of medication use when identified as a need in a transition plan of the patient

Persons served and their families are an integral part of the treatment plan including the participation in pharmacotherapy.

Prescribers will consult with South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS) before issuing a prescription for any Schedule II through IV controlled substance. Providers must maintain documentation that the SCRIPTS database was verified before the issuance of a Schedule II through IV controlled substance prescription.

II Maintenance

The physician or nurse practitioner will review and evaluate medications prescribed on a regular basis. Prescribers of medications and staff members responsible for medication management and monitoring will ensure compliance with all applicable laws and regulations pertaining to medication and controlled substances. The following will be addressed and documented on the Physician Medication Order form as the person served is followed on medication:

- Appropriateness of each medication
MEDICATION MANAGEMENT including STORAGE AND CONTROL

Page: 3

- Efficacy of medication
- Presence of side effects, unusual effects, any contraindications
- Ensure documentation of any involuntary movements at initiation of any neuroleptic medication and every 6 months thereafter
- Use of multiple medications to include drug interactions
- Use/abuse of substances
- Documentation of the use and benefits of any “prn” (as needed) doses
- Patient’s involvement in treatment
- Any medication prescribed will be documented on the PMO form along with other medications (prescription and over the counter) with name, strength, dosage and frequency.

III. Licensure

The Center will maintain the following license:

A. South Carolina Pharmacy Drug Outlet Permit
B. Federal DEA License

Physicians and nurses will maintain current SC Licensure as required by law. These credentials will be maintained in each individual credentialing file.

IV. Storage

All medications (except samples) will be stored in the Center medication room. This room will be locked at all times except when nursing or other medical staff are accessing the room. Within the room, a cabinet will hold all stock and emergency medications. Medications that require refrigeration or protection from light will be stored appropriately according to their manufacturer’s instructions. Supplies to include syringes, alcohol pads, gloves, syringe disposal boxes and ancillary materials (current Physicians’ Desk Reference, medication logs, antidote charts, maximum recommended doses, etc.) will also be kept in this room.

Medication in the cabinet will be separated according to internals, externals, current and stock. All boxes, vials and containers will be labeled with date and patient name or stock as appropriate.

The following staff will have keys to the medication room and cabinet: nurses and nursing supervisor. Center physicians have keys to the room but may request a nurse to open cabinet and document medications removed. A set of master keys is kept in a secure place known to the Executive Director and Nursing Supervisor.

V. Accountability

All medication is logged in as it is secured in the medication room. Date, medication name, quantity and supplier are recorded in the appropriate log book. Medical staff are the only individuals to make entries in the logs, and they are to sign all entries.

Each time a medication is removed from the cabinet to be distributed or administered, the appropriate log entry must be made before leaving the room.

Once each month, designated nursing staff (2 nurses minimum) will audit the logs against stock of injectables and emergency medicines in the cabinet. Results of these audits will be documented in each log book. Discrepancies in supplies will be reported immediately to the nursing supervisor for investigation. Results of investigation will be reported immediately to the Medical Director and Executive Director.
All required records will be readily retrievable for a period of two years.

VI. Stock Medication
Emergency medications, to be used when patients are extremely agitated or experiencing side effects to Center prescribed medications, are ordered by Center physicians and stored in the medication room. These medications are labeled and secured as described above.

VII. Administration
All medications are administered or distributed by qualified, licensed nurses or physicians as the result of a physician’s order documented in the patient’s chart.

Injectable medications will be drawn in the medication room. All documentation in appropriate logs will be completed prior to leaving and securing the cabinet and room. The Center name, address, physician name, patient name, center supplies of oral medications will adhere to accountability procedures already described.

Quantities of oral medications distributed to a patient from his/her supply maintained in the Center will be documented in his/her medical record.

Physician’s orders are required to distribute and/or administer emergency medication. In circumstances requiring emergency medications, it may be most feasible to act on verbal orders and follow as soon as possible with documented orders. It is the physician’s and nurse’s responsibility to assure written documentation is completed.

When assisting patient in filling their med boxes, the SCDMH Pill Pack Procedure will be followed.

VIII. Expired Medications
All vials are to be dated and initialed when opened. The expiration date entered will be 28 days from the date opened. It is the responsibility of the nurse administering an injection to be aware of the expiration date on the vial from which the dose is being drawn. When vials of injectables expire, they will be sent to the Pharmacy Consultant for destruction. Nurse will void patient prescriptions which have not been picked up after thirty days. He/she will document on Physician Note sheet, mark prescription “void” and file in patient’s chart.

IX. Drug Recalls
Drug recalls consist of three classes:
- Class I - Situation in which there is a reasonable probability that the use of or exposure to the product will cause serious adverse health consequences.
- Class II - Situation in which the use of or exposure to the product may cause temporary or medically reversible adverse health consequences; or where the probability of serious adverse health consequences is remote.
- Class III - Situation in which the use of or exposure to the product is not likely to cause adverse consequences.

A file will be maintained in the medication storage room of all notifications of drug recalls. The recall notice should be signed and dated by the responsible party receiving it before being placed in the file. This notice will be kept in the file for a minimum of two years.
If no product is found to be in the Center, that will be documented on the drug recall notification.

If medication recalled is found, it will be documented and attached to the drug recall notification as to how that medicine was disposed of.

The recalled drug shall be removed from stock and sent to Columbia for disposal as described above in “Expired Medications”; or if special handling is needed, it will be handled as outlined in the manufacture’s notice.

For sample meds kept by doctors, the doctors will be informed of the recall and doctors will give the recalled medication to the nurses to dispose of and document.

Copies of the notification of recall will be circulated to all medical personnel in the Center.

X. Illegal and Legal Drugs on Center Property

Any person or persons bringing illegal drugs onto Berkeley Community Mental Health Center grounds will be reported to the local police, who will provide guidance and action. Any person or persons (staff or patient) who have legal drugs (prescribed or over-the-counter) in their possession for their own personal use would be expected to keep these drugs in their possession or in a locked personal area at all times. In no case are these drugs to be shared with others. Patients attending stabilization service may ask staff to lock their medications in a safe place until needed. Staff have personal locking spaces in offices. Patients who have medicines that have been discontinued are encouraged to turn these in for proper disposal according to procedures outlined in Section VIII.

XI. Pharmacy Consultant

Registered pharmacist from SCDMH will provide consultation and supervision of the medication program, specifically the control and accountability.

The pharmacist’s responsibilities include the following:

a. Sign any new or renewal application for a Drug Outlet Permit.

b. Supervise all of the employees of the permit holder in so far as their duties relate to the procurement, storage and distribution/administration of medication.

c. Conduct monthly inspections of the medication storage room and document inspections on medication room audit form. Original audit form will be filed with the pharmacy consultant and a copy retained in the medication room.

d. Pick up any outdated medicines for destruction.

XII. Off site administration of medications

A. Medicines and syringes, which are carried to patients in the field, are carried in a locked box and placed in the trunk of the car. A sharps container accompanies the box if the medicine is in injectable form.

B. At the designated patient's home, the box and sharps container are taken into the home.

C. Patient is then assessed following the medication monitoring guidelines. The physician is contacted if there are questions concerning administration.

D. Evaluation of abnormal involuntary movements conducted every 6 months.

E. Privacy is sought at the site and if assessment warrants administration, medicines are given. If the medicine is an injection, the blood pressure is taken before and 20 minutes after the
MEDICATION MANAGEMENT including STORAGE AND CONTROL
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medicine is given, per Center guidelines. If there is an emergency reaction, EMS is called.

F. Syringes are disposed of in the sharps container. Locked box and sharps container are
   returned to the Center in the locked trunk and stored in the medication room.

G. If there is a safety concern, two staff will do the home visit together.

XIII. Poison Control
In case of overdose or accidental poisoning, all staff have the number of poison control entered in the
speed dial portion of their telephone and posted on all telephone equipment.

Patients are given the poison control telephone number in their orientation packet.

XIV. Peer Review
The Center employs a program of medication utilization evaluation to include measures of
medication effectiveness and client satisfaction. The documented peer review occurs at least
annually, but when possible quarterly, and is coordinated by the Medical Director or an identified
person with prescribing authority. The peer review process includes two components: 1) a medical
records review, and 2) a regular meeting of prescribers and appropriate nursing and clinical staff.

A. Records Review: The Peer Review includes an audit of a representative sample of records
   (typically those selected for the Center’s quarterly record review as part of the Center’s
   Quality Improvement Plan). The Records Review assesses the appropriateness of each
   medication as determined by the needs and preferences of the person served and the efficacy
   of the medication prescribed. Its purpose is to determine if the presence of side effects,
   adverse effects, or contraindications were identified and addressed; and to identify
   simultaneous use of multiple medications in the same class, as well as, any medication
   interactions. The results of the record review are reported to the appropriate staff, which
   should include at minimum, Center prescribers, nursing staff, and the Quality Improvement
   Director. The Quality Improvement Director will analyze the results of the record review as
   part of the Center’s Quality Improvement Plan and utilize the findings for performance
   improvement activities of the Center.

B. Medical Staff Meeting: The prescribers, nursing staff and any applicable participants will
   meet regularly, but at least quarterly, for the purpose of improving the effectiveness of the
   Center’s Medication Monitoring and Management programs. The meetings’ agenda may
   include any of the following:
   • Patient case reviews or Records Reviews results
   • Adherence to guidelines and treatment algorithms
   • Documentation of appropriate clinical exceptions
   • Review of current journal articles, prescribing information, trends in medical care
   • Off-formulary prescribing
   • Polypharmacy and inappropriate or excessive prescribing
   • Monitoring for medication side effects
   • Therapeutic benefits
   • Practitioner trends
   • Patient Safety issues
   • Patient Care Coordination with internal and external practitioners
MEDICATION MANAGEMENT including STORAGE AND CONTROL

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- Medication Errors or Adverse Incidents
- Adverse medication reactions
- Debriefing crises/critical incidents
- Center Policies & Procedures
- Other items as determined by the Medical Director or participants
STORAGE AND DELIVERY OF SAMPLE AND PATIENT ASSISTANCE MEDICATIONS

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PURPOSE: To define the scope and practice of assisting patients without resources gain access to samples and PAP medications from pharmaceutical companies. Procedures are established for the storage, handling, and administration of sample and PAP medications in compliance with State and Federal regulations and in consultation with a Registered Pharmacist.

POLICY: Berkeley Community Mental Health Center explores options to assure that patients who have no resources to purchase medicines receive appropriate medicines to enhance their recovery. The Center, in accordance with the established standards for safety, security and legitimacy, will establish a system for the storage and delivery of PAP and sample medications. This system will be in accordance with DHEC regulations and State Licensure Board.
PROCEDURES:

**PHYSICIAN/APRN MEDICATION SAMPLES**

It is the prerogative of the physician/APRN to receive sample medications. Samples are provided to help the patient without means to purchase medications initiate and/or adjust medicines. Samples are not intended to supply medicines over any length of time. Physicians/APRNs meet with the pharmaceutical company representatives at their discretion so as not to interfere with patient care and scheduling.

Sample medications are received by physicians/APRNs and stored in a locked cabinet. At no time are samples to be stored with Center stock medications or patient assistance medications.

Sample medications are inventoried by the physician/APRN with assistance from a nurse as requested.

Expired and recalled medications are handled in accordance with Center Policy and Procedure Medication Management Including Storage and Control (MM033).

Samples are to be dispensed in the manufacturers’ packaging by the physician/APRN only in accordance with all State and Federal regulations for proper labeling. The physician/APRN may direct nurses to give labeled samples to patients.

The date, medication, dosage, amount given, and “Sample” for each sample must be documented by the prescribing physician/APRN on the Physician Medication Order sheet. If a nurse is directed to give the labeled sample to a patient, a medication order note signed by physician/APRN will also be placed in the medical record.

Patients receiving samples will have current proof of income on file. Except in emergency situations, patients will be expected to have made current payments on their accounts to receive samples.

**PATIENT ASSISTANCE PROGRAM MEDICATIONS**

The Center has personnel in place to access pharmaceutical company patient assistance programs as an ancillary service to patients. PAP medications are intended to help patients with no other resources to purchase medications. Continued availability of such programs is dependent on the pharmaceutical companies’ resources.

The physician/APRN and/or clinician initiates the PAP process by referral to the person designated to complete and transmit the application and all required accompanying documentation to the pharmaceutical company. This designee also handles reapplications as needed.

Upon arrival at the Center, PAP medications are handled by medical staff until the patient receives them. Nursing staff are responsible for opening, logging-in, labeling and storing PAP medications. All
STORAGE AND DELIVERY OF SAMPLE AND PATIENT ASSISTANCE MEDICATIONS
PAGE 3

PAP medications are stored separately from stock medications in the medication room.

When given to the patient, the date, medication, strength, dosage and amount dispensed of medication and “PAP” will be documented on the PMO note and signed by the physician/APRN.

As PAPs are given to patients, the PAP log will reflect the medication, amount given and date, and name of patient receiving medication.

PAP medications may be picked up according to BCMHC Medication Refill Policy (MM054). Patients receiving PAP medications will have current proof of income on file. Except in emergency situations, patients will be expected to have made current payments on their accounts for continued processing of PAP.

If a PAP medication is discontinued, the manufacturer’s instructions for disposition will be followed. The PAP log will indicate the procedure and outcome for each PAP medication.
# MEDICATION REFILLS

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**PURPOSE:** To establish procedures for handling requests for medication refills outside the prescribers' medical assessment appointments, to insure appropriate medical care, and to increase the efficiency and effectiveness of prescriber, nurse and clinician time, the Center has established the following procedures.

**POLICY:** Prescribers will limit the refilling of medications without face-to-face evaluation by the attending prescriber and clinical staff. The amount of refills will usually be limited to the next scheduled appointment at the Center. Requests for medication refills will warrant an appointment with a nurse for medication monitoring unless there are reasons to do otherwise. Patients and families will be informed of the medication refill procedures and will have opportunities to have their requests evaluated on an individual basis.
PROCEDURE:

I. Patients and families will be given information concerning medication refills in the orientation packet, and as they are placed on new medications will be reminded by prescribers, clinicians and nurses. Medication requests are to be scheduled with a nurse for medication monitoring to obtain medications/prescriptions. Patients and families are to call seven (7) days prior to running out of medications. Appointment with a nurse will be scheduled within a three (3) day time frame. Nurses will review history and collaborate with prescribers to honor requests. Nurses are permitted to call in refills of medications to the pharmacy after authorization by a Center prescriber.

   A. Refills will be given at the prescriber’s discretion.
   B. If the patient misses a Physician Medical Assessment (PMA) appointment, based on consultation and review of the patient’s treatment history, the attending prescriber may renew medications as indicated or request evaluation by nursing or clinical staff prior to authorizing refills. Refills will only be authorized through the next scheduled appointment. If more than one (1) PMA is missed, requests may not be granted.
   C. Allow up to three (3) business days for med monitoring appointment.
   D. Allow up to five (5) business days for RN to staff request with prescriber.
   E. Patients who have been without medication for an extended period of time will need to schedule PMA to restart medication.
**CONSENT FOR NEUROLEPTIC MEDICATIONS**

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**PURPOSE:** The purpose of this policy is to provide adequate information to all patients who are prescribed neuroleptic medications and may be at risk of developing side effects, such as abnormal involuntary movements.

**POLICY:** Berkeley Community Mental Health Center physicians and clinical staff have the responsibility to educate and monitor patients that are prescribed neuroleptic medication. Management of neuroleptic medications requires patient’s signature on the Berkeley Community Mental Health Center Consent or Denial of Consent to Use Neuroleptic Medication form.
PROCEDURES:

I Neuroleptic Medication Consent (no evidence of abnormal involuntary movements)
A. Upon determination by attending physician that neuroleptic medications are clinically indicated, said physician will inform the patient and/or family of the purpose, benefit and possible side effects of specific medication to be used and alternative treatments.
B. Physician and/or APRN will review consent form with patient/responsible party and obtain a signature. In the event patient refuses to sign consent, but verbally consents to take medication, the physician and/or APRN will document such on the form. Patients’ refusal to consent to taking medications will be documented in the physician’s services notes. The physician will document the patient has been informed of the risks/benefits of any new medication.

II Neuroleptic Medication Consent (with the presence of abnormal involuntary movements)
A. Upon determination by attending physician that signs of Tardive Dyskinesia are suspected, said physician will inform the patient and/or family of present effect of the medication and discuss appropriate treatment options.
B. Attending physician and/or APRN will review BCMHC consent form with responsible party and obtain a signature to consent to neuroleptic drug treatment.

III General Psychotropic Medication
Medical services shall be made available to ensure the health and safety of patients on general psychotropic medication as prescribed by BCMHC prescribers. Patient education shall include information on any medication so prescribed, including but not limited to targeted symptoms, potential adverse drug interactions and most common side effects.

Documented assessment of abnormal involuntary movements will be made at initiation of any neuroleptic medication and every 6 months thereafter by appropriate medical personnel.

IV Procedure for Patients Declining Recommended or Continuation of a Medication
A. The attending physician and/or clinician shall document the patients declining/refusing the medication.
B. The patient shall be advised of the reasonable anticipated medical consequences of not taking the prescribed medications, if any.
C. The physician shall review with the patient acceptable standard treatment modalities, seeking to identify a viable treatment alternative which is acceptable to the patient.
D. There may be extenuating circumstances when a clinical conference may be necessary to explore treatment options and make recommendations. This conference may include: patient, patient’s family and/or significant others, primary clinician, attending physician, adjunct staff, Medical Director, other care providers.
MONITORING PROTOCOLS FOR USE OF ATYPICAL ANTIPSYCHOTIC MEDICATIONS

Section Number: V – MEDICATION MANAGEMENT
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Revision Date: 3/09, 4/10, 5/13, 5/14
Date Approved by Board: 4/12/07

PURPOSE: To identify standards for monitoring patients’ (adults and children) responses to atypical antipsychotic medications prescribed at Berkeley Community Mental Health Center.
RESPONSIBILITIES:

- The MD/APRN is responsible for ordering medications, directing the plan of care for the patient, and ordering any laboratory testing needed to monitor the patients.
- The nursing and clinical staff are responsible for following established protocols to monitor response to medication.
- The patient is responsible for attending scheduled appointments and obtaining lab work as advised, which may include but is not limited to CBC, CMP, lipid panel, TSH.

PROCEDURES:

1. All patients (adults and children) receiving atypical antipsychotic medications will give informed, signed consent before receiving antipsychotic medication. Education regarding effects, side effects, efficacy related to the condition for which it is prescribed, and possible development of metabolic syndrome and other possible effects such as Tardive Dyskinesia will be given and documented in the patient’s medical record. The importance of regular lab testing will be explained to the patient.

2. All patients will be advised to get baseline labs concerning blood sugar and lipids done at a local laboratory. They will also be advised to inform their primary care physician that they are taking these medications. The psychiatrist/APRN will write a prescription for any laboratory procedures needed by the patient to monitor their well-being while on medications.

3. The attending psychiatrist/APRN will devise a treatment plan and advise patients when they need lab work. If the patient refuses, the physician/APRN will make the judgment regarding the need for the medication.

4. Patients will be responsible to keep appointments and follow treatment recommendations.

5. Any abnormal findings, to include metabolic, will be reported to the primary care physician of the patient’s choice for follow-up and treatment recommendations.

6. Abnormal involuntary movements will be assessed and documented at the initiation of any antipsychotic medication and every six months thereafter. Medications for side effects will be prescribed accordingly.
### BLOOD GLUCOSE TESTING AT THE CENTER

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<tr>
<th>Section Number: V – MEDICATION MANAGEMENT</th>
<th>DMH Reference:</th>
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<tbody>
<tr>
<td>Policy Number: MM103</td>
<td>Date of Origin: April 2007</td>
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<tr>
<td>Revision Number: 03</td>
<td>Revision Date: 3/08, 4/10, 5/13</td>
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<tr>
<td>Approved by: Debbie Calvert</td>
<td>Date Approved by Board: April 12, 2007</td>
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**PURPOSE:** To establish protocols for the ordering and monitoring of blood glucose levels in identified patients.
RESPONSIBILITIES:
Any patient the physician deems necessary may be asked to get blood glucose testing. If the patient is indigent, or in the case of emergency, the test may be done at the Center. Patients will be notified of the risks of developing metabolic syndrome in certain medications and the importance of monitoring for these conditions. Patients will be advised to obtain baseline laboratory values upon initiation of atypical antipsychotic medications and to inform their primary care physicians that they are taking these medications.

COMMUNITY CONTINUITY OF CARE:
Any abnormal readings of metabolic lab work will be referred to the primary care provider for evaluation and possible treatment.

PROCEDURES:
1. All laboratory testing will follow CLIA guidelines. CLIA permit will remain up-to-date.
2. Patients in need of urgent blood glucose testing will be referred by the physician to the nurse for testing. The physician/APRN will write the order for the testing on the PMO note.
3. Only nurses/MDs/APRNs will perform the testing.
4. A nurse/MD will meet with the patient and explain the procedure and perform the test adhering strictly to the package insert manufacturer instructions and following universal precautions.
5. Nurses/MD will document results of test(s) on Blood Sugar Consent Form and in EMR.
6. Supplies will be kept in the medication room. The medication room nurse will be responsible for keeping supplies current and in working order.
7. Any abnormal findings will be reported to the psychiatrist/APRN and the primary care physician immediately for follow-up and any proposed treatment.
PURPOSE: To facilitate access to treatment documents by establishing a uniform system of organizing information in the medical record.

POLICY: Documents required by Quality Improvement and other pertinent treatment information will be filed in the medical record according to established guidelines.
PROCEDURE:

The organization of all Center medical records will adhere to the format as outlined by DMH Electronic Medical Record Manual.
MEDICAL RECORD DOCUMENTATION

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<tr>
<th>Section Number: VI – MEDICAL RECORDS MANAGEMENT</th>
<th>DMH Reference:</th>
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<tr>
<td>Policy Number: MR053</td>
<td>Date of Origin: 7/96</td>
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<tr>
<td>Revision Number: 17</td>
<td>Revision Date: 1/98, 8/98, 10/00, 3/03, 7/04, 3/06, 2/07, 2/08, 3/08, 2/09, 2/10, 2/11, 2/12, 6/12, 4/13, 8/15, 6/16</td>
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<td>Approved by: [Signature]</td>
<td>Date Approved by Board: 11/09/00</td>
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PURPOSE: To monitor compliance with Quality Improvement requirements for medical record documentation for clinicians, supervisors and quality improvement staff will provide consistent feedback to clinicians about the completeness and quality of documentation. This process will also include a medical records auditing protocol which monitors completeness, quality, and appropriateness of medical records documentation. Audit results will also provide information on clinicians' job performance in meeting quality improvement requirements and will be integrated into the annual EPMS process.

POLICY: There will be a complete and accurate medical record developed and maintained for each person served which contains all relevant information pertaining to services provided. Relevant medical record information will be accessible to appropriate individuals on a need to know basis and the security and confidentiality of medical records information will be protected at all times. Ability to access confidential patient information does not mean employee has the right or the authority to access such information. Accessing confidential information, including identification of an individual as a DMH patient, is limited to the execution of each employee’s essential job duties as listed in their position description. Access outside of the execution of essential job duties constitutes a privacy violation. Compliance with medical record documentation is considered an essential job function for all clinical staff.
PROCEDURE:

A medical records auditing system exists with the following objectives:

1. To maximize compliance with SCDMH/BCMHC documentation standards.
2. To implement a monitoring and evaluation system that is effective in proactively maximizing medical records compliance and quality.
3. To implement a monitoring system that provides aggregate review of data and utilizes the data in our quality improvement efforts.
4. To use standardized data sources so data can be reliably integrated into a medical record completeness summary according to program area to provide useful information for supervisors in daily management operations of their respective program areas. Clinician specific data will also be available which can be used as part of the EPMS process.
5. To avoid redundancy, not only in indicators reviewed among the various data sources, but also the records that may be selected for review among the various reviewers/functions.

I. COMPLETENESS TIME FRAMES

Time frames for medical records documentation are as follows:

A. Plan of Care (POC) For Clinic Based Services - The initial POC is completed upon completion of the initial clinical assessment but no later than the 90th day after admission. Progress Summaries are due 90 days from the date of admission and 90 days thereafter for all patients and at the time of discharge or transfer. Progress Summaries may be completed up to two (2) weeks prior to due date. Treatment plans may be completed up to 30 days prior to the due date and referenced as “effective” on the due date. Plan of Care must be reviewed and re-signed at least annually. The clinician, patient and doctor should sign and date the plan of care. A Physician’s Medical Assessment (PMA) must be accomplished within 90 days of admission and documented on the PMO sheet. For RBHS services, the service must be authorized on POC within 30 days of admission. If service is not utilized, it must be reauthorized.

B. Clinical Service Notes (CSN) - Collaborative documentation is completed as often as possible for services rendered. CSN’s for services rendered are completed immediately after the delivery of service, but if this is not possible due to the nature of the service, the CSN must be completed no later than ten (10) working days from the date of the service. This time frame is applicable to all clinic based services and RBHS services provided and documented on a CSN from the time of admission.

C. Berkeley Community Mental Health Center will adhere to all SCDHHS Community Mental Health Manual Section 2, Rehabilitative Behavioral Health Services Manual and Targeted Case Management standards applying to medical records.

II. AUDIT TOOLS

Data sources are standardized throughout the Center according to the South Carolina Department of Mental Health Audit Tool. This tool addresses the following elements of review:
A. DHHS standards of care as outlined in the Community Mental Health Section 2, Rehabilitative Behavioral Health Services and Targeted Case Management manuals  
B. Quality of Care  
C. Utilization Management  
D. Corporate Compliance  
E. CARF Standards  
F. Billing audit  

III. METHODOLOGY  
Reviews will be conducted through the following mechanisms:  
A. DMH Quarterly Audit – A representative sample of charts based on age, sex, race, diagnosis, and service area are chosen for quarterly audit, which is reported to DMH. This audit is done by the Quality Improvement Program Director.  
B. DMH Annual Audit: DMH QI selects a representative sample of charts to be audited annually. This audit takes the place of one Center quarterly audit. This audit is also reported to HHS.  
C. Supervisors may request a review/audit of records for specific clinicians at any time.  

IV. FEEDBACK TO CLINICIANS  
A. Record review findings will be forwarded to clinicians through their immediate supervisor to review and make corrective actions when indicated.  
B. Once responses are documented by the clinician, corrections will be verified and forwarded to QI.  
C. QI will provide summary reports to clinicians, supervisors, Leadership Council, DMH, Corporate Compliance and HHS on a quarterly basis.  

V. INTEGRATION WITH EPMS PROCESS  
Audit findings and information will be maintained in files. This information, along with quality improvement related information, will be available to the supervisor at any time before or at the time of the clinician’s EPMS review. All clinicians are expected to average at least 90% on cumulative audits during the year.  

VI. RETENTION AND DESTRUCTION OF MEDICAL RECORDS  
BCMHC adheres to all State of S.C. Guidelines for the retention/destruction of medical information. This would include information in the chart as well as any other information maintained by the Center such as billing records and/or electronic information about or for the medical record. In the event of legal action against the Center, the Center would follow all directions issued from the SCDMH Legal Department regarding stopping destruction of information generated by the Center concerning the legal action. Center IT would be responsible for saving/recovering/maintaining any electronic information.
# CONFIDENTIALITY OF MEDICAL RECORDS AND PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Section Number: VI - MEDICAL RECORDS MANAGEMENT</th>
<th>DMH Reference: Directive #837-03</th>
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<tr>
<td>Policy Number: MR076</td>
<td>Date of Origin: September 1997</td>
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<tr>
<td>Revision Number: 08</td>
<td>Revision Date: 12/00, 3/03, 3/06, 2/09, 2/10, 2/12, 8/15, 6/16</td>
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<td>Approved by: [Signature]</td>
<td>Date Approved by Board: 12/14/00</td>
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**PURPOSE:** To set forth policies and procedures concerning disclosure or exposure of confidential information in accordance with South Carolina Mental Health Directive #837-03.

**POLICY:** It is the policy of Berkeley Community Mental Health Center that all patient information be protected to ensure the patient’s right to privacy and confidentiality. Ability to access confidential patient information does not mean employee has the right or the authority to access such information. Accessing confidential patient information, including identification of an individual as a DMH patient, is limited to the execution of each employee’s essential job duties as listed in their position description. Access outside of the execution of essential job duties constitutes a privacy violation. Each employee, volunteer, and contract worker will protect the confidentiality and right to privacy of all patients.
PROCEDURES:

I. **New Employee Orientation** - At the time of employment, each employee shall receive South Carolina Department of Mental Health Directive #837-03 and shall sign an acknowledgement stating they have received this directive. This receipt shall be kept in the employees’ credentialing folder. One element of orientation is training on the content and application of this directive. Each new employee will be tested on his/her understanding of the directive. If the results of this test are not acceptable, the employee will be referred to the appropriate Program Director for supplemental training and follow-up. Each employee must retain a copy of this directive for reference during the execution of his/her job duties.

II. **Annual Training** - Annual training will be provided to all Center staff related to confidentiality of patient information.

III. **Securing Confidential Information**

A. **Medical Records.** The storage and control of patient medical records will be the responsibility of medical records room personnel. All medical records will be returned to the medical records room at the close of business each day. If a clinician is working late, a locking space in the mail room is provided to store medical records until the morning where they will be retrieved by the medical records clerk. In these areas, records are stored in locking cabinets behind locked doors. Procedures are in place to control and monitor the flow of records in the Center. As of March 7, 2011, Berkeley CMHC began using the SCDMH Electronic Medical Record (EMR) system. All medical, clinical and administrative forms, plans and treatment documentation are stored within the EMR. The Medical Records Department no longer creates hard copy charts as of March 7, 2011. Each patient that is entered into the CIS system is automatically maintained within the EMR system (See CSS Policy Number: 03-002, R7, sections V and VI for specific EMR functionality). Open physical charts with admission dates prior to March 07, 2011 are scanned into Portable Document Format (PDF) and then imported into the EMR. A sticker with staff initials is placed on the physical chart indicating it has been scanned into the EMR. The physical chart is returned to the medical records room for storage.

B. **Electronic Medical Records.** Staff should be careful about information on computer screens and treat with utmost confidentiality. When leaving workstation, computer must be locked and secured. Paperwork for scanning into EMR should be stored in designated area of workroom.

C. **Mail Room.** Employees’ mailboxes will be emptied routinely. Inter-office envelopes will be available for confidential information. Information with patient names or identifying information will be secured until it has fulfilled its purpose at which time it will be shredded. Shared printers will be checked frequently by users and information removed as needed. The mail room is locked at the close of business each day.

D. **Employee Offices.** Each employee will have a locking space (desk, file cabinet, etc.) to place confidential materials (charts, messages, identifying patient information). When they are out of the office during operating hours, all confidential materials (schedules, notes, messages, charts, etc.) shall be put away and locked. This includes locking or logging off of computers which contain EMR access and other confidential patient information.
information. All medical records will be returned to the medical records room at the end of business. Staff will not retrieve voice mail using the intercom/hands free feature of the telephone.

E. Public Areas. Conversations pertaining to patients will not be held in the public areas of the facility. Such discussions will be held in offices to insure confidentiality.

F. Community Based Consultation, Outreach and Mobile Services. BCMHC staff and employees who are conducting services, consultation or staffings outside of designated treatment facility will ensure the safety and security of BCMHC patient’s PHI. This shall include, but not limited to, ensuring any and all PHI documents shall remain free from unwanted exposure to those unauthorized to review information.

IV. Release of Confidential Information - Requests for information will be handled in accordance with South Carolina Department of Mental Health Directive #837-03.
COURT COMMITTED PATIENTS

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<tr>
<th>Section Number: VII - CLINICAL SERVICES</th>
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<tr>
<td>Policy Number: CS006</td>
<td>Date of Origin: March 1998</td>
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<td>Revision Number: 04</td>
<td>Revision Date: 3/10, 2/11, 2/12, 6/13</td>
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<td>Approved by:</td>
<td>Date Approved by Board: April 9, 1998</td>
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PURPOSE/ POLICY: The Berkeley Community Mental Health Center will cooperate to the fullest extent with any court order to treatment. Patients will be engaged into treatment and explained the provisions of the order to treatment. All necessary correspondence will be provided to the Court at the required times.
PROCEDURE:

A. Patients that are court ordered to treatment shall be admitted to the Center. If the court ordered treatment cannot be provided by the Center, the court shall be notified and other provisions made through the court for the treatment. The court and/or supervising agency shall be notified in writing of the patient admission and recommendations for treatment. If the patient refuses to comply with or engage in treatment, including keeping scheduled appointments and following recommendations for therapy (including medication), the court shall be notified in writing of the noncompliance. The court or the clinician may request a supplemental hearing to determine the next course of action.

B. All patients that are court ordered to treatment shall receive in writing an explanation of responsibilities of the Mental Health Center in notification of the court regarding their treatment. A copy of this notification shall be placed in the medical record of the patient and a copy given to the patient.
PATIENTS WHO ARE COURT ORDERED TO TREATMENT

If you have been court ordered to treatment, this means that the Mental Health Center has a responsibility to work with the Court to ensure that you are in compliance with the order to treatment. We will need to contact the Court to let them know that you have entered treatment and that you are or are not following treatment recommendations. If you should cease your compliance with the order from the Court, we are required to contact the Court with this information. This may result in a supplementary hearing by the Court to decide the next course of action. The Mental Health Center desires a good working relationship with patients who are court ordered to treatment; however, patients should be aware of the requirements of their Court order. If records or your counselor are subpoenaed to Court, information may be released by Court order without your permission. All information requested by the judge must be released, but only the specific information requested is released.

I have read and understand the above information.

NAME_____________________________
DATE_____________________________
WITNESS__________________________
If a patient is court ordered to outpatient treatment at BCMHC the following procedures will apply:

1. All court orders received will be placed in designated location for availability for Medical Records staff.

2. Medical Records staff will enter/edit the court order section under the Patient’s Overview tab in the EMR indicating that the patient is court ordered for treatment and will include the start and end dates of the court order. This will assist you in identifying those patients that have been court ordered to treatment.

3. Medical Records staff will import the court order into the patient’s EMR.

4. Medical Records staff will update the necessary information in CIS as well.

   New patients coming into treatment can be entered on the page 8 form under type of commitment. The codes for Type of commitment are as follows:
   
   01 Voluntary
   02 Emergency
   03 Judicial
   04 Criminal/Circuit Court Order (NGRI)
   05 Family Court
   06 Medical Certification
   07 Order of Mental Health Commissioner
   08 Court to Judicial
   09 Other

5. If your patient becomes court ordered, BCMHC policies and procedures (CS006) state that a letter to the court stating whether the patient has shown for appointments and is following recommendations of the treating physician should be sent immediately. If the patient becomes non-compliant or refuses to follow recommendations, another letter should be sent to the court informing them of the patient’s non-compliance. All patients who receive services under court order shall receive in writing an explanation of responsibilities of the Center to notify the court regarding their treatment. A copy of this explanation should be imported in the medical record. Be aware that sometimes, in the case of those patients that are court ordered and are involved in legal matters with DJJ/Probation and Parole, etc., treatment compliance and recommendations should be sent to Probation Officer and sometimes Solicitor.
PURPOSE/POLICY:

Berkeley Community Mental Health Center’s mission is to provide mental health services to the community. This community includes employees, family members of employees, former employees and family members of former employees. The Center is available to explore the treatment options available in the private sector and Department of Mental Health community mental health system for employees, family members of employees, former employees and family members of former employees while upholding confidentiality of patient information and standards of professional conduct for all employees.
PROCEDURE:

I. EMPLOYEES
For the purposes of this procedure, an employee is defined as currently employed in a permanent, temporary, full time, part time or contractual position at any Center location/facility. Employee options for accessing mental health services are as follows:

A. Employees have the right to exercise their choice in selecting a mental health provider to meet his/her needs. The employee would make all arrangements with this provider (e.g. appointment scheduling, payment of fees, etc.). Employees requesting a list of private providers will be referred to directory assistance or other publicly available resources. The employee will request sick leave or annual leave to attend appointments scheduled during work hours.

B. Center employees have access to the DMH Employee Assistance Program for counseling needs. This program is operated from offices in Columbia and involves a state-wide provider network. Should an employee choose this option, and make such known to the Center management, the appropriate program manager will facilitate access to this system and follow-up to ensure it is acceptable to the employee. The employee will request sick leave or annual leave to attend appointments during scheduled work hours.

C. Services at a neighboring mental health center are available to address the needs of employees. The Executive Director or designee will contact the Executive Director or designee of the neighboring mental health center to begin this process. The employee will be given the name of a person to contact to initiate services. The employee will be responsible for the fees based on services rendered. The employee must request sick leave or annual leave to attend appointments during scheduled work hours.

D. Employees may discuss treatment options at BCMHC with the Executive Director should extraordinary circumstances eliminate all the options described above.

II. FAMILY MEMBERS OF EMPLOYEES
For the purposes of this procedure, family members of employees are defined as spouse, great-grandparents, grandparents, parents, brothers, sisters, children, grandchildren or great-grandchildren of either the employee or the spouse. Family members of employees have the following options for mental health services.

A. The family member and employee may locate a provider of their choice for treatment through publicly available resources (e.g. personal physician, friends, directory assistance). If the employee accompanies the family member to appointments during his/her scheduled work hours, annual leave or dependent sick leave (when applicable) is to be requested.

B. Services at neighboring mental health centers are available to family members. The Executive Director or designee will contact the Executive Director or designee of the neighboring center to begin this process. The family member and/or employee will be given the name of a person to contact to initiate services. The family member will be responsible for fees based on services rendered. The employee will request
annual leave or dependent sick leave (when applicable) to attend appointments during scheduled work hours.

C. Employees may discuss treatment options at BCMHC with the Executive Director should extraordinary circumstances eliminate all options described above.

III FORMER EMPLOYEES
For the purposes of this procedure, former employee is defined as person who in the past has worked for Berkeley Community Mental Health Center in a full time, part time, permanent or temporary position. Former employees have the following options for community services:

A. Former employees may identify and choose a private provider to address their mental health needs. The Center does not have a referral list for such providers and will direct former employees to publicly available resources to locate a service provider.

B. Former employees residing in Berkeley County may choose to be served at the Berkeley Center. As with all persons requesting services, the assessment process will determine if Center resources can address the former employee’s needs for service/treatment. Should appropriate services be available at the Center and the former employee chooses to participate as a Center patient, he/she will follow all procedures and policies that guide the treatment of Center patients, including but not limited to:

1. Assessment
2. Establishment and payment of fees
3. Working with clinician and psychiatrist
4. Referral to other community resources
5. Scheduling of appointments
6. Communication with treatment team
7. Documentation of medical record
8. Patient satisfaction/complaint processes

Former employees will not have access to mechanisms in conducting business as patients that are not available to all other patients (e.g. access to clinicians or physicians, appointment scheduling, etc.). Current employees are to interact with former employees in the same manner as with all Center patients and visitors.

C. Services in neighboring mental health centers are available to address the needs of former employees. The Executive Director or designee will contact the Executive Director or designee of the neighboring center to begin this process. The former employee will be given the name of a person to contact to initiate services.

IV FAMILY MEMBERS OF FORMER EMPLOYEES
For the purposes of this procedure, family members are defined as spouse, great-grandparents, grandparents, parents, brothers, sisters, children, grandchildren, great-grandchildren of either the former employee or the spouse of the former employee. Family members of former employees have the following options for mental health services:

A. Family members may identify and choose a private provider to address their mental health needs. The Center does not have a referral list for such providers and will direct family members to publicly available resources to locate a service provider.
B. Family members of former employees residing in Berkeley County may choose to be served at the Berkeley Center. As with all persons requesting services, the assessment process will determine if Center resources can address the former employee’s needs for service/treatment. Should appropriate services be available at the Center and the family member chooses to participate as a Center patient, he/she will follow all the procedures and policies that guide the treatment of Center patients, including but not limited to:
1. Assessment
2. Establishment and payment of fees
3. Working with clinician and psychiatrist
4. Referral to other community resources
5. Scheduling of appointments
6. Communication with treatment team
7. Documentation of medical record
8. Patient satisfaction/complaint processes

Family members of former employees will not have access to mechanisms in conducting business as patients that are not available to all other patients (e.g. access to clinicians or physicians, appointment scheduling, etc.). Current employees are to interact with family members of former employees in the same manner as with all Center patients and visitors.

C. Services in neighboring mental health centers are available to address the needs of family members of former employees. The Executive Director or designee will contact the Executive Director or designee of the neighboring center to begin this process. The family member will be given the name of a person to contact to initiate services.

V. PSYCHIATRIC EMERGENCIES
Psychiatric emergencies are defined as situations in which a person’s or persons’ safety is at risk and immediate intervention is needed.

A. Employees - if an employee contacts his/her supervisor and presents emergent psychiatric needs, the Center will respond by accessing the closest possible emergency resources for that employee. The mobilization of resources to meet this level of need would be the same as for other persons calling in emergently. If an employee presents with psychiatric needs so acute as to be emergent while in the work setting, the Center staff will provide interventions necessary to address this emergency. Once the crisis needs have been met, options described above for outpatient services will be available.

B. Former employees and family members of current or former employees - Former employees, and family members of current or former employees, residing in Berkeley County who present to the Center in psychiatric emergency will receive crisis management services. Once the crisis needs have been met, options described above for outpatient services will be available.
**ADVANCE DIRECTIVES**

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<tr>
<th>Section Number: VII - CLINICAL SERVICES</th>
<th>DMH Reference: Directive #849-05; #850-05</th>
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<tr>
<td>Policy Number: CS020</td>
<td>Date of Origin: 5/98</td>
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<tr>
<td>Revision Number: 04</td>
<td>Revision Date: 9/00, 4/04, 4/05, 2/11</td>
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<td>Approved by:</td>
<td>Date Approved by Board: 9/14/00</td>
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**PURPOSE/POLICY:**

In accordance with SCDMH Directive Numbers 849-05 and 850-05, the Berkeley Community Mental Health Center will promote patient awareness of health care and psychiatric advance directives.
PROCEDURES:

I. Patients shall receive information concerning health care and psychiatric advance directives in their Patient Orientation Package for their use and education. The clinician and physician will be available to discuss and explain any questions the patient may have after reading the information. Copies of such directives will be provided to the patient upon the patient’s request.

II. If the patient chooses to execute any advance directives, a copy shall be kept in the person’s record. If hospitalized, it is the responsibility of the Center to forward a copy of the directive to the hospital as stated in the SCDMH Directive Numbers 849-05 and 850-05.

III. The mental health center shall educate and train staff concerning health care and psychiatric advance directives in order to properly assist patients who desire to create these directives.

IV. The mental health center shall honor, to the best of our ability, all advance directives where they exist and when we are made aware of them.
POLICY/
PURPOSE: Each fiscal year, the Center allocates funds to the category of case services to purchase prescribed medications and outpatient laboratory tests for patients who have no means to pay for such. All Center patients have access to these funds according to the following procedures.
PROCEDURE:

Prior to accessing Center funds, the clinician or Care Coordinator will discuss with the patient all options for purchasing medications/tests including DSS, Salvation Army, family/friends, etc. Clinician or Care Coordinator will consult attending physician or Medical Director to determine if sample medications are available to meet the patient's need. If all options are exhausted, clinician or Care Coordinator will use the Center's system as described below. The clinician will refer the patient to the Center Entitlement Specialist for evaluation.

I. **Medications** - Center purchases of patient medication are restricted to Delta Pharmacy in Moncks Corner. The maximum quantity of medication purchased at one time is a 30 day supply. Smaller quantities are considered based on clinical/medical indicators. Exceptions to the 30-day maximum can be approved by the Center Executive Director/designee.
   A. Clinician or Care Coordinator staffs the patient's prescription needs with the immediate supervisor and completes the Center requisition form. Patient's name, medication, quantity of medication and cost of medication are documented on the form.
   B. For expedience, verbal approval may be obtained from the Business Manager, Executive Director, Director of Administration or Program Director to purchase medications. The requisition is routed for signatures. A copy of the form is filed in the patient’s electronic medical record. The Business Manager retains the completed original.
   C. The clinician or Care Coordinator completes the prescription authorization form letter. This completed form must accompany the patient to the pharmacy.

II. **Outpatient Laboratory Tests** - Center purchase of outpatient laboratory tests is restricted to Roper St Francis Medical Center-Berkeley laboratories in Moncks Corner. The physician documents the tests needed on a prescription.
   A. Clinician or Care Coordinator asks the patient how much he/she/family will be able to pay toward the cost of the lab work. Clinician or Care Coordinator then staffs the patient's laboratory needs with the immediate supervisor or designee and completes the Center's REQUISITION FOR LAB SERVICES form. Patient's name, laboratory test(s), cost of test(s) and how much the patient will pay towards the bill are documented. Costs are determined by telephone calls to Roper laboratory.
   B. Requisition for lab services form requires supervisor/designee signature. In emergency circumstances, verbal approval for purchase can be obtained. A copy of the completed form is filed in the patient's electronic medical record.
   C. Clinician or Care Coordinator completes the Roper St. Francis billing form only with the patient name, date of birth and “Bill Patient/M.D.” box checked under the section entitled “Insurance/Billing information.” (Sample copy is located in file with forms).
   D. The physician’s original prescription must be attached to the original white copy of the billing form and sent with the patient to Roper Labs.
   E. Yellow copy of the billing form is filed in the patient’s electronic medical record.
   F. Business Manager reconciles supporting documentation with invoices from Roper Labs.
POLICY:
The Berkeley Community Mental Health Center shall provide appropriate and quality services to patients in a manner which enhances dignity and protects the rights of individuals.

PURPOSE:
The attached procedures establish mechanisms for patients, concerned individuals and staff to protect and review rights which include privacy (confidentiality), dignity, right to treatment/refuse treatment, absence of abuse/neglect, safe environment and a complaint process.
PROCEDURES:

The below procedures govern patient rights in the Center:

I. Confidentiality
   Patient status and information are controlled by State and Federal laws. South Carolina Department of Mental Health Directive #837-03 guides disclosure of patient information in accordance with these statutes. Center employees, volunteers, student interns and temporary employees are instructed about patient confidentiality. They receive a copy of SCDMH Directive #837-03 and sign acknowledgement of receipt (see BCMHC Policy and Procedure “Confidentiality of Medical Record and Patient Information”, MR076).

II Medical Records Security - EMR
   All paper medical records are kept in locked cabinets in designated areas and are scanned in and out of the fileroom. Requests from all sources for copies of patient information are processed through the medical records custodian for Electronic Medical Records. Computers are secured with password protection and locked when clinician is out of office.

III Right to Treatment/Right to Refuse Treatment
   A Consent to Treatment will be signed by all patients prior to beginning treatment. For persons 16 or 17 years of age, the Center’s practice is to obtain consent from a parent or guardian whenever possible along with the patient. Exception to this is option of patients 16 or 17 years old to receive a single assessment without parental/guardian consent. Consent statement will be explained to patients prior to signing, and any questions will be addressed by appropriate administrative and/or clinical staff.

   Refusal to sign consent will be handled by clinical staff. Every effort will be made to explain consent and have patient sign. Services will not be provided without signed consent to individuals deemed capable of understanding and acting in their own best interest. Patients unable to comprehend and act on the consent because of acute symptoms of mental illness will be seen for emergency services without a signed consent. In these cases, a family member will be asked to sign consent for patient. If the patient is alone and unable to sign, patient’s inability to sign should be noted on the Consent Form and will be signed by the physician/clinician and one other staff member. When patient's ability to understand consent process is restored, he/she will be asked to sign consent for continued treatment.

   Patients have the right to quality, professional services rendered by trained staff and delineated in a written treatment plan. Patients are participants in developing their treatment plan as well as recipients of the services agreed upon.

IV Patient Abuse/Neglect
   Center employees, volunteers and students are governed by SCDMH Directive #885-07, “Abuse, Neglect or Exploitation of Patients Prohibited”, regarding patient abuse, neglect, and exploitation. This includes prohibition of physical or sexual abuse or harassment/punishment. It also includes psychological abuse such as humiliating, threatening, or exploitation of any kind.
V Environment
Center administration and staff are sensitive to patients' rights to receive services in a safe, dignified environment. As much as possible, environmental factors will be controlled and adjusted to meet patients' needs. If control of the environment includes the restriction of another patient being in the milieu, that patient restricted shall be treated with respect and dignity and offered an appropriate treatment milieu to meet his/her needs. The primary therapist and psychiatrist and treatment team will monitor and review the situation and restore the person back to the group or former treatment milieu as soon as possible or insure that the person served has the treatment that meets his/her need. The purpose or benefit of the restriction will be documented in the medical record.

Special treatment interventions will be applied based on the specific needs of the patient, and as determined safe and effective.

VI Treatment Preferences
The patient has the right to express his or her preferences regarding treatment to include choice of service provider, time of appointments, cultural or religious preferences, etc. Patient will be asked his/her preferences at time of assessment.

VII Complaint Process
The Center welcomes input and feedback from its patients and recognizes patients' right to express concerns/complaints about the Center's staff, services and facilities. Staff understand patients' rights as described above and are receptive to feedback.

The initial step in the expression of patient concerns/complaints/suggestions is ideally raising the issue with their treatment staff to include assigned clinician and/or psychiatrist. If patient is not comfortable with this approach, alternatives are available to him/her: immediate supervisor, Patient Advocate, Program Director or Executive Director. The immediate supervisor of clinician is available to listen, to explore the complaint, and offer resolution to the patient. If the patient chooses to make a formal complaint, the Patient Advocate is accessible to listen, document and investigate patient complaints and attempt resolution. The Executive Director or designee is available should a patient prefer to deal only with the Executive Director.

Resolution will be sought by the first staff person receiving the complaint. If patient is not satisfied with alternatives initially offered, then he/she will proceed with the following chain of authority to request a formal complaint: supervisor, Patient Advocate, Executive Director, SCDMH Patient Rights Committee, State Director of SCDMH (decision is final). Each person in the chain of authority will initiate their action to resolve the complaint within two working days and complete their phase of response, including a letter to the patient, within fifteen working days stating the findings and what resolution has been completed.

Complaints entering the Patient Advocacy system will be documented, investigated and reported to Executive Director and SCDMH Patient Advocacy Office, following the same procedures regardless of staff initiating contact with patient (see attached Patient Complaint Form, Interviewing, Documentation).

Reports of documented complaints will be provided to the Board of Directors and Quality Improvement Team. Trends needing on-going attention and/or indications for change in Center
PROTECTION OF PATIENTS RIGHTS

PAGE 4

policies/procedures will be evaluated. An annual written analysis of all formal complaints will be provided to Quality Improvement Team.

All formal, documented patient complaints will be filed with the SCDMH Patient Advocate Office.

Complaints or actions taken by a patient will not result in retaliation or barriers to service.

Complaint/request forms will be included in the Patient Orientation Package and accessible to all patients at the Center.

VIII Patient Advocate

The Executive Director will appoint a patient advocate for the Center considering characteristics of credibility with both staff and patients, ability to conciliate disputes and ability to work independently and objectively in the investigation of complaints. The advocate will assist patients in stating and documenting complaints and be involved in presenting resolution to patients. The Advocate will assist with training staff in patient rights areas.

IX Patient Rights Committee

Patients are given a copy of Patients Rights at admission in the Patient Orientation Packet and reviewed with the patient annually. All staff are trained on Patient Rights annually. To oversee the protection of patient rights, the Executive Director and Patient Advocate will appoint a representative committee to address patient right’s issues as needed. The committee's policies and procedures will be based on the SCDMH standards and policies for patient rights. Chairperson will be the Center’s Patient Advocate.

X South Carolina Department of Mental Health Patient Rights Manual

In accordance with South Carolina Department of Mental Health Directive #869-06, Berkeley Community Mental Health Center maintains this manual in the office of the designated Patient Advocate. It is available to all personnel as well as to patients for reference or further information regarding patient rights.

XI Clinicians shall have information regarding any needed referrals to advocacy groups, self help groups or legal services needed by persons served. The Patient Advocate can be a participant in this process as well.
PATIENT REQUEST/COMPLAINT PROCESS

Our Center's goal is to provide appropriate and quality community mental health center services. We need our patients' help to insure we meet this goal. Berkeley Community Mental Health Center welcomes suggestions, requests and complaints of patients.

To help us get information and feedback from patients in the form of suggestions, requests and/or complaints, we have the following options:

1. For suggestions, a suggestion box is located in the waiting room. We encourage patients to freely offer suggestions they feel are important to service delivery, staff and environment of the Center.

2. Requests or complaints about any part of the Center can be directed to several people:
   a. Your Clinician or Counselor
   b. Your Clinician/Counselor’s Supervisor
   c. Patient Advocate
   d. Executive Director

   These individuals will listen to your request/complaint and begin to investigate the issue within two working days. During this process, your confidentiality will be preserved. All reasonable efforts on the Center's part will be made to settle the problem to your satisfaction. You will receive some communication regarding the status of the inquiry within two business days. The Executive Director makes the final decision in the Center about resolving requests/complaints.

   If you are not satisfied with the Center's decision, you have the right to contact the South Carolina Department of Mental Health's Patient Advocate Office and ultimately the Director of the Department of Mental Health, whose decision is final. The Center Patient Advocate can help connect you with these groups.
PATIENT REQUEST/COMPLAINT FORM

Do you need help filling out this form? Ask the receptionist to call someone to help.

PATIENT NAME______________________________________________________________

COUNSELOR NAME____________________________________________________________

I want my treatment reviewed because (be specific):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

As a result of this review, I would like:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

________________________________________  ______________________________
Patient Signature      Date

______________________________________________________________________________
Address

______________________________________________________________________________
Telephone Number
PATIENT RIGHTS

As an individual receiving mental health services, you are entitled to certain rights as an integral part of the healing process.

1. The patient has the right to be treated with dignity, consideration and respect and free from exploitation by any employee.

2. The patient has the right to participate in the formulation of his/her treatment plan, the right to information concerning treatment including alternatives, and the right to request re-evaluation of treatment.

3. The patient has the right to refuse treatment to the extent permitted by law after being informed of the consequences of this action.

4. The patient has the right to have his/her records treated in a confidential manner except where the laws require disclosure.

5. Patients have the right to read their records if requested. A professional staff member will be present to interpret and answer questions.

6. Patients have the right of self-referral. An individual does not have to be referred to the Center by another agency or person.

7. A single assessment interview with an individual 16 or 17 years old is possible without parental/guardian consent and without cost.

8. The patient has the right to request an explanation of charges and examine his/her bill, as well as request a re-evaluation, if there is a change in his/her financial status.

9. If a patient feels any of his/her rights have been violated or has a request/complaint about the center, it is his/her right to report the violation and to express the request/complaint.

10. The patient has a right to make a complaint/comments or express their beliefs without fear of losing services or negative reaction from staff.

If you feel your rights have been violated or you have a request/complaint, please contact:

Aaron Brown
Berkeley Community Mental Health Center
P.O. Box 1030
Moncks Corner, South Carolina  29461
Telephone:  (843) 761-8282
or 1-888-202-1381
INTERVIEWING

The purpose of interviewing is to gather information about what in fact existed or happened. While investigating the possible violation of a patient's right(s), interviewing should begin with the individual expressing the complaint/violation. What follows are general recommendations to consider when interviewing individuals regarding a complaint or violation of rights.

Plan the steps of the interview process and what information is being sought from each step.

Know the requirements of statutes, regulations and policies. What rights are reported violated?

Be calm and open. Suppress personal feelings and opinions. Exhibit behavior which engenders confidence. Be non-judgmental.

Listen attentively. Pay attention to non-verbal communication. Use eye contact, gestures, nods or phrases such as "yes", "go on", or "I understand" to let the person know you are interested in what they have to say.

Prioritize multiple complaints addressing those with the most direct impact and seriousness first.

Don't let the person being interviewed feel rushed. After setting the person at ease and asking "baseline" questions, focus as soon as possible on the information the person can contribute to the investigation.

Make questions short and simple. Avoid use of technical terms and jargon. Follow a sequence going from general to more specific questions. Avoid questions that require a "yes" or "no" answer.

Do not put words in the person's mouth directly or by asking leading questions. Do not ask questions which invade the privacy of the person being questioned or which are outside the scope of the investigation.

Cover who, what, where, when, why and how.

Use phrases to take notes. Explain why you are making notes and share them with the person being interviewed.

Inform person being interviewed when he/she can expect some follow-up communication regarding concern.
Initial documentation will be on the Patient Request/Complaint Form. Statements from interviews with patient or other individuals expressing the complaint should be documented on the back of this form. Other documentation will be recorded and labeled with source and date obtained. All documentation will be filed and secured to insure confidentiality.

When compiling facts, list in chronological order. Obtain information from person complaining, witnesses or others with knowledge, physical evidence, medical records, treatment team members and documents other than medical records.

Written reports should include: statement of patient, identify patient and staff involved, findings in chronological order with copies of relevant documents or notes attached, names of persons interviewed and resolution.
CONTINUITY OF CARE
including
FOLLOW-UP OF MISSED APPOINTMENTS

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PURPOSE: Berkeley Community Mental Health Center recognizes the importance of providing a continuous array of community services in the treatment of persons with mental illness and emotional disorders. As a part of the Department of Mental Health, the Center endorses and practices procedures aimed at following clients from the community to the hospital and back to the community and share responsibility and ownership in the care and treatment of persons regardless of how, when and where they enter the DMH system. To provide staff with methods and guides to apply this commitment on a daily and consistent basis in the Center, the following policies and procedures are in place in accordance with SCDMH Directive #830-02.

POLICY: Clients’ individual needs are considered when scheduling appointments (i.e. transportation, work/school/family responsibilities, distance traveled, frequency of sessions). As attendance at scheduled therapy sessions is crucial for clients to address treatment goals, clinicians and clients will address missed appointments and their impact on services as needed throughout the therapeutic process. Both parties will participate in defining appropriate frequency of sessions and responsibilities to support this agreement. Clinicians are responsible for offering follow-up for missed appointments as an element of comprehensive service.

Clients will not be given the option of receiving some services at the Center and others elsewhere, as it interrupts the continuity of care. Clients will be given the option of receiving services from the Center or from a private provider. The Center will provide referral back to private provider if the client chooses.
CONTINUITY OF CARE including FOLLOW-UP OF MISSED APPOINTMENTS
PAGE 2

PROCEDURE:

I  ADMISSIONS
A. All requests for services are documented on DMH C-20, Mental Health Center Screening Form in EMR. A clinician is always available during office hours to receive such calls and/or walk-ins. The Access Center is responsible for responding to requests for services and offering appointments, conducting initial assessments and screening emergencies.
B. Persons who are referred to the Center by a hospital emergency room or Center on-call staff are instructed to come to the Center the following day. If they do not show, the Access Center staff, in conjunction with the on-call person, attempt to contact the client or a correspondent to stress the importance of mental health services.

II  ON-GOING TREATMENT APPOINTMENTS
A. When there has been a change in the client's level of functioning indicative of his/her illness exacerbating, or as result of stressful life events, frequency of contact with the Center will increase. The treatment team (client, family/guardian, clinician, supervisor and psychiatrist) will determine the frequency based on the client's behavior, illness, history, support system, and other pertinent information.
B. After change(s) have been made in client's medication, the client may be scheduled to see a nurse or clinician to assess the client and family at that time offering support, information/education, and feedback to the client. Any significant information requiring psychiatrist's attention will be shared while the client is in the Center. Careful and frequent monitoring of the client will continue until the treatment team agrees this level of service is no longer indicated to meet the client’s needs.

III  FOLLOW-UP OF MISSED APPOINTMENTS
A. MISSED SCHEDULED INTAKE APPOINTMENTS: Staff conducting assessments for new clients conducts follow-up of persons missing the initial scheduled assessment appointment at the Center. Follow-up consists of:
   1. The same day, or within 2 working days at the latest, staff will attempt telephone contact with the individual to offer the next available appointment.
   2. If telephone contact is not productive or not possible, then a letter is sent requesting the individual to contact the Center to discuss his/her needs. Lack of response within 14 days will be interpreted as the individual not desiring contact with the Center and the pending case will be closed.
   3. Persons who endorsed suicidal or homicidal thoughts/feelings or psychotic symptoms will be followed aggressively. Attempts at follow-up may include telephone calls to correspondent, coordination with community agencies (courts, law enforcement), follow-up activities over numerous days.
   4. All follow-up activity, including all telephone attempts, will be documented in the medical record.
B. MISSED APPOINTMENTS WITH CLINICIANS: (non-court ordered)
   1. The assigned clinician, on that same day, or within 2 working days at the latest, will attempt telephone contact with the individual to discuss reasons for the missed appointment and to offer another appointment if desired.
   2. If telephone contact is not possible or not productive, a letter may be sent within 10 days of the missed appointment. Based on each client’s individual needs and stage of
treatment, the letter will request client contact the Center to make another appointment and/or discuss desire for continued services. Clinicians and supervisors will discuss most clinically appropriate means of follow-up and disposition which may include a home visit or frequent telephone attempts to client and/or family.

3. Should the client exhibit a pattern of missed appointments, the treatment team (client, clinician, supervisor and/or psychiatrist, family/support system) will discuss continued desire for treatment, staff recommendations, and barriers to engagement. An individualized plan will be agreed upon to define the delivery of services and follow-up of any missed appointments.

4. If at any time in services the client declines services, such will be documented and discussed with the supervisor. Additional action may be recommended and implemented as clinically appropriate.

5. All follow-up activity, including all telephone attempts, will be documented in the medical record.

C. MISSED APPOINTMENTS WITH CLINICIANS: (court ordered)
Court ordered clients are those ordered to outpatient treatment at the Center by either Probate, Family or other courts. Copies of court orders must be present in the chart.

1. The assigned case manager, on that same day, or within 2 working days at the latest, will attempt telephone contact with the individual to discuss reasons for the missed appointment and to offer another appointment if desired.

2. If telephone contact is not possible or not productive, a letter may be sent within 10 days of the missed appointment. Based on each client’s individual needs and stage of treatment, the letter will request client contact the Center to make another appointment and/or discuss desire for continued services. Clinicians and supervisors will discuss most clinically appropriate means of follow-up and disposition which may include a home visit or frequent telephone attempts to client and/or family.

3. Court ordered clients will be informed of the Center’s obligation to report to the court.

4. The Center shall notify the appropriate court and/or designated court-appointed official when a client who is court ordered to outpatient treatment does not keep appointments or otherwise comply with the specifics of the order.

5. The appropriate court and/or designated court-appointed official shall be notified of clinically significant events which may include changes in client’s level of functioning, a pattern of non-adherence with court order, significant changes in mental status, and or failure to adhere with treatment recommendations.

6. All follow-up activity, including all telephone attempts, will be documented in the medical record.

D. MISSED HOSPITAL DISCHARGE APPOINTMENTS:

1. If the initial hospital discharge appointment is not kept, it is the responsibility of the staff with whom the appointment was scheduled to contact the client or family/correspondent by telephone the same day, or within 2 days at the latest. If unable to contact by telephone, clinician will consult with supervisor and/or treatment team to discuss executing one of the following:
   a. Mailing a letter indicating need for contact to discuss continued treatment
   b. Clinician and/or Access/Mobile Crisis response (home visit)
   c. If client is court ordered, notification of court of client’s missed appointment
   d. Staff client for discharge from care

2. All follow-up activity, including all telephone attempts, will be documented in the
**CONTINUITY OF CARE including FOLLOW-UP OF MISSED APPOINTMENTS**

**PAGE 4**

medical record.

E. MISSED PSYCHIATRIC MEDICAL ASSESSMENTS (PMAs) and MISSED APPOINTMENTS WITH NURSING, SUPPORTIVE EMPLOYMENT, PEER SUPPORT: The responsible administrative staff person notifies clinicians via e-mail or in person if the client misses an appointment. Clinicians are responsible for following-up on missed PMAs.

1. See applicable Section B or C

**IV HOSPITAL DISCHARGE APPOINTMENTS**

A. Initial appointments for persons being discharged from an inpatient facility are scheduled the same day as discharge, if feasible, or the next working day, but no longer than three working days after discharge. The clinical assessment will determine treatment recommendations and follow-up.

**V DISCHARGES FROM CENTER**

A. Prior to considering any case for discharge, the Center procedures for follow-up must be completed.

B. All cases must be staffed with supervisor prior to closing.

C. When appropriate, staff may do a home visit to clients prior to closing.

D. Clients ordered through Probate Court, Family Court, DJJ, DSS, Probation/Parole/Pardon Services may not be discharged from the Center without Center notifying the appropriate entity with a written clinical justification of the circumstances regarding the client being discharged from Center. Those circumstances may include: client successfully completed treatment, client moved out of county, client enrolled in services with another provider, client discontinued treatment, reasonable efforts to reach client have been unsuccessful and the client is not responding to requests to attend to appointments. A notice of discharge will be sent to the client. If the client was referred from another agency or if Center jointly staffed or provided regular updates/reports to another agency or family member about the client, Center will also send a copy to the applicable agency or family member.

**VI TRAINING**

A. All Center clinical staff will receive training regarding BCMHC and SCDMH Policy and Procedure for Continuity of Care. Staff will be tested on their knowledge of continuity of care policies and procedures. The test results will be filed in each employee’s credentialing folder.

B. As new clinical staff are employed, they will receive continuity of care training as part of orientation.

C. Documentation of continuity of care training will be entered into the DMH training system.

**VII MONITORING** - Clinical staff will be evaluated on their compliance with continuity of care policies/procedures through EPMS mechanisms. Supervisors will monitor performance as they conduct medical record documentation reviews, supervision, and staffing.
## HOSPITAL ADMISSION

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**POLICY/ PURPOSE:** Berkeley Community Mental Health Center is responsible to the communities it serves to be available to facilitate emergency screening and hospitalizations. The Center programs and services are designed to respond to such needs.
PROCEDURE:

The following procedures govern crisis management activities and will be adhered to by all staff conducting emergency services. Circumstances/conditions not addressed in the procedures below will be brought to the attention of a supervisor as they occur.

1. Adult Psychiatric Admission
   A. The Center is available for emergency screening during office hours. After hours, weekends and holidays, Center on-call staff work in conjunction with local emergency rooms to provide emergency consultations for established Center patients, indigent county residents or any person needing to access SCDMH inpatient resources.
   B. Crisis management activities take priority over other activities. When an individual presents to the Center in crisis either in person or over the telephone, staff handling this initial contact are to cease other functions and respond according to the procedure below.
   C. Individuals needing emergency treatment are to be instructed to either come to or be brought to the Center as soon as possible. Staff will facilitate transportation by accessing the Center transportation system, DSS, law enforcement or family/significant others as appropriate.
   D. The Access Center provides and coordinates emergency screening activities during office hours.
   E. Access Center will notify the receptionist of the patient's scheduled arrival. The receptionist will notify the Access Center immediately when the patient arrives. The responsible staff person will escort the patient to the Access Center and will monitor the safety and location of the patient throughout the screening process. Co-workers and/or law enforcement personnel are available to help monitor the patient. All law enforcement personnel are instructed to use the rear emergency entrance to the Center. The on-site physician is notified of upcoming emergencies.
   F. Clinician will complete Patient Identification Data as thoroughly as possible given the patient's status, making sure to attempt to have the Consent to Treatment signed. If the patient refuses to sign the consent, indicate such on the form and document staff signature as well as a witness signature, preferably a family member/significant other.
   G. A thorough assessment of the patient's mental status is conducted by the clinician as well as gathering information about present life circumstances, psychiatric history, present and past substance use/abuse, significant medical conditions, and any other information useful in identifying alternatives for the final disposition. Patients, family, accompanying friends, probate court, law enforcement, Center medical records and other care providers are all feasible sources of information remembering the statutes/directives governing confidentiality.
   H. Clinician's service is Crisis Management and is documented on Crisis Management Form. The Clinical Service Note references the Crisis Management Form.
Once the assessment is complete, the clinician notifies the physician the patient is awaiting a psychiatric medical assessment (PMA) making sure to indicate if the patient is accompanied by law enforcement. Emergencies with law enforcement personnel take priority over all other patients, even other emergencies.

The physician evaluates the emergency for the appropriateness of hospitalization in accordance with clinical findings required by the commitment statute. PMA is documented on the physician's service note sheet or the commitment papers and clinical service note references or both.

Should hospitalization be indicated, the following documents will be completed according to the nature of the admission:

1. **Voluntary Admission**
   - If a patient requires a voluntary admission, a copy of the physician’s PMA note with assessment and recommendation for voluntary admission is faxed to the accepting hospital.

2. **Emergency Psychiatric Admission**
   - Application for Involuntary Emergency Hospitalization for Mental Illness (M130)
   - Certificate of Licensed Physician Mental Examination for Psychiatric Treatment (M131)
   - Patient Admissions Information Form (admissions to DMH facilities only)

3. **Judicial Psychiatric Admission**
   - Petition for Judicial Admission (M122A)
   - Patient Admissions Information Form

Clinician contacts admission office of the appropriate facility to present the demographic information as well as reasons for admission. The Center physician and admitting hospital physician must communicate directly. Clinician records the name of the physician accepting the admission in the space provided on the papers. If there are no beds available, patient will be transported to local emergency room to wait for a psychiatric bed to become available.

The clinician notifies the law enforcement dispatcher of the committed patient to be transported and the destination. For voluntary admissions, directions to the admitting facility will be provided. When family chooses to transport a patient for emergency admission, the clinician and/or physician will address the feasibility of this and emphasize the responsibility the family is assuming. Families wanting to transport must sign in the space provided after discussion with the staff.

Three copies of completed papers are made. The original plus two copies are sent with the patient to the hospital. The third copy remains in the Center chart.

The clinician and/or physician inform the patient of the decision to hospitalize. Family and/or significant others are informed of the disposition and any questions answered. Hospital information packets may be provided to the patient and family at this time along with instructions on how to contact the hospital and Center staff if needed.

Case manager or Access Center clinician will contact the hospital by telephone within three working days to exchange information.

Hospital staff will contact the Center during the hospitalization to exchange information.
about court hearings, transfer to other facilities and discharge planning.

R. When hospital contacts to arrange a discharge appointment, Access Center staff will schedule appointments for established patients with their case managers and patients previously unknown to the Center with Access Center clinician.

S. All patients discharged from an inpatient facility are to be seen the next working day or, at the latest, within three days. All patients admitted to a hospital because of a suicide or homicide attempt will be staffed with a supervisor to determine if more extensive evaluation is necessary by psychiatrist.

T. Patients failing their first appointment after discharge will be contacted within two days at the latest (see BCMHC Continuity of Care including Follow-up of Failed Appointments, CS038).

U. Patients who are court ordered to outpatient services at the Center require written notification to the court of each instance of non-compliance (see BCMHC Continuity of Care including Follow-up of Failed Appointments, CS038).

V. All patients will be staffed with supervisor prior to closing. Compliance with Center policies regarding follow-up must be met in the process of terminating contact with patients (see BCMHC Continuity of Care including Follow-up of Failed Appointments, CS038).

II Chemical Dependency Admissions

The procedures enumerated above are applicable to chemical dependency admissions with the exception of forms listed in item K. The forms to be completed for admission to chemical dependency treatment facilities are as follows:

A. Voluntary Admission
   If a patient requires a voluntary admission, a copy of the physician’s PMA note with assessment and recommendation for voluntary admission is faxed to the accepting hospital.

B. Emergency Admissions
   1. Affidavit and Application for Involuntary Emergency Admission for Chemical Dependence (M134)
   2. Certificate of Licensed Physician Mental Examination for Chemical Dependency (M136)

B. Judicial Admissions
   1. Affidavit and Petition for Judicial Admission for Chemical Dependency (M170)
   2. Certificate of Licensed Physician Mental Examination for Chemical Dependency (M170)

III Children and Adolescent Psychiatric Admissions

In addition to the procedures above, the following must be accomplished when facilitating a child/adolescent admission:

A. When arranging for admission to William S. Hall Psychiatric Institute, efforts will be made to accomplish this during office hours if at all possible.

B. Family or significant others should be encouraged to accompany the patient to the hospital. Parents or guardians will need to furnish social history and other pertinent information at the time of admission.
C. The appropriate form for the following will be completed based on the disposition:

1. Voluntary Admission
   If a patient requires a voluntary admission, a copy of the physician’s PMA note with assessment and recommendation for voluntary admission is faxed to the accepting hospital.

2. Emergency Admissions
   a. Application for Child in Need of Emergency Admission
   b. Certificate of Licensed Physician Examination of Child in Need of Emergency Admission
   c. Medicaid and Medicaid eligible patients - see BCMHC Procedures for Gatekeeper for additional forms mandatory procedures and forms

3. Judicial Admissions
   a. Petition for Judicial Admission of a Child
   b. State Health and Human Services Finance Commission Certificate for Inpatient Psychiatric Services for Individuals Under Age 21 (Medicaid and Medicaid eligible children and adolescents)

IV Forensic Admissions
Emergency admissions are to be screened by the Center at the request of law enforcement to determine the need for acute inpatient care in accordance with the requirements of the commitment statute. Voluntary admissions are not accepted for forensic admission.

A. Having met the requirements of the commitment statute, persons must have a serious (usually felony) criminal charge and not yet been sentenced and/or have been sentenced to serve ninety days or less in a county jail.

B. Persons must be 18 years or older to be admitted to forensic unit. Persons under 18 requiring forensic services should be admitted to William S. Hall Psychiatric Institute's Child/Adolescent Unit.

C. Persons with minor charges may be admitted to other SCDMH acute care hospitals. Contact is first with the forensic unit, giving information about the patient and charges. Forensic unit staff will direct to other facilities if necessary.

D. All other admissions to the forensic unit should be court ordered by the S.C. General Sessions courts for competency to stand trial examinations.

E. Center staff complete the same admission forms described above in Adult Psychiatric Admissions - Emergency Admission. In addition to commitment forms, forensic admissions must have the following documents sent with the patient:
   1. copy of the arrest warrant
   2. copy of incident report (police may send within 10 days if not immediately available)

F. Follow-up appointment procedures for patients returned to the jail will be the same for all hospital discharges and coordinated by the nurse liaison to the Detention Center.

V Developmentally Disabled Individuals
Individuals with developmental disabilities considered to be in emergency status will be given the same priority as all other emergency cases. Procedures above in Adult Psychiatric and Chemical Dependency Admissions govern the screening of the developmentally disabled.
Listed below are additional procedures followed in screening this population:

A. If a developmental disability is suspected or evident during the assessment, the clinician will contact the local mental retardation board to obtain pertinent information and request assistance in screening and evaluating if the patient is known to them. When patients are referred by the mental retardation board, a knowledgeable staff person from that agency should be involved in the screening and disposition.

B. No person with a developmental disability who does not meet the statutory definition of mental illness will be placed in a psychiatric inpatient facility. Individuals in need of emergency residential placement or other mental retardation services will be referred to the mental retardation board.

C. Discharge from a facility to the community will be a coordinated effort among the inpatient social worker, Center mental retardation person, and mental retardation board to insure appropriate services from all agencies are provided. This Center’s mental retardation contact person is Johnette Parker, M.Ed.

VI Deaf and Severely Hearing Impaired Persons

Patrick B. Harris Hospital Program for Deaf and Hard of Hearing Persons is intended to serve persons who meet the statutory standards for psychiatric and/or chemical dependency and who:

A. Have documented history of deafness or impaired hearing of such character that they cannot understand ordinary conversation even with amplification equipment.

B. Use some form of sign language or other visual system as a primary communication modality (i.e. American Sign Language, finger spelling and/or speech reading).

C. In addition to the procedures enumerated above in Adult Psychiatric and Chemical Dependency Admission, the following procedures apply to screening and admissions of the hearing impaired:

1. Whenever possible, screening for hearing impaired persons should include consultation with SCDMH personnel with training in deafness (i.e., telephone consultation with Patrick B. Harris Hospital Deaf Program staff or SCDMH Director of Deaf Services may be conducted) and a sign language interpreter. In the absence of a sign language interpreter, notes may be written, gestures or pantomime used or speech and lip-reading employed. Whenever possible, communication should be accomplished in the manner preferred by the patient if such can be determined.

SCDMH mental health professionals in deafness:

Berkeley County Regional Services 843-852-4100
(Located at Charleston/Dorchester MHC)

Deaf Services Regional Statewide Clinical Director 803-963-3421
(Located at Piedmont MHC)

Patrick B. Harris Hospital Deaf Services 864-231-2600

Within 48 hours notice, interpreters may be obtained by contacting the South
Carolina School for the Deaf and Blind Community Resource Center in Charleston (852-4160). In emergency situations, the SCDBS will attempt to locate an interpreter as soon as possible. If it appears that more than one hour will elapse before an interpreter can be located, normal admission procedures should be followed using whatever communication means are available. See BCMHC Interpreters for Persons with Special Communication Needs, CS098.

2. Patrick B. Harris Hospital houses the inpatient programs for the deaf and hard of hearing for the entire state. Programs are in place to treat persons age 17 and under, persons with chemical dependency, and persons over age 60.

3. Upon discharge, hospital social workers, DMH Deaf Services specialists and Center staff coordinate necessary placements and community services. Clinicians skilled in providing mental health services to the deaf and hearing impaired are available as a resource at the Center.
Berkeley Community Mental Health Center Policy/Procedure

Berkeley Community Mental Health Center serves in an advisory capacity to Berkeley County Probate Court in its processing of petitions for judicial commitments and emergency involuntary commitments as defined in Sections § 44-17-410, § 44-17-510, §44-52-50 and § 44-24-60, Code of Laws of South Carolina.

At all times, the Court retains the jurisdiction and ultimate authority to act within its discretion and in accord with applicable law on all matters related to the above.

Within its authority and available resources, the Center will provide the following services to the Court during Center normal operating hours (unless otherwise specified below):

1. Referrals from the Court. Meet with individuals referred by the Court interested in the Judicial Commitment or Emergency Admission processes.
2. Education/information. Discuss with the referred individuals the Judicial Commitment and Emergency Commitment processes to include the roles of the Court, mental health, law enforcement, physicians, if applicable local emergency department, and possible outcomes.
3. Collect Facts. Gather specific, observable facts stated by and upon the belief of individuals referred by the Court about the individual who they believe needs Judicial Commitment (as Petitioner) or Emergency Admission (as Applicant).
4. Record Facts. Assist the Court referred individuals to document their applicable facts and beliefs on the required document/forms (as Petitioner or Applicant).
5. Transmit Forms. Provide completed forms to Court for review and appropriate execution.
7. Emergency Admission Screening. During available hours (Monday through Friday 8:30 am to 5:00 pm) provide screening for individuals referred by the Court. Within its capacity, facilitate admission based on Application and Certifying physician’s examination and findings and opinion by Certification.
South Carolina State Laws and Involuntary Treatment for Mental Illness or Chemical Dependency

South Carolina State Statutes provide for involuntary treatment for mental illness or chemical dependency. Based on the individual’s needs, this treatment can be in an outpatient setting or inpatient facility.

The Probate Court in each county executes the steps in the involuntary commitment process.

**Judicial Involuntary Commitment**

**Mental Illness** is used when a concerned party believes a person is mentally ill and because of this condition needs treatment, but is refusing to get treatment. Specific, observable facts are presented to support this belief.

**Chemical Dependency** is used when an interested party believes that a person is chemically dependent and because of this chronic disorder of repeated and excessive use of alcohol and/or drugs is in need of involuntary commitment. This belief is supported by facts such as: (a) recent overt acts or recent expressed acts of violence; (b) episodes of recent serious physical problems related to the habitual and excessive use of drugs and/or alcohol; (c) incapacitation by drugs and/or alcohol on a habitual and excessive basis as evidenced by numerous appearance before the court within the preceding 12 months, repeated incidences involving law enforcement, multiple prior treatment episodes, or testimony by family or by members of the community known to the person relating a lifestyle adversely affected by alcohol and/or drugs.

What happens:

- Interested person contacts the Probate Court. The Court usually refers the interested party to the mental health center (mental illness) or alcohol commission (chemical dependency). These agencies provide assistance to the Court in gathering facts on the petition for commitment.
- The mental health staff talk with the person to hear the specific, observable facts which need to be supplied to the Court.
- The completed petition is notarized and sent to the Court for review and action.
- The petition is filed and a copy is served on the identified person and his/her attorney or family.
- A date is scheduled for the person to be examined by two professionals…one counselor, one doctor. A hearing is scheduled for the recommendation of the examiners to be presented to the Probate Judge.
- Based on the recommendations, the Judge can order the person to outpatient treatment or to treatment in an inpatient facility.
- If the person does not show up for the examinations and was served a Bench Warrant, the Judge can issue an order for law enforcement to take the person in to custody.
Involuntary Emergency Admission

Mental Illness. An interested party believes a person to be mentally ill and because of this mental condition is likely to cause serious harm to self or others if not immediately hospitalized. The specific type of harm and facts supporting this belief are provided.

Chemical Dependency. An interested party believes a person is chemically dependent and because of this chronic disorder of repeated and excessive use of alcohol and/or drugs poses a substantial risk of physical harm to self or others if not immediately provided with emergency care and treatment and is incapable of exercising judgment concerning emergency care. The specific type of harm thought probable and specific threats or attempts to seriously harm self or others are stated.

What happens:
- Interested person contacts the Probate Court. The Court refers the interested party to the mental health center. The mental health center assists the Court in gathering the facts on the petition for commitment.
- The mental health staff talk with the interested party to hear specific, observable facts which need to be supplied to the Court.
- The completed petition is notarized and taken to the Court for review.
- The Judge issues an Order of Detention authorizing the Sheriff’s Department to take the person in to custody for evaluation by a medical doctor.
- To assist the Sheriff’s officers, the mental health staff will ask the interested party for information to identify and locate the person as well as information about dangers such as weapons or dogs.
- The medical doctor evaluating the person may be in a hospital emergency room or in the mental health center.
- If the doctor deems emergency admission is indicated, an accepting inpatient facility is located. The Sheriff’s department transports the person to the facility.
ACCESSING SERVICES IN THE CENTER AND COMMUNITY

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<td>Approved by: Debbie Calcote</td>
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PURPOSE: To support individualized treatment plans, patients will have access to services offered throughout the Center and community.

POLICY: To afford patients the benefit of therapeutic interventions across the Center and community, clinicians will coordinate services recognizing the issues of continuity of care, confidentiality, patient input, sufficient time for patients to make decisions regarding treatments, communication, therapeutic readiness and system effectiveness and efficiency.
PROCEDURE:

The following describes the procedures to ensure patients access clinically indicated services across the Center and in the community.

I. CLINICIAN*
A clinician will be designated to work with each patient. This clinician is responsible for delivering treatment services, documentation and update of the medical record, communication with attending psychiatrist and coordination of referrals to services within the Center and to services outside the Center.

A. Clinicians are selected to work with specific patients based on the patient's needs and clinician's job description and professional skills. Consideration is also given to the clinician's ability to provide the majority of therapeutic interventions to assigned patients.

B. In developing the Plan of Care (POC) with the patient and family, the clinician documents services indicated to address treatment goals. Patient and/or family signature and physician signature indicate support of this treatment plan.

*The terms case manager, clinician, therapist and counselor are used interchangeably to describe the individual designated to coordinate, organize and provide services for the patient.

II. ADJUNCT SERVICES
Services clinically indicated to address patient treatment goals which cannot be provided by the assigned clinician are adjunctive services. Once identified by patient, clinician and physician as appropriate and timely interventions, the clinician coordinates the access to adjunct service.

A. Adjunct Services Inside the Center. The clinician reviews with his/her immediate supervisor the patient's needs and goals as related to this service and the adjunct staff offering this service. The clinician coordinates with the adjunct staff and his/her supervisor to staff patient's treatment plan as a whole, and specifically the need for the adjunct service and outcome of the service. An appointment is scheduled for the adjunct clinician to meet the patient during which the patient and clinician address future sessions. This process of review, coordination with adjunct staff, meeting the patient and developing plan to initiate service will take no longer than 10 working days. All contacts and communication during this process will be documented in the patient's medical record. Adjunct clinician is responsible for documenting service on clinical service notes reflecting the treatment goals and progress toward these goals. Should the patient fail to keep appointments for adjunct service, the provider is responsible for informing the clinician in a timely manner. Responsibility for documenting additional services on the POC and POC updates remains with the clinician. The clinician is responsible for delivering other services indicated on the
POC and for follow-up of all failed appointments.

B. Adjunct Services Outside the Center. The assigned clinician is responsible for exploring community resources for adjunct services the Center does not offer. The majority of adjunct services accessed outside the Center may be supportive in nature. Clinician’s refer patients to Center’s Care Coordinator for these supportive services. Examples of such services include: physical health care services, financial assistance, public/subsidized housing, legal aid, patient support groups. The Care Coordinator advocates with other providers on the patient's behalf, gathering information and scheduling appointments when indicated. During contacts with the patient, the clinician checks on the status of these adjunct services.

III PATIENT TRANSFER

Patient transfers involve the active participation of the patient and/or family/guardian and the treatment team. The clinician, patient and/or family/guardian and physician use the treatment planning process to continually assess the patient’s needs and goals as well as the providers involved in service delivery. Should it become evident that the patient’s needs are not being met by the current treatment team, the option of transfer to another clinician will be discussed by the clinician, patient/family/guardian, and treatment team. The following practices/procedures apply to all patient transfers.

A. As one of the professionals responsible for treatment, the clinician will initiate discussion of transfer with immediate supervisor. Factors considered to determine appropriateness of transfer are:

1. Patient’s status is such that he/she cannot appropriately participate in discussion of treatment goals and transfer. Patients experiencing acute psychotic symptoms and/or active suicidal or homicidal ideation are not to be transferred.

2. Patients who have not been active in treatment as described in the POC are not to be transferred until follow-up and treatment planning activities are attempted to re-engage the patient in treatment.

The clinician and supervisor will review the patient’s treatment, current needs and goals, history, and availability of services in Center programs. If the current clinician/program is no longer offering the array of services to meet the patient’s needs, transfer is indicated. Option for transfer will be presented to the attending physician for review. When the clinician, supervisor, and attending physician concur that transfer will offer more appropriate services, the patient and/or family/guardian are presented this option.

B. The clinician and patient and/or family/guardian will meet to review needs/goals, services and staff involved in current treatment plan. The clinician will discuss transfer to a clinician/program to more adequately address the patient’s needs at this time. The patient is encouraged to discuss all issues related to transfer in this session and in subsequent session with current clinician and/or new clinician.

C. All information for the medical record will be documented, filed by clinician and then audited by the supervisor before clinician staffs with receiving supervisor to
facilitate transfer. Referral procedures, if applicable, will be followed.

D. The time frame between discussion with patient and connection with new clinician/program will not exceed 10 working days. Transfers will not disrupt continuity of care.

E. Patients who become dissatisfied with their clinician have the right to request a change. Such requests will be handled through the program directors and/or Center’s Patient Advocate.

F. Clinicians and physicians have the right to request not to work with a specific patient. Such requests must be supported by clinical justification presented to the supervisor, Medical Director and Executive Director.

IV TRANSFER WITHIN SAME PROGRAM
In some instances, it may be determined that patient’s needs are not being addressed by the current clinician. The majority of services being provided by an adjunct clinician in the same program is one such instance.

A. Steps in PATIENT TRANSFER, Sections A-C above, will be completed.
B. Clinician and supervisor will determine which clinician can most appropriately and effectively meet the patient’s current needs/goals. Referral procedures, if applicable, will be followed.
C. The transferring and receiving clinicians will coordinate a joint appointment with the patient. The clinicians will address issues about transfer. Treatment planning will continue with the involvement of the new clinician.
D. The transferring clinician will request supervisor or designee to transfer patient to receiving clinician in Electronic Medical Record.

V TRANSFER BETWEEN PROGRAMS
When a patient’s needs are not being effectively met in a Center program, the treatment team will work to identify appropriate services in other programs to offer the patient.

A. Steps in PATIENT TRANSFER, Sections A-C above, will be completed.
B. With support of the patient, clinician, and physician for the transfer, the clinician coordinates transfer with the receiving program director. The clinician presents the patients current needs and goals, treatment history and all other pertinent information to facilitate an appropriate disposition.
C. The program director identifies a new clinician in the receiving program. Referral procedures, if applicable, will be followed.
D. The transferring and receiving clinicians will coordinate a joint appointment with the patient. The clinicians will address issues about transfer. The POC will be updated to reflect new program and goals by the patient and new clinician.
E. The transferring clinician will request supervisor or designee to transfer patient to receiving clinician in Electronic Medical Record.

VI TRANSFER BETWEEN CENTERS (VIA EMR)
Refer to BCMHC CSS Policy 03-004, EMR Transfer Between CMHCs.
### Purpose:
Patients and their families will be informed of Center operations, treatment processes, and their rights as patients. Each patient will receive information during assessment that facilitates his/her involvement in the Center.

### Policy:
At the time of admission, patients will receive information orienting them to the Center. The clinical and clinical support staff will work cooperatively to ensure patients receive and understand this information.
PROCEDURES:

Clinical and clinical support staff will coordinate to ensure patients receive the Patient Orientation Packet during their initial assessment.

I. Clinical Support Staff Responsibilities
   Clinical Support Staff meeting patients to complete admission paperwork will provide each patient and/or parent/guardian a Patient Orientation Packet. The staff will review content of the package with patients, answering questions as appropriate. The Orientation Checklist will be signed by the patient and/or parent/guardian and staff person. This will become part of the medical record.

II. Clinician Responsibilities
   During assessment, clinicians will address the Orientation Packet. In a manner respectful of each patient, the clinician will review information to determine patient’s understanding. All questions from patients and/or family will be addressed. If the patient cannot read or comprehend the information, the clinician will orally provide the information along with the written packet.

   As patients access various programs and services throughout the Center, the clinician/case manager is responsible for orientating the patient and family to these new programs and services.

III. Patient/Family Responsibilities
   Patients and their families have the right to have any unclear information explained. They are encouraged to read the information provided and ask questions as often as needed.
**ABUSE, NEGLECT AND EXPLOITATION OF PATIENTS PROHIBITED**

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<th>Section Number: VII - CLINICAL SERVICES</th>
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<td>Policy Number: CS069</td>
<td>Date of Origin: September 1997</td>
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<td>Revision Number: 03</td>
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**PURPOSE/ POLICY:** Berkeley Community Mental Health Center adheres to South Carolina Department of Mental Health Directive #885-07 for the reporting and investigation of any abusive, neglectful or exploitative conduct of patients or their families, and for governing staff relationships with patients.
PROCEDURES:

All staff shall sign acknowledgement of receiving SCDMH Directives, including Directive #885-07, upon being employed at Berkeley Community Mental Health Center. Signed acknowledgement will be kept in the employee’s personnel file. Mandatory annual training on patient abuse, neglect and exploitation will be required for all employees.
## ETHICS IN RESEARCH

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<th>Section Number: VII - CLINICAL SERVICES</th>
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<td>Policy Number: CS073</td>
<td>Date of Origin: September 1997</td>
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<td>Revision Number: 01</td>
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**PURPOSE/POLICY:**

The Berkeley Community Mental Health Center supports and adheres to South Carolina Department of Mental Health Directive #750-91 on Ethics and Research.
PROCEDURES:

It is the policy of this Center that any research be characterized by the highest standards of integrity and ethical behavior. Each employee has personal responsibility to report any alleged or apparent misconduct involving research, research training or related research activities. All research activity must be approved by Leadership Council, who also monitor research activity.

Procedures described in South Carolina Department of Mental Health Directive #750-91 shall be adhered to and confidentiality preserved in the reporting and investigation of any alleged violations.
PRE-ADMISSION SCREENING AT LOCAL COMMUNITY LEVEL

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<th>Section Number: VII - CLINICAL SERVICES</th>
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PURPOSE: To mandate that Berkeley Community Mental Health Center, in accordance with South Carolina Department of Mental Health Directive #688-86, screen all potential admissions to the State inpatient facilities from Berkeley County, voluntary or involuntary, and evaluate and utilize local resources prior to referral to state psychiatric hospitals.

POLICY: Prior to referral to state psychiatric hospitals, all admissions from Berkeley County, voluntary or involuntary, shall be screened through Berkeley Community Mental Health Center. All appropriate local resources shall be considered, evaluated and utilized to best serve the patient’s needs in his/her own community setting before referral to South Carolina Department of Mental Health inpatient facilities.
PROCEDURES:

Berkeley Community Mental Health Center shall be designated as the pre-screening facility for citizens of Berkeley County.

Prior to referral to state inpatient facilities, all residents of Berkeley County presenting with psychiatric or chemical dependency emergencies at the Center or in local hospital emergency rooms shall be screened by staff from Berkeley Community Mental Health Center. During regular operating hours, it shall be a mental health professional in the Access Center. After hours, weekends, and holidays, Center on-call staff work in conjunction with local emergency rooms to provide emergency consultations.

Staff shall review comprehensive assessments and evaluate availability of community resources for the patient before considering admission to state facilities.

Before beginning admission procedures to any state facility, local hospitals will communicate to the Center. Center staff may go to the hospital for the purpose of screening potential admissions or provide consultation via telephone.

There will be on-going education with local physicians and other care providers regarding treatment availability and resources for individual patients in their community.

(See Berkeley Community Mental Health Center Policy CS039 “Hospital Admissions” and Berkeley Community Mental Health Center Policy HR019 “After-Hours Emergency Screening Staff”)
CONSENT TO TREATMENT

Purpose: In accordance with South Carolina Department of Mental Health Directive #772-92 and South Carolina Code Section 44-22-40 and Section 44-22-140 relating to obtaining consent, this policy establishes procedures for informed consent to treatment for all persons served by the Berkeley Community Mental Health Center.

Policy: It is the policy of Berkeley Community Mental Health Center to provide informed consent to all patients receiving services. Patients must show consent by signing or having a substitute decision maker, such as a parent or guardian, sign “Consent to Examination and Treatment” (SCDMH Form C-107). “Consent or Denial of Consent to Use Neuroleptic Medication” form must be signed by the patient or guardian if neuroleptic medicines are prescribed.
PROCEDURES:

All patients or guardians shall sign a consent to treatment upon admission. Exceptions to this apply if the patient is seen in a crisis situation and is unable to sign due to his/her condition. The circumstances justifying or rendering treatment without consent must be documented in the medical record. Persons unable to sign because of acute psychiatric distress will be asked to sign consent when distress has subsided. Persons exhibiting acute psychiatric symptoms who refuse to sign consent for treatment but are willing to receive services will be provided services necessary to ensure their safety and the safety of others. Repeated attempts to address signed consent will be made. When appropriate, family members will be involved in this process. All efforts to obtain written consent will be documented. Treatment team will seek guidance on ethical and legal implications of this situation from Center’s Executive Director, Center’s Medical Director and South Carolina Department of Mental Health Office of General Counsel.

Any patient prescribed neuroleptic medication shall be informed of effects and side effects, including Tardive Dyskinesia, and asked to sign a consent or denial of consent.

The physician shall document information given to the patient and family in the patient’s medical record.

For minors 16 or 17, the Center practice is to obtain consent from a parent or guardian whenever possible as well as from patient.

Minors 16 or 17 years of age may be seen once without consent of parent or guardian and without charge.

Minors 15 years of age or younger are legally unable to give consent.

Consent for treatment will be obtained from patient’s guardian/conservator for patients who have been deemed by the court as incapacitated and in need of guardian and/or conservator.

“Significant Other Participants Involved In The Identified Patient’s Services” (Consent to Examinations and Treatment Form) is provided so that family members and significant-others given written consent may participate in therapy focused on an identified patient. Staff will inform other participants in the patient’s therapy of the request for written consent, and date and witness signatures.

All consent forms shall be witnessed appropriately according to South Carolina Department of Mental Health Directive #772-92.
TREATMENT TEAM COMMUNICATION

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PURPOSE/POLICY: To establish procedures to support communication among members of the treatment team for the enhancement of quality of care. For Center purposes, treatment team refers to: the patient, patient’s family and/or significant others, primary clinician, adjunct clinicians, treating psychiatrist.
PROCEDURES:

I. Weekly Consultation/Briefings
Clinical providers have time allocated throughout the week for consultation/briefing. Clinicians receive a weekly listing of their patients with an appointment with a psychiatrist or APRN. Throughout the week, each clinician uses allocated time for consultation/briefing with the prescriber. This structure provides focused time for providers to communicate about mutual patients. Documentation is entered in EMR on a generic note.

II Joint Sessions
Based on the individual patient needs to be addressed, team members may choose to have joint sessions. These may be two (2) clinical members, clinician and prescriber, or patient with significant others and treatment providers. These sessions will be documented in the patient’s medical record.

III Treatment Team Meetings
At any given point, a member of the treatment team may schedule a team meeting to address a patient’s needs, services and outcomes. Involvement in this meeting may be expanded to include persons designated by the patient, family, clinician or psychiatrist/APRN (i.e. other care providers, friends, neighbors, etc.). The goal of such meeting is to ensure the patient’s needs are addressed in ways that respect his/her preferences, and builds on his/her strengths. Documentation of the meeting is included in the medical record.

IV Evidenced Based Consultation Teams
Clinicians using evidenced based therapies participate in monthly consultations to maintain fidelity to the models, receive supervisory and peer case consultation, and strengthen clinical outcomes.

V Program Area Meetings
The following program areas meet to address clinical and operational needs, issues, and enhancements, as well as more in-depth case consultation.
A. Adult clinicians
B. Child/adolescent clinicians (to include school based clinicians)
C. Medical staff, to include prescribers and nurses

VI Inservice Training Groups
Monthly, clinical staff participate in mandatory inservice training groups. These groups offer a structured and uniform mechanism for staff to receive information related to their job responsibilities. Coordinated by the Quality Improvement Program Director, these trainings address administrative and clinical issues. The trainers have expertise specific to the topics they present. Handouts are available for those who are unable to attend. Make-up sessions are held for mandatory trainings. Records of training are maintained by the Human Resources Representative.

All members of the treatment team - patient, family, clinicians, physician/APRN - are expected to communicate through numerous mechanisms during the treatment process. Communication is documented as part of the patient’s medical record on an on-going basis.

Emergent needs are communicated person-to-person by the most expedient means available.
CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES TO PATIENTS WHO HAVE LIMITED ENGLISH PROFICIENCY (LEP) OR ARE HARD OF HEARING OR DEAF

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PURPOSE: To insure culturally and linguistically appropriate services are provided to BCMHC patients who are not proficient in the English language, to the extent that they cannot access services or programs offered by the Center without language assistance.

POLICY: It is the policy of BCMHC to recognize and respect the cultural diversity of its patients and to provide culturally and linguistically appropriate services to all of its patients without regard to national origin or disabilities, to include individuals who have limited English proficiency or are hard of hearing or deaf. The Center will have in place procedures to provide communication services, including interpreter services, at no cost to the patient, as a necessary element for providing quality care.
PROCEDURES:

I. DESIGNATED STAFF
The Center’s Executive Director will designate a LEP Coordinator (Customer Service Supervisor). Coordinator will be responsible for oversight of procedures implementation, monitoring of compliance with procedures, education of employees, liaison with SCDMH, generation of reports, delivery of reports to Executive Director and Center Quality Improvement Team and update of procedures as needed.

II. ASSESSMENT OF CENTER’S NEED FOR INTERPRETER SERVICES
Assessment of the Center’s need for interpreter services will include the following:
- Current demographic data for Berkeley County to identify the non-English languages that are likely to be encountered.
- Information about patients collected at assessment and recorded in the medical record. This will include race, ethnicity, degree of fluency in the English language and language of preference.
- Language needs of patients with limited English proficiency.

This information will be used to develop and update procedures for accessing interpreter services.

III. NOTICE TO PATIENTS
Patients with limited English proficiency will be given notice of their right to language assistance and the availability of such assistance free of charge via the following mechanisms:
1. Language cards will invite patients to identify themselves as needing these free services.
2. Translation of written materials as described below.

IV. ARRANGEMENT OF APPROPRIATE LANGUAGE ASSISTANCE SERVICES
A. Translation of Vital Documents: The following documents will be translated into the languages identified in the Center assessment described above:
   - Consent to Examination and Treatment
   - Community Mental Health Center Determination of Ability to Pay Reduction
   - BCMHC Patient Emergency Information Sheet
   - Neuroleptic Consent Form
   - Voter Registration Declaration Form
   - Patient Orientation Packet

   Translation of other documents will be provided, if needed, orally.

B. Procedures for Use of Interpreters: The following measures will be taken to provide for accurate and adequate communication with patients who are not proficient in English or are hard of hearing or deaf to the extent that they cannot access services offered by the Center without language assistance:
1. Mental Health Center Screening Form/C20. Included in the information captured as patients are requesting services and/or being referred for services is the need for interpreter services. Access Center staff will arrange for interpreter services as indicated for the admissions appointment and inform the administrative staff of such arrangements. Case managers assigned to serve patients needing interpreter services will be informed of this need and will coordinate access of such resources for the patient’s appointments.

2. Patient Information. Information about the patients’ race, ethnicity, and degree of fluency in English and language of preference will be documented in the medical record and/or patient data base.

3. Interpreter Resources. SCDMH contractual resources identify qualified interpreters for persons with limited English proficiency or hard of hearing or deaf. An updated Qualified Provider List (QPL) for Foreign Language Interpreters is located on the Center staff resource page. Staff must contact the Center Business Manager to coordinate billing of interpreter services.

4. Patient Preference for Family/Friend to Interpret. When a patient insists on the use of a family member or friend to do the interpretation, staff will emphasize the availability of a qualified interpreter at no cost to the patient. Staff will discuss the benefits of a qualified interpreter or communicator to the patient and the family. The family’s role in support and treatment will be stressed. The patient’s decision to use or not use the Center interpreter will be documented in the medical record. See Attachment A for Declination of Qualified Interpreter/Communicator. Clinical staff will consider the use of qualified interpreters to assure the accuracy and effectiveness of communication, especially related to specialized mental health concepts and terminology.

5. Probate Court. It is the Center’s responsibility to provide advanced notice to the Probate Court when patients with limited English proficiency or hard of hearing or deaf are the subject of an involuntary or judicial commitment proceeding. It is the court’s responsibility to provide interpreter services during the hearing.

6. Development of Center Staff as Certified Interpreters. The Center will seek to expand its resources to include bilingual staff certified as interpreters as the applicant pool and financial resources allow.

V. STAFF EDUCATION
Orientation for new employees will address this policy and its procedures to inform staff of their responsibility and resources. Inservice education will be provided annually to staff regarding culturally and linguistically appropriate services to patients.

VI. MONITORING OF POLICY IMPLEMENTATION
The effectiveness of the processes in place to implement culturally and linguistically appropriate services is monitored by the Center on an ongoing basis. This includes the communication needs of patients using Center services, Center’s abilities to meet these needs, community profile, availability of language assistance in the county, and on-going efforts to keep staff informed of this policy and procedure.
DECLINATION OF QUALIFIED INTERPRETER/COMMUNICATOR

I understand that the mental health center has offered to provide me with a qualified interpreter or communicator at no cost to me or my family. The benefits of such an interpreter have been explained to me.

I do not want to use an interpreter or communicator provided by the mental health center.

I want to use a person of my choice to help me communicate with the mental health center.

I understand that at any time, I can ask the mental health center to provide me with a qualified interpreter or communicator.

___________________________________________  __________________________________
Name                                           Date

___________________________________________  __________________________________
Witness                                         Date
PURPOSE/POLICY: The Center is available to the residents of Berkeley County seeking mental health services. Within the mission of the Center, services are offered to address an array of needs. The Center does not maintain waiting lists for services. From the initial contact with the Center throughout assessment and treatment, communication between patients and staff is on-going to promote the most effective and satisfactory means to address patients’ needs.
PROCEDURES:

I. ADMISSION

As a facility of the South Carolina Department of Mental Health, the Center’s priority is to serve adults with severe, persistent mental illnesses and children and adolescents with serious emotional problems and to fulfill its mandated responsibility to provide screening for psychiatric and substance abuse emergencies. The Access Center receives all requests for services and determines eligibility for Berkeley County residents based on the following procedures.

Priority Populations:
- Adults with severe, persistent mental illnesses
- Children and adolescents with serious emotional problems

In evaluating for admission, the following information is needed:
- Emergent needs – BCMHC continues to fulfill its responsibility to provide screening for psychiatric and substance abuse emergencies. As gate keeper of the SCDMH inpatient facilities, it is incumbent upon us to maintain a level of screening to offer services which divert admissions from DMH. Persons with multiple admissions to state hospitals are appropriate for the array of Center services. Referrals from DMH inpatient facilities for discharge follow-up will be scheduled an assessment.
- Symptoms – Contacts with persons requesting services, beginning with telephone calls, will gather information on the ways they are feeling, thinking and behaving that have led them to seek mental health services. To use language familiar to mental health professionals, what symptoms are these individuals describing that tell us something about their level of distress, functioning and potentially, the presence/absence of serious persistent mental illness or serious emotional problems?
- Role functioning – To what degree has the individual's ability to carry out his/her usual roles and responsibilities been impaired by the ways he/she is feeling, thinking and behaving? Impairments which substantially interfere with or limit role functioning in one or more areas, including basic living skills, instrumental living skills, and functioning in social, family and educational or vocational contexts, are identified through contacts with the individual and other informants as appropriate.
- History of mental illness/emotional disorders and/or treatment – Persons are asked to identify other times when difficulty with their feelings, thoughts, behaviors or symptoms may have impaired their role functioning. Have other contacts with mental health providers/systems resulted in specific interventions, treatments or diagnoses?
- Substance use/abuse – The individual requesting services will be asked about his/her use of alcohol and other drugs to include the last episode of use and the longest period of time without use. History of participation in any substance abuse treatment/recovery programs will be gathered. Should a history of substance abuse without periods of abstinence (6 months) be presented in individuals not describing emergency needs, a referral to the local alcohol/drug abuse agency may be made.
- Medical emergencies – Person in need of immediate medical intervention due to
physical illness, injury, suicide attempts (e.g. overdose, self-inflicted wounds) or alcohol intoxication will be directed and given assistance to access primary medical care.

- Court orders to services – Persons seeking treatment as the result of a court order will be asked to provide specific documentation from the referring court. Probate Court, as a standard practice, forwards copies of its orders for outpatient mental health treatment to the Center. Family Court, Magistrates Court, and General Sessions Court, as a practice, simply tell individuals to contact the Center for services. It will be the individuals’ and families’ responsibility to provide documentation of the court’s expectations regarding type of mental health services. It has been an established practice that referrals of children/adolescents from DJJ are accompanied by DJJ paperwork. Assessments to determine the Center’s capability to fulfill the court mandates will be offered.

- Evaluation/Report Generation – If the request for services is solely an evaluation for the purpose of generating a report for an attorney or court, the individual will be referred elsewhere. Center assessments and evaluations are associated with the intent to engage in treatment services.

- Pastoral Counseling – Persons specifically requesting pastoral counseling or counseling based on a specific religious/belief system are referred to other resources. The Center provides services in a manner that respects individual belief systems, but does not offer services founded on schools of thought based in such belief systems.

- Financial resources (i.e. private insurances) – The persons for whom the Center has the capability to serve are not denied services because of an inability to pay for services. As a DMH facility, the Center’s mission is to address the mental health needs of indigent citizens. Based on experience, the coverage of most Center patients with mental health coverage as a part of their private insurance plan (excludes Medicare, Medicaid, Champus) does not reimburse the Center because of provider network limitations or level of provider credentialing. Individuals with mental health coverage as a part of their private insurance plan who have the means to access other providers in the community will be asked to do so.

Participants in access process (includes telephone and face-to-face contacts):
- Individual requesting services
- Family/support system of individuals requesting services, as allowed
- Referral source such as agency, pastor, primary care doctor, school, etc.
- Center staff

II. INTAKE

A. During Center business hours, a clinician is always available to receive requests for services by telephone and face-to-face.

B. For every person requesting an initial appointment, a Community Mental Health Center Screening Form is completed.

C. Based on the needs and wants of the person seeking treatment, the clinician offers the
person the option of enrolling in services without a scheduled appointment. This process is known as ‘same day access’ which allows any person who meets admission criteria the opportunity to present to BCMHC without an appointment and enroll in treatment. In the event a person indicates suicidal or homicidal thoughts/intent or psychotic symptoms, he/she will be directed to come as soon as possible to the Center for assessment/crisis management.

D. Ineligible for Services – persons deemed ineligible for services at Berkeley Community Mental Health Center will be referred to appropriate resources in the local area. After discussion with the individual, the intake clinician will explore options for services outside the Center. If there is any question about the Center’s ability to meet the individual’s needs, the intake clinician will consult a supervisor. Effort will be made to assist the person in finding appropriate options. Persons not eligible for Center services will be documented and reports generated for use by the Executive Director, Board of Directors and Quality Improvement Team.

III. ASSESSMENT

A. As part of the initial appointment, patients meet with an administrative employee to complete admission paperwork. Included in this process is review of Patient Orientation Packet, establishment of fees, release of insurance providers and verification of income and insurance information. Eligibility for any entitlements is reviewed by the Center Entitlement Specialist.

B. Initial Assessments. All assessments are performed by mental health professionals. A comprehensive assessment form guides this process, so that patients and their families actively participate in the identification of needs, abilities and strengths, as well as social, cultural, medical and psychiatric information. One product of this assessment is a treatment proposal which initiates services to address patient needs and goals.

C. On-going Assessment. As part of treatment, the patient and counselor communicate about the patient’s goals and needs. As these evolve, so do the services offered to the patient. In addition to this on-going dialogue, the counselor and patient will reassess needs, abilities, strengths and preferences at least as often as the intervals indicated by the Plan of Care (POC). This periodic assessment is facilitated with the patient and family. Providers of adjunct services in the Center and community may provide information and feedback to the patient and counselor throughout treatment and specifically at times of reassessment. At any point in treatment, significant changes in the patient’s needs, strengths, abilities and preferences indicate the need for reassessment.

IV. Psychiatric Medical Assessment

A. Initial Psychiatric Medical Assessment. All patients of the Center are offered a Psychiatric Medical Assessment (PMA) with a psychiatrist. The assessment by the psychiatrist is designed to further identify patient’s needs, evaluate the need for psychiatric medical intervention to augment treatment services, and to finalize a multiaxial diagnosis based on the Diagnostic and Statistical Manual (DSM-5). The information used by the psychiatrist includes the patient and family,
counselor(s), and observations to recommend and support services offered to the patient. This initial PMA may result in recommendations for medication and/or outpatient laboratory tests. The psychiatrist communicates with the counselor all recommendations for treatment and medical interventions initiated.

B. On-going Psychiatric Medical Assessments. Based on the patient’s needs, the psychiatrist determines the frequency of subsequent PMA appointments. This is communicated to patient, family and counselor. Once established with a psychiatrist, the patient continues to work with this psychiatrist as the treating psychiatrist. On-going PMA’s are scheduled with the treating psychiatrist. Another psychiatrist may assist a patient with emergent needs. Treating psychiatrist will evaluate medication needs, responses to services and make recommendations for continued services. The psychiatrist is responsible for informing the patient and family about the proper administration of each medication prescribed and its side effects.
# THERAPEUTIC URINE DRUG SCREENING (UDS)

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<td>Revision Number: 04</td>
<td>Revision Date: 4/08, 3/09, 4/13, 4/14</td>
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<td>Date Approved by Board: 4/12/07</td>
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**PURPOSE:** A urine drug screen is ordered to detect illicit drugs in the urine and/or to verify compliance with prescribed controlled substances. It may be used to determine a safe course of treatment during admission or ongoing treatment process. The screens will only be used for therapeutic determination and not for legal purposes.
THERAPEUTIC URINE DRUG SCREENING (UDS)

RESPONSIBILITIES:

- Patients who have a history of substance use or who clinical staff have “reason to believe” based on observed behaviors and/or reports from significant others that the patient is currently using substances may be requested to submit to UDS, for therapeutic reasons.

- A clinician who has concerns about a patient being under the influence of illicit drugs who verbally denies use, will staff with the supervisor and the prescriber of record. The patient may be requested to submit to a urine drug screen as part of their previously agreed upon plan of care, if therapeutically indicated.

- The prescriber must order the UDS after the request has been staffed. Patients receiving controlled substances (from primary care provider or MHC prescriber) may be periodically requested to submit to a UDS.

- Prescribers will consult with parents of minors that prescribers believe are in need of therapeutic urine drug screens for parental permission to test their child. Children sixteen (16) years old may give their own consent.

PROCEDURES:

1. Confidentiality and privacy of the patient will be maintained at all times during the procedure.

2. An order for a UDS from the prescriber must be given prior to all UDS. The prescriber has final authority in determining therapeutic necessity of UDS.

3. Clinician working with the patient will staff with a supervisor and the prescriber any concerns about the patient possibly under the influence of illicit substances despite denial of such. If the prescriber is not available for verbal review, the clinician will submit a “Request for Urine Drug Screen” form to the prescriber’s support staff.

4. The procedure will be initiated by a staff person who has received training to do the procedures.

5. A history of all substances ingested, inhaled, etc. will be taken by the staff person (to rule out false positives).

6. If a staff person accompanies the patient to the restroom, the staff person will be of the same sex as the patient. A staff person of the same sex may be asked to accompany the patient into the bathroom, if needed, but will not directly observe the voiding process. If patient is a youth, parent may be asked to accompany patient to bathroom.

7. The staff person will test the specimen according to manufacture’s directions on the package insert for the testing device. Results will be reported to the prescriber for determination of treatment.

8. Involved staff persons will always observe universal precautions when subjected to any body fluids.

9. The patient may refuse to submit to the test. This will be documented in EMR. The plan of care may be reevaluated if other substances might interfere/interact with prescribed treatment/medications.
10. If the patient tests positive for any illicit substance:
   a. The plan of care will be adjusted to accommodate the needs of the patient.
   b. The patient will be offered treatment to best address his/her needs, including any needed referrals.
RECEIPT OF TIME SENSITIVE DOCUMENTS

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<tr>
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<td>Approved by:</td>
<td>Date Approved by Board: May 8, 2014</td>
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PURPOSE/ POLICY: Staff of Berkeley Community Mental Health Center receiving time sensitive documents will time/date stamp all such documents immediately upon receipt.
PROCEDURE:

A. Immediately upon receipt of any time sensitive documents, including but not limited to court orders and subpoenas, receiving staff will time/date stamp document.

B. Time/date stamp is located in the mailroom as a central location for all staff access.

C. After documents have been time/date stamped by receiving staff, handling of the documents will follow appropriate procedures already in place for that particular type of document (i.e. import into EMR, notification to supervisor, etc.).
PURPOSE: To ensure that patients who are eligible to receive Telepsychiatry services will receive proper orientation and have necessary staff support during these services, and to ensure the Telepsychiatry equipment utilized by staff members will be maintained properly.

POLICY: Patients who are screened to receive Telepsychiatry services will be afforded proper orientation, staff support and IT equipment to ensure excellent care via the Telepsychiatry program. Staff members providing or supporting Telepsychiatry services will be properly trained in the practice, use, and maintenance of the Telepsychiatry equipment.
PROCEDURES:

1. Current patients of the Center are eligible to receive Telepsychiatry Services when all of the following conditions have been met:
   a. When the patient has given signed consent to receive the Telepsychiatry services (including signed consent for audio/video recording of the session);
   b. When the patient’s mental status is stable enough to fully participate in the Telepsychiatry service;
   c. As an adjunct to treatment when face-to-face psychiatry interventions are unavailable;
   d. When necessary IT equipment is available and functioning at both the originating and remote site;
   e. When all personnel involved in the delivery of services are trained in the use of the equipment.

2. Both the remote and the originating site for Telepsychiatry services will take place at a DMH approved site which is capable of providing the IT and staff support necessary for the successful delivery of the service. Telepsychiatry services will not be provided to patients who are in a public area or at a private residence.

3. Trained support staff are required to be available during the Telepsychiatry intervention at the remote (patient’s) site to: aid the originating site staff in the provision of the service as necessary; to support the patient; and to troubleshoot technology issues that may arise with the equipment.

4. Center staff who participate in the provision or support of Telepsychiatry services must ensure, prior to the provision of Telepsychiatry services on that date, that the equipment is functioning appropriately according to the manufacturer’s specifications. Poorly functioning or non-functioning IT equipment will not be used to deliver Telepsychiatry services to patients of the Center.

5. Center staff who deliver Telepsychiatry services must be trained and demonstrate competency on the features of the Telepsychiatry equipment; procedures for setting up the equipment; maintenance of the equipment, as needed; safety considerations for patients at the remote site; infection control procedures; and equipment troubleshooting prior to being eligible to provide Telepsychiatry services.

6. Patients and members of their family/support system who participate in Telepsychiatry services must be oriented to the unique aspects of Telepsychiatry services prior to receiving these interventions. This will include: the name(s) and role(s) of the support staff who will be present at the patient’s location; the name(s) and role(s) of the staff at the originating site; how the equipment is utilized by the originating and remote site to provide the service; appropriate guidance concerning infection control; safety and confidentiality considerations for the patient/family/support; and, how the staff will respond to technology equipment errors or failures during the provision of the service, including the possibility of the cancellation/rescheduling of the service.
7. The Information Technology utilized in the delivery of Telepsychiatry services will be maintained as per the manufacturer’s guidelines and be inspected at least annually for wear. Staff utilizing the equipment must notify the local IT administrator of any equipment errors or failures as they are discovered.

8. All staff involved in the provision of Telepsychiatry services must be trained to respond to and manage any safety or patient crises that arise during the provision of these services. Staff at the originating (physician’s and/or APRN’s) site must be familiar with the emergency procedures in place at the remote (patient’s) site prior to the delivery of service, to include knowledge of local emergency resources and emergency phone numbers of the remote site.
OVERVIEW OF SAFETY PROGRAM AND ACTIVITIES

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PURPOSE: The purpose of the safety program is to prevent the loss of life and property as well as to reduce suffering and injury to patients, staff and visitors in the event of disaster. This Safety Policy is followed by the following policies and procedures in support of the safety program:

- S005 Criminal Sexual Assault
- S023 All Hazards Disaster Plan
- S027 Visitors to Center
- S030 Fire Emergency
- S037 Code Blue Emergency
- S040 Violent Workplace Emergency Responses
- S042 Utility Emergency
- S044 Bomb Threat Emergency
- S047 Infection Control
- S050 Tobacco Use in Center
- S051 TB Infection Control Plan
- S052 Reporting Adverse and Unusual Incidents
- S057 Quality of Care Review Boards
- S058 Material Safety Data Sheets (MSDS)
- S059 Security/Fire Alarm
- S060 Red Cross First Aid and CPR Training
- S067 Seclusion and Restraints
- S078 Use of TDD
- S082 Urgent Care for Patients, Employees and Visitors
- S083 Health and Safety
- S105 Safety Protocol for SMI Adults on the SC Sexual Offender Registry

POLICY: The Berkeley Community Mental Health Center is committed to providing a therapeutic, safe and pleasant environment for all patients, staff and visitors of the Center through the development, implementation and ongoing monitoring of the safety program.
PROCEDURES:

I. AUTHORITY: The Executive Director, in concert with Center employees, develops implements and monitors the Center’s Safety Plan to include Technology and Risk Management Plan. The Executive Director appoints a Safety Coordinator to implement activities as specified within this safety policy. The implementation of this safety program and subsequent policies is managed by the Safety Coordinator and is reported to the QIT quarterly.

II. ORGANIZATION: An ongoing Safety and Risk Management Committee consists of members of clinical and clinical support staff and is chaired by the Safety Coordinator. The purpose, functions and membership of the committee are outlined in the centerwide Quality Assurance and Quality Improvement Plan and the safety program and subsequent activities are integrated with QA/QI activities. Furthermore, the Safety Coordinator fulfills the following duties and responsibilities:
   A. Assurance of safety education for new employees
   B. Assurance of ongoing safety education for staff at least annually
   C. Works closely with Human Resources in identifying safety issues relating to work injuries
   D. Active leadership and participation on the Safety and Risk Management Committee
   E. Maintenance of committee minutes and supporting documentation with review by appropriate authorities
   F. Periodic review/revision of safety policies and procedures
   G. Development and successful implementation of safety policies and operational procedures
   H. In coordination with Facilities Manager, assures implementation of preventive maintenance/safety surveillance program for equipment and plant management
   I. Maintaining files including safety drills, internal inspection reports and other inspection reports conducted by external authorities

III GENERAL SAFETY AND HAZARD SURVEILLANCE PROGRAM: Semi-annual self inspections are conducted for all buildings owned, rented or leased by the organization. In addition, inspections are conducted by external authorities, among which includes annual fire inspections. These reports and any subsequent recommendations are reviewed by the Executive Director along with plans for corrective action. The Safety Coordinator maintains files of all inspections and follows through on any corrective actions or recommendations from the inspections.

First aid equipment, supplies and plans are located in designated locations throughout Center buildings. Staff are trained in basic first aid as well as CPR.

IV RELATIONSHIP WITH INFECTION CONTROL: The infection control nurse is a
member of the Safety and Risk Management Committee. As healthcare issues are identified, they are discussed, tracked and monitored within the scope of the Safety and Risk Management Committee. The infection control nurse is also responsible for periodic review/revision of employee health and infection control policies and procedures.

V QUALITY ASSESSMENT AND IMPROVEMENT: Safety and infection control activities also serve as a source for identification of problems and opportunities to enhance the therapeutic environment. As patterns evolve which relate to risk management issues, the potential problem area is identified and managed by the Safety and Risk Management Committee.

VI SAFETY AND INFECTION CONTROL EDUCATION: The Safety Coordinator is responsible for assuring ongoing orientation and staff training in safety related areas. This includes employee orientation for new employees and ongoing inservice training. The safety education component of the employee orientation program for new employees includes but is not limited to:
A. Incident reporting and procedures
B. Tobacco policy
C. Work injury reporting procedures
D. Use of fire extinguishers
E. Disaster preparedness
F. Behavioral Emergency Stabilization Training (BEST), which includes prevention of workplace violence
G. Emergency codes and procedures
H. Evacuation procedures

The infection control nurse is responsible for providing ongoing orientation and staff training in infection control related areas. This infection control education component of the employee orientation program for new employees includes but is not limited to:
A. Storage and disposal of biohazardous waste
B. Hazardous material/MSDS
C. Universal precautions
D. Handwashing procedures
E. Exposure plan and procedures
F. Blood borne pathogen training
G. HIV/AIDS training
VII HOUSEKEEPING SERVICES: The infection control nurse and Facilities Manager provide coordination to housekeeping staff relating to application of safety procedures and universal precautions relating to the provision of housekeeping services. Housekeeping supplies are stored in secure locations. MSDS sheets are found in locations accessible to all staff.

VIII SECURITY AND WORKPLACE VIOLENCE: It is the responsibility of all employees of the Berkeley Community Mental Health Center to provide and monitor the security of patients, staff, visitors and property; as well as being aware of the potential for workplace violence. Security issues should be monitored through hazard and incident reporting procedures. Routine activities which minimize security and safety risks include:
A. Visitor identification badges
B. Limited and secure access to building
C. Training and implementation of “Violent Workplace Emergency Responses” procedures
D. Duress system
E. Staff training on managing aggressive behavior
F. Patients and visitors escorted throughout building
G. Emergency information is maintained for all staff and patients

IX EMERGENCY PREPAREDNESS: An extensive All Hazards Disaster Plan is an integral part of the safety program. As such, an agreement is maintained with Roper Berkeley, Medical Wing, in the event of an emergency and temporary shelter is needed. All emergency plans are tested at least annually.
CRIMINAL SEXUAL ASSAULT

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<td>Date of Origin: 11/94</td>
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PURPOSE: To establish procedures, in accordance with Department of Mental Health Directive No. 789-94 (1-40), to follow in the event an incident of criminal sexual assault occurs at the Berkeley Community Mental Health Center (BCMHC). (BCMHC is defined as any location Center staff provide treatment services to patients).

POLICY: To insure a patient who is an apparent victim of criminal sexual assault receives emergency care, psychological treatment, and full incident investigation, BCMHC staff are responsible for reporting any knowledge of such an incident.
PROCEDURE:

A. Reporting
   Any employee having knowledge of alleged criminal sexual assault involving a patient will immediately notify his/her supervisor and the Executive Director. The appropriate local police will be called to investigate. The Department of Mental Health Office of Public Safety will also be notified. If the apparent victim is a minor, the parent/legal guardian will be notified, and the Department of Social Services will be notified in compliance with South Carolina state laws. If an adult victim desires, a correspondent will be notified.

B. Emergency Care and Psychological Treatment
   An appropriate staff member will remain with the patient during reporting to police and emergency medical evaluation to provide emotional support. A Center physician will provide a psychiatric medical assessment.

   The patient/victim will be transported to the emergency department of their choice to receive medical care and a sexual assault protocol examination.

   Consent for transport must be obtained from the parent/legal guardian in the case of a minor.

   The Center will arrange for psychological treatment to meet the patient's needs using Center and community resources.

C. Documentation
   All incidents of alleged criminal sexual assault will be documented on SCDMH Adverse Incident Report form (C-174) as outlined in BCMHC policy Reporting of Significant Adverse and Unusual Incidents.

D. Employee Victims
   Procedures outlined above will be followed as applicable for employees sexually assaulted at the Center.
**ALL HAZARDS DISASTER PLAN**

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**PURPOSE:** Federal legislation requires that states provide crisis counseling to victims of natural and terrorism disasters. This responsibility rests with the state and local mental health centers. Among the unexpected circumstances during a disaster is the disruption of the mechanisms designed to cope with disaster. The purpose of this plan is to define the role of the Center in responding to disasters/acts of terrorism as a facility of the South Carolina Department of Mental Health.

**POLICY:** Disasters by definition are unplanned and often result in feelings of fear, anger, stress, anxiety, depression and many other emotional reactions. Mental health professionals are called on to address such emotional reactions in these situations, defining the role of mental health in disaster response and recovery.
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PROCEDURES:

I. PLANNING AND PREPAREDNESS

A. Assignment of Responsibilities: The Center’s plan will be activated by the Executive Director or designee. The Center’s Leadership Council will be responsible for coordinating essential operations of the Center.

1. Executive Director - Notification of DMH Disaster Response Office/Office of Public Safety; staffing of County Emergency Operation Center; coordination of services on county and state levels; coordination of staff personal and family needs; security of medical records; coordinate personnel assignments.

2. Director of Administration - Securing of Center buildings; distribution of essential telephone numbers and staff rosters; security of computer data and equipment; assessment and readiness of Center vehicles; polling staff personal and family needs; maintenance of service area.

3. Medical Director - Coordination of medical/psychiatric coverage; facilitate implementation of crisis counseling services to victims and workers; facilitate identification of patients with special needs; polling staff personal and family needs.

4. Adult Services Program Director - Polling of staff’s personal and family needs; security of medication and medical supplies; identification of patients with special needs; responsible for Center patients in community care homes; coordinate patient education about disaster preparedness and reconnecting with Center after disaster.

5. CAF Program Director - Polling of staff’s personal and family needs; liaison with Center patients in residential placement in the county; coordination with DSS about mutual patients; identification of patients with special needs; facilitate patient education about disaster preparedness and reconnecting with Center after disaster.

6. Community Mental Health Nurse Manager(s) - Identification of patients with special needs; polling of staff’s personal and family needs; liaison with local emergency rooms; availability of emergency commitment paperwork; coordination with Hotline, Inc.; facilitate patient education about disaster preparedness and reconnecting with Center after disaster.

B. Emergency Shelters: Upon notification of shelter activation by the DSS County Director, trained non-clinical volunteer staff may be deployed to operational control of DSS Director.

1. DSS and DMH have a commitment to fulfill certain statewide obligations under Order of the Governor and work together with other agencies to ensure mass care staffing responsibilities are met within the available resources of the respective agencies.

2. Center will solicit volunteers from its non-clinical staff to receive American Red Cross shelter training in conjunction with DSS.

3. Center will maintain shelter training records for its staff, After Action Report relevant to the number of staff deployed, shift hours worked and document any
issues related to shelter work.

C. Minimum Requirements for Center Operation: If the Center and its staff are victims in the disaster, the following would be minimum requirements for Center to respond to its patients and community:

1. Medical personnel: psychiatrists (3); nurses (4)
2. Clinical staff: mental health professionals (40)
3. Support staff: clerical (4); physical plant support – will vary with nature and scope of disaster
4. Medical supplies: medications (oral and intramuscular), syringes, stethoscopes, and blood pressure cuffs
5. Equipment: vary with nature and scope of the disaster and may include vehicles, fuel, generators, food supplies, office supplies, lighting, etc.

D. Policy Review: Center’s plan will be reviewed and updated periodically by the Leadership Council. It will be reviewed annually with all Center staff.

II. ALERT AND MOBILIZATION

A. Disaster Definitions: The following are general guidelines. In all instances, the magnitude of the disaster shall take precedence over size of the affected area in governing BCMHC and DMH responses.

1. Community Incidents/Emergency Situations – In situations where a small group of individuals are affected by a traumatic event or where only the BCMHC catchment area is affected, the Center is responsible for activating its plan. In these situations, casualties and property losses are minimal and the response needed is within the capacity of the Center to address. The Executive Director or designee is responsible for immediately notifying DMH Disaster Response Office/Office of Public Safety when the plan is activated. DMH will secure any outside assistance or special expertise on behalf of the Center if needed.

2. Small Scale Disasters – A small scale disaster is generally defined as affecting one or two service areas, four or fewer counties or one facility or portion of a facility. The Center is responsible for activating its plan and notifying DMH Disaster Response Office/Office of Public Safety of its status and needs. Center staff will be immediately deployed to the County EOC.

3. Large Scale Disasters – Three or more service areas or more than four counties are affected by a disaster or a Presidential Declaration constitutes a large scale disaster. The Center, DMH and inpatient facilities will automatically activate their plans. The Center will contact DMH Disaster Response Office/Office of Public Safety as soon as possible.

B. Specific Disaster Alerts and Response:

1. Earthquake – Center safety contact receives email, text and phone messages from County Emergency Operations Center. If earthquake is live, staff should drop and cover if caught in building during earthquake.

2. Tornado – Center safety contact receives text and phone messages from County Emergency Operations Center. Staff are given email, announced or face to face
ALL HAZARDS DISASTER PLAN
PAGE 4

updates depending on severity of threat. If tornado is live, staff should get to safe
interior location in the building, with minimal exposure to exterior windows and
doors. Available supervisors will coordinate this evacuation, wherever they are
physically located.

3. Hurricane – The Center receives email, text and phone updates from County
Emergency Operations Center for storm tracking and OPCON changes. Staff are
given email, announced or face to face updates depending on severity of threat.
The Executive Director or designee is responsible for activating the plan and notifying
DMH Disaster Response Office/Office of Public Safety.

C. Needs Assessment - The Center will conduct a needs assessment to evaluate the
magnitude of the disaster with regard to damage to Center facilities/offices, status and
needs of staff affected by the disaster, assessment of staff’s ability to respond, estimates
of casualties, and estimates of the amount and kind of assistance needed. DMH Disaster
Response Office/Office of Public Safety will be advised of needs identified.

1. Community Incidents/Emergency Situations – The Center will conduct a needs
assessment to include needs of victims, their families, by-standers or witnesses,
first responders and the community at large. The Center will work collaboratively
with existing community based Crisis Response Teams to provide debriefing,
crisis counseling and public education.

2. Small Scale Disasters – Once the Center plan is activated, an assessment of the
scope and magnitude of the event and number of people directly and indirectly
affected will be conducted. Crisis counseling and debriefing services will begin
immediately. DMH Disaster Response Office/Office of Public Safety will be
notified as soon as the plan is activated and will be kept advised of needs.

3. Large Scale Disasters – Center staff will link with the DMH needs assessment
teams at the county EOC unless other arrangements are made beforehand. State
teams will work with Center staff to determine the full impact of the event and
resulting needs.

III. RESPONSE
In the event the Center is affected by a disaster, DMH will provide assistance.

A. Crisis Counseling Teams - Crisis counseling teams will be sent to assist the Center in
providing crisis counseling, debriefing and support to survivors when the disaster
exceeds the Center’s capacity to respond effectively. Teams may provide operational
assistance to DMH programs and supplemental assistance to Disaster Application
Centers, Emergency Operations Centers, shelters, feeding and relief sites, American Red
Cross, FEMA personnel, and other agencies responding to the disaster. Each team will
have a team leader who generally has previous disaster response experience and hold
program management or middle management roles in community mental health centers
or facilities. While responsible to the DMH Disaster Response Team to carry out his/her
overall mission, the team leader will report to the Center Director or designee for
supervision. Team members will report directly to the team leader for supervision.

B. Support Services - The DMH Division of Administrative Services is responsible for
procuring, coordinating and disseminating supplies, equipment and other resources
needed by teams responding to the disaster and to the Center(s) affected by the disaster.
C. Debriefing - Participation in debriefing is mandatory for all staff involved in disaster work. Debriefing encompasses the exchange of information for purposes of planning and coordinating services, as well as the need for all staff involved in the disaster to deal with the emotional effects of the experience. Debriefing is a specialized clinical skill and only people trained in a debriefing model will carry out this function.

IV. RECOVERY
This phase begins when the Center returns to normal operations and provides long-term crisis counseling services to survivors. Services will be provided by existing staff when it is within their capacity to do so. If supplemental staff are needed, DMH will assist.

A. Focus of Services
1. Home-based and community-based outreach activities
2. Debriefing local groups who served as responders and who were also survivors
3. Culturally appropriate
4. Focus on active listening, normalization of emotional responses, problem definition and resolution, advocacy, linkage, support, affirmation, support network development or re-establishment, education, information and referral
5. Priority populations will be children and their families, persons with deafness, the elderly, persons with sensory or other disabilities, and persons with a serious and persistent mental illness.

Evaluation - Within three months after the conclusion of the Recovery Phase, an evaluation will be done to refine and improve the Center’s capacity to respond.

V. HOMESHARE PROVIDERS
In the event of a disaster, HomeShare providers are expected to be responsible for the safety of their patient. Providers have quarterly fire and evacuation drills in their homes. Documentation of such is in provider’s file. There is an annual safety inspection of the provider’s home. Copies of automobile and home owner’s insurance are in the provider’s file. “What To Do In Case Of A Disaster” is presented periodically at HomeShare provider’s meetings.

VI. CRCF
CRCF owners have the responsibility of assuring the safety of their residents in the case of a disaster as documented in DHEC Standards.
LOCAL ACTION GUIDE

In the event a disaster is predicted or has occurred in the area, take the following immediate action:

1. Notify Center Director or the person acting in that capacity:
   
   Name: Debbie Calcote  
   Office Phone: 843-761-8282, ext. 370  
   1-888-202-1381, ext. 370  
   Home Phone: 843-871-7037

2. Notify the Office of Public Safety at the Department of Mental Health:
   
   Public Safety Headquarters 803-935-5470  
   Emergency Assistance 803-935-5499

   Give the name, location, directions and phone number of the mental health contact person in the area.

3. Send a CMHC staff member to the county emergency operations center located at:
   
   Address: 223 N. Live Oak Drive, Moncks Corner, SC  
   Directions: Highway 17-A and Belt Drive, Moncks Corner, SC

   Name of County Emergency Preparedness Director: Marvin “Tom” Smith  
   Phone Number during regular working hours: 843-719-4166  
   Cell Phone: 843-729-2968

4. Implement Center’s Disaster Plan.

5. Maintain contact with the Department of Mental Health Office of Public Safety at least every two hours until advised otherwise.
STATE ACTION GUIDE

1. County: Berkeley

2. Local Mental Health Center Contact Person:
   Name: Debbie Calcote, Executive Director
   Home Address: 190 Telfair Court, Summerville, SC
   Home Phone: 843-871-7037
   Home Directions: From Columbia - I-26 East to Summerville exit - 17A. Merges onto Main Street - stay on Main Street until Berlin G. Myers Parkway. Take left. Intersection of Berlin G. Myers Parkway and Gahagan Road, take left. Right off Gahagan Road at Gahagan Subdivision entrance - Blackoak Boulevard. First right - Factors Walk. Next left - Telfair Court. House on left.
   Office Address: 403 Stoney Landing Road, Moncks Corner, SC
   Office Phones: 843-761-8282, 1-888-202-1381
   Office Directions: From Columbia - I-26 to Jedburg/Pinopolis exit. Turn left onto Highway 16. Follow Highway 16 until intersects Hwy. 6 (becomes Main Street). Stay on Highway 6/Main Street until intersects with Highway 52 (first traffic light after crossing railroad tracks). Left onto Highway 52. Approximately quarter mile, Stoney Landing Road on right (see attached map).

3. County Emergency Preparedness Office Contact Person:
   Name: Marvin “Tom” Smith
   EOC Address: 223 N. Live Oak Drive, Moncks Corner, SC
   EOC Phone: 843-719-4166
   Directions: From Columbia - I-26 to Jedburg/Pinopolis exit. Turn left onto Highway 16. Remain on Hwy. 16 until intersects with Hwy. 6. Turn right onto Hwy. 6. Hwy. 6 turns into Main Street. Turn left at 2nd traffic light on Main Street (intersection of Hwy. 6 and Hwy. 17-A) onto Hwy. 17A. Office building quarter mile on left.
FROM COLUMBIA:
Follow Interstate 26 East towards Charleston. Take the Jedburg/Pinopolis exit, Highway 16. Turn left onto Highway 16. Follow Highway 16 until it intersects with Highway 6. Turn right onto Highway 6. Follow Highway 6 into Moncks Corner (Highway 6 becomes Main Street). Stay on Highway 6 until you cross railroad tracks. The first traffic light after crossing tracks intersects with Highway 52. Turn left onto Highway 52 - follow for several blocks until you see Stoney Landing Road on right. Grace Episcopal church will be on the corner. Turn right onto Stoney Landing Road. Entrance to the mental health center is the second driveway on left.
ANNEX J TO BERKELEY COUNTY
EMERGENCY OPERATIONS PLAN

Mental Health

PURPOSE:
To organize within Berkeley County government the capability to meet the basic human needs of persons experiencing extreme emotional and psychological stress in a disaster situation.

Berkeley Community Mental Health Center will follow policies and procedures outlined in BCMHC policy number S023, DMH Disaster Recovery Plan, and the Berkeley County Emergency Operations Plan.

APPENDICES:
1. Organizational Chart
2. Mental Health Alert List
3. Service Locations
4. Adjacent Mental Health Centers
APPENDIX 2 TO ANNEX J
MENTAL HEALTH ALERT LIST
BERKELEY COUNTY

Berkeley Community Mental Health Center - Moncks Corner 843-761-8282
1-888-202-1381

Debbie Calcote, Executive Director 843-871-7037 (Home)

Lamar Butler, Director of Administration 843-761-5675 (Home)
843-499-2340 (Cell)

Matt Dorman, Clinical Program Manager 843-343-7616 (Home/Cell)

Richard Albarran, After-Hours Emergency Services 843-881-1228 (Home)

Margaret Rittenbury, MD, Medical Director 843-709-4287 (Center Cell)
843-469-7228 (Personal Cell)

Catherine C. Parker, M Ed, LPC 803-534-2532 (Home)

DMH Disaster Manager 803-898-8571

Public Safety Headquarters 803-935-5470
Emergency Assistance 803-935-5499
APPENDIX 3 TO ANNEX J
SERVICE LOCATIONS

BERKELEY COUNTY

Berkeley Community Mental Health Center
843-761-8282
403 Stoney Landing Road
1-888-202-1381
Moncks Corner, SC 29461

APPENDIX 4 TO ANNEX J
ADJACENT COUNTIES’ MENTAL HEALTH CENTERS

Charleston/Dorchester Community Mental Health Center
2090 Executive Hall Rd, Suite 170
Charleston, SC 29407
Phone: 843-852-3633
Fax: 843-852-3640

Dorchester County Mental Health Center
106 Springview Lane
Summerville, SC 29483
Phone: 843-873-5063
Fax: 843-851-2110
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HOMESHARE/HOMESHARE ENHANCED RESPITE PROVIDERS:

1. Eunice Washington- HS & HER
   Post Office Box 906
   1074 Hickory Street
   St. Stephen, SC  29479
   843-567-3839
   Hwy. 52 through St. Stephen to Hickory St. Right onto Hickory St. – 2nd house on right.

2. Ethel Parker HS & HER
   106 Arthur Gillins Lane
   Moncks Corner, SC  29461
   843-899-4980 / Cell 843-209-7908
   Hwy. 52S, turn right onto Main St., then left onto 17A. Approximately 1 mile, turn right onto Arthur Gillens Lane. Large house on right.

3. Larrellyn Jones HS & HER
   125 George Wigfall Road
   Cross, SC  29436
   843-753-3231/Cell # 843-697-4690
   Hwy. 6 to Cross; bear right on Hwy. 6 at the 311 & 6 intersection. Take 1st left onto George Wigfall Rd.

4. Barbara Gaillard HS & HER
   4625 North Highway 52
   St. Stephen, SC  29479
   843-567-4815/ Cell 843- 697-8658
   Hwy. 52 through St. Stephen & over canal. Approx. 4 miles on right–small gray house with large lawn.

5. Allen Bryant HS & HER
   139 George Wigfall Road
   Cross, SC  29436
   843-753-3651/ H-Cell.# 843-297-0706(James)
   Hwy. 6 to Cross, right at the 6 & 311 intersection. 1st road on left is George Wigfall.

6. Celestine Scott HS & HER
   156 Venning Street
   St. Stephen, SC  29479
   843-567-7901
   Hwy. 52 to St. Stephen; turn left at traffic light; turn left onto Venning St. House on right at end of street.
7. Cynthia Croker HS & HER
1212 Old Mill Road
St. Stephen, SC 29479
Cell # 843-312-6503
Hwy. 52 to St. Stephen; turn left at traffic light; turn left onto Venning St. House on right at end of street.

8. Wilhelmina Hunt- HS & HER
10442 Highways 78
Summerville, SC 29483
843-563-7517
843-534-6817 & 843-419-6198
Turn right onto Hwy 52 N, then left onto Hwy 17-A South. Continue to follow Hwy 17-A South for 16 miles then left onto SC-165 (Berlin G Myers Parkway). Approx 1.5 miles then left onto Hwy US-78. House .4 miles past Polar Grove off of Hwy 78.

9. Andrea Horry- SR & ER-Only
106 Arthur Gillins Lane
Moncks Corner, SC 29461
843-899-4980 & 843-607-4655
Hwy. 52S, turn right onto Main St., then left onto 17A. Approximately 1 mile, turn right onto Arthur Gillens Lane. Large house on right.

10. Elizabeth Davis-HS, HER
1318 Pineville Circle
Pineville, SC 29468
843-351-2021 Cell# 843-870-2218
N. Highway 52 travel 11.9 miles; turn left onto Mandella Road; turn right onto Highway 35; turn left onto Highway 45. Travel 7.12 miles. Turn left onto Pineville Circle – address on right.

11. Brenda Morgan-HS & HER-Pending Complete Training
993 Sheep Island Road
Summerville, SC 29483
843-437-8126
From Highway 17/N. Live Oak Drive, turn right onto Black Tom Road. Turn left onto State Road (US Highway 176). In 1.41 miles, turn right onto Sheep Island Road. Travel 1.9 miles – address on right.

12. Sandra Bennett-HS HER ---Contract will expire Nov. 2016/ Will not use as a provider
Post Office Box 1061
105 Palmetto Road
St. Stephen, SC 29479
843-567-3369 Cell. # 843-696-4443
Hwy. 52 to St. Stephen; 1st left after tire store inside town limits is Palmetto Rd. 1st trailer on the left.
13. JoNells Cooper-HS-HER  ---Contract will expire Nov.2016/Will not use as a provider
   1102 Peru Road
   St. Stephen, SC  29479
   Cell #  843-697-0876
   Hwy. 52 through St. Stephen.  Approximately 4 miles past St. Stephen, turn left onto Peru Road.
   House is white doublewide on the left, several miles down the road.

NURSING HOMES:
UniHealth Post-Acute Care of Moncks Corner
505 South Live Oak Drive; Moncks Corner, SC  29461; 843-761-8368
Right out of Center parking lot onto Stoney Landing Rd.  End of road, turn left onto Hwy. 52.  Turn
right at first traffic light onto Main Street (by Exxon station).  At second traffic light, turn left onto Hwy.
17A.  Follow 17A until you get to the town limits and the nursing home is on the right.
PURPOSE: To insure the protection of patient confidentiality and to expedite the transaction of Center business with outside visitors.

POLICY: All visitors on Center premises will be supervised by a Center employee for the duration of their visit. Visitor is defined as any person other than Center employees and patients (i.e. DSS staff, drug company representatives, office supply salespersons, vocational rehabilitation staff, law enforcement personnel, job applicants, maintenance workers, volunteers, students).
VISITORS TO CENTER
PAGE 2

PROCEDURE:

Scheduled visitors will be asked at the time they make an appointment to report to the receptionist. Staff will notify the receptionist of the visitor's appointment. Receptionist will notify staff at time of visitor's arrival. Each visitor to the Center will be given a badge by receptionist. Staff will be responsible for escorting the visitor to area where their business will be conducted. Visitor's access to Center will be confined to this area.

Unscheduled visitors will be directed to the staff person they request or to a program area supervisor.

Maintenance persons (i.e. plumbers, UPS delivery, copy machine repair, telephone repair) will be escorted to designated area by a member of administrative staff. As often as needed, these visitors will be checked on to ensure they do not access unnecessary areas. They will be told to report to administrative staff before leaving the building.

Law enforcement personnel will be asked to use rear entrances to buildings. They and patients will be escorted to an appropriate room where all are to remain for the time they are in the Center.

Any personal visitors during employee lunch hours/breaks will be escorted as described.

Once visitors have completed their business, staff will escort them out of the Center.
CODE RED EMERGENCY RESPONSE

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<td>Date Approved by Board: 9/14/00</td>
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PURPOSE: To maximize the safety of all persons in the Center’s buildings, specific emergency systems and response plans are in place in the event of fire. The staff of the Center will receive training and drills at least annually in the execution of these systems and response plans.

POLICY: The safety of patients, visitors and staff is the first objective in all situations posing a threat of injury/harm. All actions to ensure the safety of individuals will be executed first. Consideration will be given to securing confidential information if deemed feasible by the responsible staff. Specific duties will be assigned to staff in emergency fire situations.

MISSION STATEMENT
To support the recovery of people with mental illnesses.
PROCEDURES: The procedures listed below govern staff actions to ensure the safety of all individuals in and around the Center in the event of fire.

Physical Elements
A. Smoke detectors are located throughout building
B. Exits in building are clearly labeled
C. Emergency interior lighting is located throughout building
D. Fire extinguishers are mounted throughout building. Staff are trained annually on the usage of fire suppression equipment.
E. Fire escape routes and location of fire extinguishers are posted in places visible to patients, visitors and staff

II Staff Responsibilities
A. Evacuation
1. Smoke/fire detection devices throughout building will warn occupants of danger. Upon hearing the alarm, staff should execute evacuation procedures. Staff will escort patients and visitors from the offices and rooms using designated fire escape routes. Office/room doors are shut once emptied. If staff and patients cannot evacuate an office/room, the blinds to the outside window are to be raised as an alert for rescue personnel.
2. Zone coordinators will be assigned responsibility for checking common areas in the buildings and escorting patients and visitors from these areas.
3. Zone coordinators will ensure everyone in their area evacuates building.
4. Zone coordinators will check all bathrooms in area.
5. Designated zone coordinators are responsible for collecting the fire extinguisher from their zone and the staff roster. The roster will be removed from the building and used for checklist after evacuation.
6. Receptionist will take the patient and visitor sign in/out sheet with them as the building is evacuated. This list will be used for checklist after evacuation.
7. The Administrative Wing Zone Coordinator is responsible for ensuring the emergency kit and OSHA kit are taken out of the building during evacuation. Emergency kit contains emergency information on all staff.
8. Medical Records staff will take printed patient emergency information and Center laptop (including Mi-Fi Hotspot) when evacuating building to ensure the identification and continuation of essential services. This includes but is not limited to the provision of medications.

B. After Evacuation
1. Staff will escort patients and visitors to designated locations after evacuation.
   a. Front of Building - meet in visitor parking lot to the left of the bridge toward the flag pole and grassy area.
   b. Rear of Building - meet in staff parking lot in front of storage shed.
2. The Safety Coordinator will report to the fire officials responding to the alarm providing as much information as possible about the fire.

3. The fire department officials will determine if it is possible to re-enter the building to secure confidential information. Supervisory staff will accompany the firemen to perform this task if allowed.

4. The staff rosters and patient/visitor sign in/out sheets will be used to determine if all occupants have left the buildings. All zone coordinators and receptionist will meet Safety Coordinator outside to ensure all staff, patients and visitors have evacuated.

5. All actual and drill evacuations will be documented on the Fire Evacuation Form. These forms will be reviewed by Executive Director or designee.
CODE BLUE EMERGENCY RESPONSE
MEDICAL EMERGENCY

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PURPOSE: In accordance with South Carolina Department of Mental Health Directive #791-94, specific emergency systems and response plans are in place in the event of a life-threatening medical emergency occurring in the Center. The staff of the Center will receive annual training and drills at least annually in the execution of these systems and response plans.

POLICY: It is the policy of the Center to safeguard the health of its patients, staff and visitors by establishing procedures to respond promptly in the event an individual develops urgent, life-threatening medical problems in the Center.
PROCEDURES:

For the purpose of this policy and procedure, CODE BLUE is defined as:

“Any medical emergency which appears to involve a potentially life-threatening situation which requires urgent response by medical and nursing staff. CODE BLUE covers patients, staff, visitors and others on Center property.”

The individual experiencing distress will be assisted within the capacity of the available staff. When determined to be necessary by staff physician, Center staff will promptly notify trained emergency response technicians (EMS) for transportation to an acute medical facility where further life-saving methods are available.

In the event of a life-threatening medical crisis, the following protocol is to be followed:

**CHECK, CALL, CARE**

In accordance with American Red Cross CPR training, staff will use the CHECK/CALL/CARE method.

**CHECK**  The staff member discovering the CODE BLUE will check the individual as taught in CPR training. Staff should be alert to wearing gloves and cautious about their exposure to infectious substances.

**CALL**  Staff person will notify front office. Front office staff will access overhead intercom system and state “Code Blue, Room _______”.

**CARE**  Staff will administer care within the best of his/her capabilities until help arrives.

I. **EMERGENCY MEDICAL ASSISTANCE**
   A. As the CODE BLUE is announced, staff using the telephone may be asked to clear the lines immediately until EMS has been reached.
   B. All available staff will respond to the call. Staff will coordinate addressing needs of patients present in building. The first doctor on the scene will take charge and direct other staff members.
   C. The staff member closest to the emergency kit and OSHA kit will immediately take the boxes to the site of the CODE BLUE.
   D. If directed by the doctor, staff will call for EMS, making sure to give directions to the Center and any other information requested by the dispatcher.
II ROLE OF PHYSICIANS AND NURSES  
A. Physicians and nurses throughout the Center will respond to the location of the CODE BLUE. The first physician on the scene will be in charge of administering the emergency medical care. Nurses arriving will assist in the medical care.  
B. The emergency and OSHA kits will be on site, having been brought by the staff member closest to them at the time the code was announced.  
C. The physician will direct care until appropriate medical assessment and intervention has been determined or the arrival of EMS.  

III ROLE OF STAFF  
A. In each CODE BLUE event, the Zone Coordinator of that area of the building will serve as lead coordinator. The non-medical staff will serve to coordinate:  
1. Removal of bystanders from the area  
2. Escort EMS personnel to site  
3. Clearing exit for departure of EMS with patient  
4. Having patient’s family notified  
5. Returning all medical supplies to storage site  
6. Clean-up of any hazardous substances according to OSHA standards  
7. Supervisors will arrange coverage for the staff involved with the crisis to process performance, feelings, etc.  

IV TRAINING OF CENTER STAFF  
A. All staff members will have access to CODE BLUE procedure in the policy and procedure shared directory.  
B. Staff will be trained in community CPR and first aid by a certified American Red Cross trainer.  
C. CODE BLUE drills will be conducted at least annually. All actual or drill emergencies will be documented on the CODE BLUE Emergency Form. These forms will be reviewed by the Executive Director or designee.
VIOLENT WORKPLACE EMERGENCY RESPONSES

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<td>Approved by:</td>
<td>Date Approved by Board: January 11, 2001</td>
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PURPOSE: To afford maximum safety for patients, staff and visitors, the Center established policies and procedures to respond to violent, aggressive or unsafe behaviors. The staff of the Center will receive annual training and drills at least annually in the execution of these procedures and response plans.

POLICY: It is the policy of the Center to safeguard its patients, staff and visitors by establishing procedures to respond promptly in the event of aggressive behavior and/or violence in the workplace. In responding to such emergencies, the first consideration is given to the safety and protection from injury for patients, staff and visitors. Center employees will respond to emergencies according to the procedures outlined, always cognizant of their safety and the safety of others in the area.
PROCEDURES:

I. BEHAVIORAL EMERGENCY STABILIZATION TRAINING
   Staff will receive periodic training in techniques to prevent and manage aggressive
   behaviors in the Center. The focus of this training is on the prevention and early
   intervention of such situations. Physical skills focus on protection and release skills.
   The role of Center staff and law enforcement personnel is specifically addressed.

II. DURESS AND PAGING SYSTEM
   All telephones are programmed with a panic/duress button, overhead paging button and
   handset paging button used in situations of aggression and/or violence in the workplace.

III. CODE DR. ARMSTRONG (Emergency warranting staff assistance)
   1. If possible, staff involved will push the duress/panic button. If unable to reach the
      panic button, staff should use any viable means to draw attention to the situation.
   2. Reception staff will announce a “Dr. Armstrong, meet your party in room ___” via
      the overhead and handset paging.
   3. All supervisors and emergency staff will respond to the scene. Additional staff may
      be directed to respond by any supervisor in the building. Staff closest to the
      Emergency Kit and OSHA Kit will bring them to the scene. Use of these supplies
      will be in adherence with the Center’s policy for Infection Control.
   4. The supervisor in charge will assess the situation, make contact with the staff
      signaling for help, and delegate tasks to other staff. Tasks may include: contacting
      police and/or EMS, moving people from the adjacent area, intervention with the
      person displaying aggressive/threatening/violent behavior.
   5. Once the situation is resolved, debriefing for effected persons – patients, visitors,
      and staff – will be provided. Debriefing for patients affected will be structured
      according to individual need and may include processing the incident in therapy.
      Debriefing for visitors will be structured according to individual need. Debriefing
      for staff will be structured according to individual need and may include referral to
      the Employee Assistance Program if problems or symptoms persist.
   7. All Dr. Armstrong codes will be documented on SCDMH Adverse Incident Report
      as outlined in BCMHC Policy S052.

IV. CODE DR. DANGERFIELD (Potential for violence – stay away from the area)
   1. Staff involved will announce “Dr. Dangerfield go to room ___” over the overhead
      and handset paging systems.
   2. The supervisor or person in charge will assess the situation and remain involved
      until resolution.
   3. Uninvolved staff will avoid the area and may relocate themselves along with patients
      and visitors to another part of the facility if the supervisor determines it is safe to do
      so.
   4. If the situation ends without warranting another type of code being called, the
      supervisor/person in charge will announce “Dr. Dangerfield is all clear” via the
      overhead and handset paging systems.
   5. Once the situation is resolved, debriefing for effected persons – patients, visitors,
      and staff – will be provided. Debriefing for patients affected will be structured
according to individual need and may include processing the incident in therapy. Debriefing for visitors will be structured according to individual need. Debriefing for staff will be structured according to individual need and may include referral to the Employee Assistance Program if problems or symptoms persist.

6. All Dr. Dangerfield codes will be documented on SCDMH Adverse Incident Report as outlined in BCMHC Policy S052.

V. CODE DR. SHARP (Weapon other than a firearm including but not limited to knife, razor, needle, bat, board, etc. Avoid the area and protect in place/lockdown.)

1. Staff involved will call the code via the duress/panic button. If unable to reach the duress/panic button, staff should use any viable means to draw attention to the situation.
2. Immediately after pushing the duress/panic button, involved staff will attempt to indicate the type of weapon being used through a conversation such as “John, that knife/razor/needle is making me nervous.”
3. Receptionist receiving the code will notify the Center Director or a Clinical Supervisor. If the involved staff have not called the code, the Director/Supervisor will call the code saying “Dr. Sharp is in room ____.”
4. Director/Supervisor will have staff call 911 and direct law enforcement upon arrival to the scene.
5. Upon hearing the “overhead/handset page”, staff, patients and visitors will lock down and protect in place. Available supervisors will coordinate lock down in respective areas.
6. Once protected in place/locked down, staff will not open the door for anyone who does not repeat the confidential safe word. This safe word will change regularly.
7. Supervisors should attempt to account for all persons in the building at the time of the incident using safe means such as Scotland Yard and EMR scheduler.
8. If evacuation is warranted, it will be executed under the direction of emergency/law enforcement personnel.
9. If the situation ends without evacuation, involved staff will announce “Dr. Sharp is all clear.”
10. Once the situation is resolved, debriefing for effected persons – patients, visitors, and staff – will be provided. Debriefing for patients affected will be structured according to individual need and may include processing the incident in therapy. Debriefing for visitors will be structured according to individual need. Debriefing for staff will be structured according to individual need and may include referral to the Employee Assistance Program if problems or symptoms persist.
11. All Dr. Sharp codes will be documented on SCDMH Adverse Incident Report as outlined in BCMHC Policy S052.

VI. CODE DR. WINCHESTER (Gun involved – avoid the area and protect in place/lockdown)

1. Staff involved will call the code via the duress/panic button. If unable to reach the panic button, staff should use any viable means to draw attention to the situation.
2. Immediately after pushing the duress/panic button, involved staff will attempt to indicate the type of weapon being used through a conversation such as “John, that pistol/shotgun is making me nervous.”
3. Receptionist receiving the code will notify the Center Director or a Clinical Supervisor. If the involved staff have not called the code, the Director/Supervisor will call the code saying “Dr. Winchester is in room ____.”

4. Director/Supervisor will have staff call 911 and direct law enforcement upon arrival to the scene.

5. Upon hearing the “overhead/handset page”, staff, patients and visitors will lock down and protect in place. Available supervisors will coordinate lock down in respective areas.

6. Once protected in place/locked down, staff will not open the door for anyone who does not repeat the confidential safe word. This safe word will change regularly.

7. Supervisors should attempt to account for all persons in the building at the time of the incident using safe means such as Scotland Yard and EMR scheduler.

8. If evacuation is warranted, it will be executed under the direction of emergency/law enforcement personnel.

9. If the situation ends without evacuation, involved staff will announce “Dr. Winchester is all clear.”

10. Once the situation is resolved, debriefing for effected persons – patients, visitors, and staff – will be provided. Debriefing for patients affected will be structured according to individual need and may include processing the incident in therapy. Debriefing for visitors will be structured according to individual need. Debriefing for staff will be structured according to individual need and may include referral to the Employee Assistance Program if problems or symptoms persist.

11. All Dr. Winchester codes will be documented on SCDMH Adverse Incident Report as outlined in BCMHC Policy S052.

VII. LAW ENFORCEMENT COMMUNITY ALERT

1. On the occasions local law enforcement issues a community alert requiring employees, patients and visitors to remain inside the facility, the supervisor in charge will use the all page feature to inform the Center (“Please remain in the building until further notice. Law enforcement has issued a community alert.”).

2. During a Community Alert, all exits will be locked. Individuals will be free to conduct business inside the Center.

3. Employees deployed in the field and/or out to lunch will be identified via Scotland Yard and notified by cell phone of the community alert.

4. When law enforcement calls off the community alert, the supervisor in charge will announce via all page “Community Alert all clear”.

5. Once the situation is resolved, debriefing for effected persons – patients, visitors, and staff – will be provided. Debriefing for patients affected will be structured according to individual need and may include processing the incident in therapy. Debriefing for visitors will be structured according to individual need. Debriefing for staff will be structured according to individual need.

6. All Community Alerts will be documented on SCDMH Adverse Incident Report as outlined in BCMHC Policy S052.
PURPOSE: To insure the safety of patients, visitors and staff in the event of an interruption in utility service and/or utility emergencies. To insure the protection of confidential information to the extent possible in such situations.

POLICY: The Center’s first objective is the safety of persons in the facility. Actions to insure safety will be guided by the following procedures. Secondarily, the protection of confidential information is to be executed to the extent appropriate for each situation.
PROCEDURES:

The procedures outlined below are to govern staff responses to utility failures and/or emergencies.

I. NOTIFICATION/WARNING
   A. Initial notification will be communicated to the Executive Director or designee.
   B. The Executive Director or designee, with the assistance of the Facilities Manager, will determine the extent of the utility disruption/emergency, appropriate actions to notify persons in the building, the extent of the response to the situation, and the type of outside assistance needed.
   C. Situations of an isolated/temporary nature (i.e. temporary power outage, water leaks, etc.) may only require partial alteration in Center operations. If evacuation is necessary, designated staff will coordinate patient, visitor, and staff exit of the building and coordinate securing confidential information.
      1. Receptionist will take the patient and visitor sign in/out sheet with them as the building is evacuated. This list will be used for checklist after evacuation.
      2. The Administrative Wing Zone Coordinator is responsible for ensuring the emergency kit and OSHA kit are taken out of the building during evacuation. Emergency kit contains emergency information on all staff.
      3. Medical Records staff will take printed patient emergency information and Center laptop (including Mi-Fi Hotspot) when evacuating building to ensure the identification and continuation of essential services. This includes but is not limited to the provision of medications.
   D. Communication to staff from the Executive Director or designee will be provided in a manner conducive to safety and efficient response to the situation. This may include designated staff making face-to-face contacts, announcements over the intercom, or use of Center alarm system.

II ELECTRIC POWER FAILURE
The Center is equipped with emergency lighting in the event of a power failure.
   A. The Executive Director or designee will initiate or direct immediate contact with power company for information and assistance.
   B. The Executive Director or designee, with the assistance of the Facilities Manager, will determine the nature of the outage and appropriate response for patients, staff and visitors.
   C. The Information Resource Consultant or designee will be notified immediately by Executive Director or designee.

III WATER SERVICE FAILURE
   A. The Executive Director or designee will initiate or direct immediate contact with the water company for information and assistance.
   B. Based on the extent of the failure, the Executive Director or designee, with assistance of the Facilities Manager, will determine the appropriate response for staff, patients and visitors.
IV PHYSICAL ELEMENTS
   A. All building exits are labeled and equipped with battery backup.
   B. Emergency interior lighting is located throughout Center.
   C. Evacuation routes are posted throughout building in visible places to patients, visitors and staff.
   D. All offices without a window are equipped with flashlights and extra batteries.
   E. Reception area is equipped with flashlight and extra batteries.
   F. Fire extinguishers are mounted throughout building. Staff are trained annually on the usage of fire suppression equipment.

V UTILITY EMERGENCY DRILLS
Utility emergency drills will be conducted at least annually. All actual and drill emergencies will be documented on the Utility Emergency Form. These forms will be reviewed by Executive Director or designee.
# CODE ORANGE EMERGENCY RESPONSE

<table>
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<td>Policy Number: S044</td>
<td>Revision Date: 11/00, 3/03, 4/04, 3/08, 3/09, 3/10, 6/13, 10/14</td>
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<td>Date Approved by Board: 12/14/00</td>
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**PURPOSE:** To maximize the safety of all persons in the Center’s buildings, specific emergency response plans are in place in the event of a bomb threat. These plans are designed to be the most efficient and safe responses according to available technology. The staff of the Center will receive drills at least annually in the execution of these response plans.

**POLICY:** The safety of all patients, visitors, and staff is the first objective in all situations posing a threat of injury/harm. All actions to insure the safety of individuals will be executed first. Consideration will be given to securing confidential information if deemed feasible by the responsible staff. The following procedures will govern staff responses in the event of a bomb threat.
PROCEDURES:

The procedures below govern staff actions to insure the most efficient and safe response in the event of a bomb threat.

I. PHYSICAL ELEMENTS
   A. Exits in building are labeled.
   B. Fire extinguishers are mounted throughout building. Staff are trained annually on the usage of fire suppression equipment.
   C. Escape routes and location of fire extinguishers are posted in places visible to patients, visitors and staff.

II. AWARENESS
    To promote on-going safety, all employees are trained in safety policies and practices and are expected to contribute to the awareness/monitoring of the workplace. Examples include: escorting visitors and patients in building, securing doors, keeping office drawers/cabinets secured, and monitoring common areas for unusual objects/behaviors. Semi-annual building inspections are conducted to ensure continuous good housekeeping practices.

III. NOTIFICATION AND WARNING
    Notification of a bomb may be received by telephone, mail, e-mail, message or in person.
    A. Person receiving bomb threat will alert another staff member as soon as the contact is recognized as a threat. The Bomb Threat Call Checklist (fluorescent orange) will be used to obtain as much information as possible, in as much detail as possible, about the bomb, contact person, etc.
    B. The Executive Director or designee will be informed immediately by the staff member that was alerted by the person receiving the threat.
    C. The Executive Director or designee will direct front office staff to evacuate various zones of the building in conjunction with Zone Coordinators, alternates and supervisors. At this time, Executive Director or designee will designate evacuation area to be used.

IV. EVACUATION
    The building will be evacuated face-to-face. Caution will be taken in using telephone, intercom, computers, duress and alarm systems, etc. as not to detonate any device.
    A. Staff will be notified to evacuate by use of the fluorescent orange Bomb Threat Call Checklist sheet. At that time, staff will also be instructed which evacuation area to use.
    B. Upon notification, all staff should examine their immediate area to determine if any objects look suspicious or out of place before executing evacuation procedures.
    C. Receptionists will check the lobby area and lobby restrooms for any suspect items.
D. Zone Coordinators and supervisors will check all common areas (meeting rooms, restrooms, unoccupied offices, etc.), for suspicious items and escort patients and visitors from these areas.

E. Zone Coordinators and supervisors will ensure everyone on the hall evacuates the area.

F. Staff will escort patients and visitors from the building using designated escape routes. Patients and visitors will be informed to take their personal belongings with them when evacuating.

G. Designated Zone Coordinators are responsible for collecting the fire extinguisher from their zone and the staff roster located behind the extinguisher. The roster will be taken out of the building and used for checklist after evacuation.

H. The receptionist will take the patient and visitor sign-in/out sheet with them as the building is evacuated. This list will be used for checklist after evacuation.

I. The emergency kit and OSHA kit will be taken out of the building by the administrative wing Zone Coordinator. Emergency kit contains emergency information on all staff.

J. Medical records staff will take printed patient emergency information and Center laptop (including Mi-Fi Hotspot) list when evacuating building to ensure the identification and continuation of essential services. This includes but is not limited to the provision of medications.

V AFTER EVACUATION

A. Staff will escort patients and visitors to designated meeting place after evacuation. Evacuation areas will be alternated.
   1. Front – left across bridge in grassy area in front of gate to wetlands
   2. Back – grassy area next to fence in front of Northbridge Apartments (behind covered emergency entrance)
   3. Evacuation area to be determined by Executive Director or designee based upon location of threat.

B. Police department will be called immediately. The designated staff will report to the authorities responding, providing as much information as possible. All zone coordinators and supervisors will meet at the evacuation area to determine if a credible threat was found during the pre-evacuation search and relay this information to the authorities.

C. The staff rosters and patient/visitor sign-in/out sheets will be used to determine if all occupants have left the building.

D. Staff will not re-enter building until instructed by Executive Director or designee.

E. All actual and drill evacuations will be documented by the Bomb Evacuation Form. These forms will be reviewed by the Executive Director or designee.
INFECTION CONTROL
BODY FLUID, BLOODBORNE PATHOGEN AND OTHER COMMUNICABLE DISEASES

<table>
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<th>Section Number: VIII - HEALTH AND SAFETY</th>
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<td>Revision Number: 11</td>
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PURPOSE: In accordance with South Carolina Department of Mental Health Directive #824-01, to establish specific guidelines on the use of standard precautions to reduce the risk of health care worker exposure to diseases which are transmitted through blood and/or body fluids.

POLICY: Center employees will receive infection control/bloodborne pathogen training and will be offered Hepatitis B vaccine series within 10 days of employment. Center employees will adhere to the following procedures to reduce the risk of exposure to diseases transmitted through blood and/or body fluids and will receive annual education about prevention and transmission of diseases such as Hepatitis B, HCV and HIV. Detailed records of reporting to include completion of Adverse Incident Report for all infection control incidents and of follow-up on exposure will be maintained.
PROCEDURE:

All blood and body fluids will be treated as potentially infectious (standard precautions). Blood and body fluid precautions detailed below will be consistently used.

I. EXPOSURE CATEGORIES

All employees' risk of skin or mucous membrane exposure to all blood and body fluids in their routine job tasks will be assessed and categorized as follows:

A. Category I  Assigned tasks routinely involve direct contact to blood, all body fluids or tissue such as IM injections, blood drawing, CPR, clean-up of exposed blood, all body fluids or tissue resulting from accidents. Personnel in this category are all licensed nurses and occasionally physicians.

B. Category II  Assigned tasks do not routinely involve, but may occur in emergency, to blood, all body fluids or tissues, but employment may require performing some unplanned Category I tasks in an emergency. Routine interaction with patients that do not require physical contact. Personnel in this category are case managers, social workers, mental health counselors, maintenance/janitorial and most physicians.

C. Category III  Tasks that involve no exposure to blood, body fluids or tissue and Category I tasks are not a condition of employment. Such tasks do not require any patient contact. Personnel in this category are administrative personnel.

Center will offer all employees Hepatitis B vaccine series at no cost to the employee. Dates of vaccination or declination of vaccination will be documented in each employee's health file. Employees may reconsider their declination at any time during their employment at the Center, and the vaccination series will be provided at no cost.

Post vaccination testing shall be offered to employees and performed from 30 to 60 days after completion of the vaccine series at no cost to the employee. Re-vaccination with the three dose series will be offered for employees who do not respond to the initial vaccine series.

II EMPLOYEE EDUCATION

The Center has a responsibility to educate its employees about the prevention and transmission of Hepatitis B, HCV and HIV as well as standard precautions to reduce the risk of exposure. As part of orientation, new employees will receive training about standard precautions/infection control within ten (10) working days of initial assignment. All employees will receive annual training. Documentation of this training/education will be filed in credentialing folders and employee health file located in the office of the infection control nurse.

III PATIENT EDUCATION

The Center has a responsibility to educate its patients about the prevention and transmission of infectious diseases. Educational information is available to patients in the lobbies and in the patient orientation package, as well as provided in psychosocial group settings.
IV PERSONAL PROTECTION EQUIPMENT
Personal equipment including gloves, masks, gowns and protective eye wear will be available to employees performing tasks which involve risk of exposure.

Employees wear gloves if they have an open skin wound. Gloves are available to each staff member in their offices.

V INTRAMUSCULAR INJECTIONS
Only licensed nurses or physicians will administer injectable medications using the procedures detailed below.

A. Gloves: Hands will be washed before and after patient contact. Gloves will be worn when administering IM injections. Each nurse will have gloves available in the office as well as in the medication room. Gloves will be removed and discarded immediately after use in the designated receptacle. Hands will be washed after glove disposal. When circumstances warrant, contact with a patient's non-intact skin for purposes of examination or administration of minor first aid, gloves will be worn.

B. Needle Disposal: Center will use only safety syringes and needles that cover needle after use. Immediately after injection, the syringe/needle will be disposed of in a Sharps container. Under no circumstances will anything be removed from a Sharps container. These containers will be available to nurses in all spaces where injections are given. When containers are three-quarters full, they will be placed in bio-hazardous container and will be picked up by bio-hazardous collection company.

C. Injection Site: Before administering the injection, the site will be wiped with a sterile alcohol pad. Upon removing the needle, the site will be wiped again with a new sterile alcohol pad and immediately covered with a band-aid. Used alcohol pads are disposed of in the designated trash receptacles.

VI ACCIDENTAL EXPOSURE/NEEDLE STICKS
Any accidental percutaneous (needle stick, laceration or bite), permucosal (ocular or mucous membrane) or cutaneous (chapped, abraded or otherwise non-intact skin) exposure to blood or body fluids will be handled as follows:

A. Thoroughly flush or wash the wound with soap and warm water and cover with band-aid.

B. The employee will report the exposure incident to the appropriate supervisor and a SCDMH P-16 "Report of Injury" form will be initiated.

C. If consent can be obtained, exposure source patient (if known) will be transported to primary care physician, local physician or emergency room for blood to be drawn and tested to guide the medical treatment of the exposed employee.

D. The employee will be promptly referred WITHIN TWO HOURS to private primary care physician, local emergency room or private physician for examination, treatment and follow-up.

E. If medical treatment beyond just evaluation is rendered, the occupational exposure will be reported to OSHA and the DMH Office of Quality Assurance (Adverse Incident Report form).

F. The post-exposure evaluation, treatment and follow-up will be provided at no cost to the employee.

G. If the employee terminates employment prior to completion of the Hepatitis B vaccine
series, HCV testing series or HIV testing series after a job related exposure, the employee may make arrangements through previous facility or mental health center to complete the series.

1. Post-exposure treatment for Hepatitis B may involve testing for employee immunity and vaccination for Hepatitis B.
2. Post-exposure treatment for HIV may involve testing immediately, with re-testing again at six weeks, twelve weeks and six months.
3. Employee should report and seek medical evaluation for any acute febrile illness that occurs within twelve weeks after exposure.

H. The original P-16 and all bills incurred will be forwarded to the Worker's Compensation Coordinator in the Benefits Office of DMH Human Resources Services.

I. Responsibility for monitoring the completion of all recommended/necessary medical evaluation and treatments will be shared by the immediate supervisor, infection control coordinator and Executive Director or designee.

VII RECORD KEEPING

A. Center shall establish and maintain a medical record for all employees with potential for occupational exposure. Employee health records of training, vaccinations, immunizations, etc. shall be maintained for the duration of employment, plus thirty (30) years. Employee health records shall be kept confidential and will not be disclosed or reported without the employees expressed written consent to any person within or outside the Center except as required by OSHA Standard or other federal, state or local regulations.

B. Center shall establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps. The information in the sharps injury log is recorded and maintained in such a manner as to protect the confidentiality of the injured employee. The sharps injury log contains at a minimum the type and brand of device involved in the incident, the department or work area where the exposure incident occurred and an explanation of how the incident occurred. If medical treatment beyond minor first aid is rendered, the occupational exposure is recorded on the OSHA log and summary of occupational injuries and illnesses and on the Adverse Incident Report.

VIII HIV/HCV/HBV - PATIENT/VISITOR EXPOSURE

If a person served or a visitor is accidentally exposed to blood or body fluids, staff shall follow procedures as outlined in the BCMHC Infection Control Policy.

IX HBV, HCV OR HIV POSITIVE EMPLOYEES

A. Only those health care workers who perform invasive procedures which qualify as “Exposure-Prone Invasive Procedures” (EPIPs) are required in accordance with the Health Care Professionals Compliance Act (HCPCA) to determine their HBV, HCV or HIV serostatus. Employees with HBV, HCV and/or HIV comply with current CDC recommendations and the HCPCA. Those who perform EPIPs must seek Expert Panel review and recommendations. If those specific recommendations include notification of a supervisor or employer, this must be complied with or grounds for dismissal exist.

B. For any other employee, it is requested, but not required, that the employee report their HIV positive status to the Employee Health Nurse to allow for accurate interpretation of the annual PPD and to assist in determining need for further evaluation.
INFECTION CONTROL
PAGE 5

C. If the HBV, HCV or HIV positive employee does not comply with measures recommended to prevent transmission or there is evidence that the employee may be transmitting infection, the need for removal from direct patient care shall be assessed by the Executive Director or designee to assure staff and patient safety.

X CONFIDENTIALITY

The fact that a patient or employee is seropositive for HBV, HCV or HIV is confidential medical information.

XI OTHER COMMUNICABLE DISEASES

A. CMV (cytomegalovirus): The cytomegalovirus (CMV) is recognized as a member of a group of herpes-type viruses that may cause related diseases. CMV is a virus with which most people eventually become infected. Virus circulation is much more prevalent among the population age two years and younger. CMV is spread from person to person by direct contact with body fluids such as blood, urine or saliva. The Center shall seek to prevent and control exposure to CMV by adherence to the BCMHC Infection Control Policy. First infection with CMV presents a significant risk to pregnant women due to the congenital infection of the child. Such can cause hearing loss, mental retardation and other birth defects. Employees who are or may become pregnant should seek information concerning CMV from their personal health care provider. If suspected exposure to the virus occurs, personal health care provider should be contacted for recommended follow-up.

B. STD (sexually transmitted diseases): The Center recognizes the incidence and prevalence of sexually transmitted diseases among the population at large. While the Center neither permits nor condones sexual activity on premises, we establish our policy as providing but not limited to referral for educational materials and/or medical treatment upon request or demonstrated need by staff or patients.

C. Staph Infection (staphylococcal infection): Staph infection (or staphylococcal infection) is an infection caused by staphylococcus, a type of bacteria. Some kinds are normally found on the skin and in the throat; certain kinds cause severe pus-forming infections or produce a poison which may cause nausea, vomiting and diarrhea. Life threatening staphylococcal infections may arise in hospitals. Since the Center performs no major medical procedures at any of its locations, threat of the later is minimal. Any staff, patient or visitor observed with an open, draining wound or necrotic tissue shall immediately be referred to their primary health provider for medical attention. The Center shall respond according to medical recommendations.

D. Rubella (German measles or 3 day measles): Rubella is a serious disease. It is spread from person to person by breathing in droplets of respiratory secretions exhaled by an infected person. It may be spread when someone touches his or her nose after their hands have been in contact with infected secretions. Active symptoms include fever, swollen lymph nodes behind ears and a rash that starts on face and spreads to the torso and then to arms and legs. It is required that any staff, patient or visitor who is exhibiting these symptoms remain away from the Center until a physician certifies the individual's safe return. Exclusion should last until 6 days after the onset of the rash. Vaccination is the best way to protect against rubella. Because most children get the
MMR (measles, mumps & rubella) vaccines, there are now fewer cases of these diseases. Most doctors recommend that almost all young children get MMR vaccine. But there are some cautions. Tell your doctor or nurse if the person getting the vaccine is less able to fight serious infections because of:

1. a disease she/he was born with
2. treatment with drugs such as long-term steroids
3. any kind of cancer
4. cancer treatment with x-rays or drugs

Also:
1. people with AIDS or HIV infection usually should get MMR vaccine
2. pregnant women should wait until after pregnancy for MMR vaccine

XII BLOOD AND/OR BODY FLUID SPILLS

A standard precaution clean-up kit is located in the mail room as well as combination First Aid PPE/Body Fluid Clean-Up Kits located over the fire extinguishers. Center staff are aware of the kits and how to clean up a spill using them.

In case of a body fluid spill, staff should immediately notify the receptionist and request a clean-up kit and assistance to include medical personnel. The receptionist announces over the paging system "Operation OSHA" and the location where assistance is needed.

All Center vehicles will have an OSHA approved kits to be used if blood or body spills occur in route. If a patient experiences a blood or body spill in a Center vehicle, the vehicle operator will stop as soon as is safe, assist the patient in containing his/her spill and call the Center for assistance. EMS will be called if it appears the patient is in need of immediate emergency treatment.

Soiled articles from accidental spills will be disposed of in the designated bio-hazard bag in the clean-up kit. Such bags containing bio-hazardous materials will be placed in Center bio-hazardous container and will be picked up by bio-hazardous collection company.
## TOBACCO USE IN CENTER

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<tr>
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**PURPOSE/POLICY:** To establish procedures regarding tobacco use for Berkeley Community Mental Health Center.
PROCEDURES:

The use of all tobacco products, including electronic devices, is prohibited inside all Center buildings and vehicles. Designated areas are available for patients, visitors and staff. The sale of tobacco products is also prohibited on Center property. In the case that staff become aware of a situation in which tobacco products are being sold on premises or being provided to minors, staff will intervene in accordance with state or local laws.

Persons using tobacco in places other than designated areas will be escorted to a designated area and asked to confine tobacco use to such spaces.

Persons refusing to comply with Center tobacco policies will be addressed through appropriate clinical and/or administrative resources.
TUBERCULOSIS INFECTION CONTROL PLAN

Section Number: VIII – HEALTH AND SAFETY  
Policy Number: S051  
Revision Number: 09  
Approved by: [Signature]

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Date of Origin: March 1995  
Revision Date: 9/97, 8/98, 7/00, 10/01, 4/04, 5/05, 2/07, 5/13, 6/14  
Date Approved by Board: 9/14/00

PURPOSE: In accordance with South Carolina Department of Mental Health Directive #790-94, this plan establishes uniform guidelines for the assessment and follow-up of patients and employees for early detection and treatment of tuberculosis infection or active/suspected tuberculosis disease.

POLICY: It is the policy of Berkeley Community Mental Health Center to prevent and control tuberculosis in patients and employees.
PROCEDURES:

1. Procedure for Patients
   Employees who are the first point of contact in the mental health center shall be trained to recognize, and bring to the attention of the infection control nurse or physician, any patients with symptoms of tuberculosis, such as productive cough of greater than three weeks duration, especially when accompanied by other tuberculosis symptoms, such as blood in sputum, significant weight loss, fever, chills, fatigue, and loss of appetite.

   Patients who have pulmonary symptoms of unknown etiology shall be instructed to cover their mouths and noses when coughing or sneezing and shall spend minimum time in common waiting areas.

   If symptoms of active tuberculosis are identified or suspected in any patient of the Mental Health Center, the Center's infection control nurse shall be notified. The infection control nurse and/or a physician shall assess the patient for signs and symptoms of tuberculosis and if clinically indicated the patient shall be referred to the local health department's TB control clinic or to their private physician for evaluation and tuberculin skin testing.

   When a patient who may have infectious tuberculosis must be transported, the patient shall wear a surgical mask.

2. Procedure for Pre-Employment TB Skin Test
   A. Call Industrial Medical Center to schedule an appointment for TB skin test.
   B. Take the Berkeley Community Mental Health Center Tuberculosis Screening form to Industrial Medical Center to receive the first step of the two step Mantoux TB skin test. Keep this record with you until completion and required signatures are obtained.
   C. Return to Industrial Medical Center in 2-3 days after the first test to have the results read, interpreted and documented on the required form. The second step of the two step Mantoux TB skin test will then be scheduled.
   D. Return to Industrial Medical Center within 2-3 days to have the second test read, interpreted and documented by Industrial Medical Center personnel. No other signature will be accepted.
   E. Bring or mail the completed form from Industrial Medical Center for the TB testing. Mail to BCMHC, Human Resources, P. O. Box 1030, Moncks Corner, SC 29461.
   F. For questions, please call 1-888-202-1381 or 843-761-8282.

IMPORTANT NOTES:
   A. Industrial Medical Center is located at 255 North Highway 52, Suite 8, Moncks Corner, SC, 29461, 843-899-9420.
   B. Berkeley Community Mental Health Center will pay the cost for the two step Mantoux TB skin test if it is administered by Industrial Medical Center. If personal physician is used for the two step Mantoux TB skin test, the employee will be responsible for the cost.
B. Do not read or interpret your own TB skin test. The results must be read and interpreted by Industrial Medical Center.

C. NO ONE WILL BE ALLOWED TO BEGIN WORK WITH BERKELEY COMMUNITY MENTAL HEALTH CENTER UNTIL THE HUMAN RESOURCES DEPARTMENT RECEIVES THE REQUIRED DOCUMENTATION OF THE TWO STEP MANTOUX TB SKIN TEST. THERE WILL BE NO EXCEPTIONS.

D. Any employee presenting for employment with a positive PPD shall have documentation of a negative chest x-ray that was performed within at least three months prior to employment.

3. Procedure for Employees

All Center employees with direct patient contact and a history of non-reactive PPD shall be referred to Industrial Medical Center for skin testing for the presence of tuberculosis prior to employment, unless a documented skin test has been performed within three months prior to employment. Volunteers will receive education on TB and will be screened by the Infection Control Nurse. The Center will incur the cost of skin testing at Industrial Medical Center. Employees transferring from one DMH position to another shall provide copies of results of the most recent PPD skin test.

On the initial tuberculin (Mantoux PPD) skin test (no PPD history within a year), two-step testing shall be performed to detect boosting phenomena that might be misinterpreted as a skin test conversion.

Tuberculin skin testing shall be provided at least annually thereafter using the one-step method. This skin test will be performed by a Center nurse at no cost to employee.

An employee converting from negative to positive during employment shall be referred to the local county health department or PCP for evaluation and follow-up.

A history of Bacillus of Calmette and Guerin (BCG) vaccination is not a contraindication to TB skin testing.

If there is any question regarding a history of a positive PPD reaction, then a test dose shall be administered following the manufacturer's instructions. A test dose is a partial test using half the full dose.

A physician or the infection control nurse shall provide, for those employees with positive PPDs, an annual assessment for signs and symptoms of tuberculosis and education regarding the need for prompt evaluation of any pulmonary symptoms suggestive of tuberculosis.

Employees who have pulmonary symptoms of unknown etiology shall be instructed to cover their mouths and noses when coughing and sneezing and shall spend a minimum of time in common waiting areas.

All Center employees shall receive education about tuberculosis appropriate to their job before initial assignment and annually thereafter.
Employees referred to the health department or PCP for preventive treatment do not require physician clearance prior to returning to work.

Employees requiring treatment for active tuberculosis must be cleared by a physician in consultation with DHEC before returning to work. Clearance must be provided by the Occupational Health Services physician if an employee's case of active tuberculosis is determined to be work related.

Contact investigation shall be conducted according to DHEC protocol. DHEC Tuberculosis Control personnel are available to assist in investigating possible exposures and transmission of disease.

4. Tuberculin Skin Testing Procedure
Physicians and/or licensed nurses shall administer and interpret PPD Mantoux skin testing.
A. Cleanse rubber cap of vial with alcohol and allow to dry.
B. Draw up required amount of tuberculin in syringe.
C. Cleanse site of injection with alcohol and allow to dry. (usually on the flexor surface of left arm about 4 inches below elbow)
D. Inject solution just below the surface of the skin, intradermally, needle bevel upward. A 6 to 10 elevation of the skin (wheal) will appear if performed correctly.
E. Measure the area of induration in millimeters 48 to 72 hours after test administered. Do not include redness around induration.
F. If first step to two-step method reaction is negative (0 to 4 mm), repeat in 1 to 3 weeks to check for boosting effect.
G. An induration of 10mm or greater is interpreted as a positive reaction indicating infection with Mycobacterium tuberculosis and the person shall be evaluated for tuberculosis disease.
H. Induration measuring 5 to 9 mm indicates a doubtful reaction. Interpretation of this size reaction could include: previous BCG vaccination, previous contact with atypical mycobacterium or perhaps a waned sensitization due to age.
I. If the person is HIV+ or a known contact of a person diagnosed with active tuberculosis, then a reaction to 5 to 9 mm shall be interpreted as positive.

5. Reporting
All positive PPD reactions and suspected or diagnosed cases of tuberculosis shall be reported to the Center infection control nurse immediately.

In accordance with the State Statute 44-31-10, all known or suspected cases of tuberculosis shall be reported to the Executive Director and DHEC by the infection control nurse.

TB injection (positive TB Mantoux skin test) and TB disease of employees are both recordable on the OSHA log, except on pre-employment screening.

A P-16 "Report of Injury" form shall be completed and processed on all employee cases of active tuberculosis.
REPORTING OF ADVERSE AND UNUSUAL INCIDENTS

PURPOSE: To establish a uniform and routine method of reporting significant adverse and unusual incidents to the appropriate supervisor or designee, to the Executive Director or designee, to the Board of Directors and to appropriate DMH line of authority.

POLICY: It is the direct responsibility of each BCMHC staff member to ensure that his/her supervisor is promptly, accurately, and adequately informed of every significant adverse and unusual incident occurring within the area of their responsibility that relates to safety, rights, well-being or patient's care, in accordance with Department of Mental Health Directive No. 897-10.
PROCEDURE:

Employees will verbally inform their supervisor immediately learning of any adverse or unusual incident (refer to SCDMH Directive #897-10). The verbal report will be followed by a written report utilizing the approved departmental form citing the patient's name, age, diagnosis, admission date, date/time/location of adverse/unusual incident, description of what happened, corrective action taken, who has been notified, and whether or not debriefing was necessary or description of debriefing provided.

The responsible supervisor will immediately inform the Executive Director or designee verbally of any adverse/unusual incident reported to them. The supervisor will insure that a written report of the incident is submitted to the Executive Director.

The Executive Director or designee will report telephonically all major incidents of a catastrophic or urgent nature, regardless of the time of day or night, as soon as possible via the established DMH line of authority. The Executive Director will also notify the Center Board Chairperson or Vice Chairperson in these situations as appropriate.

Original incident reports meeting DMH criteria for reporting will be forwarded to the QA-SAM office at SCDMH upon receipt. Other incidents reported will be maintained for a period of one calendar year.

Incidents that occur after Center office hours and are reported to on-call staff will be communicated to the Executive Director or designee as soon as possible by this staff. The Executive Director will communicate as appropriate with SCDMH authorities and Board Chairperson as indicated above. Incident form will be completed the next working day by on-call staff.

Incident reports are reviewed monthly by Safety/Risk Management Committee to identify trends, patterns or systematic problems. This information is given to Leadership Council and Quality Improvement Team quarterly for review and/or feedback and/or to initiate operational enhancements to address trends/patterns.

A written annual report is submitted to the Safety/Risk Management Committee during the first scheduled meeting after the end of the calendar year.

The following incidents will be reported:

- Medication errors
- Use of seclusion or restraints
- Incidents involving injury
- Communicable disease
- Infection Control
- Violence or aggression
REPORTING OF ADVERSE AND UNUSUAL INCIDENTS
PAGE 3

• Use or possession of weapons
• Elopement and/or wandering
• Vehicular accidents
• Biohazardous accidents
• Unauthorized use or possession of legal or illegal substances
• Abuse and neglect
• Suicide or attempted suicide
• Sexual assault
• Other sentinel events
QUALITY OF CARE REVIEW BOARDS

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<th>Section Number: VIII - HEALTH AND SAFETY</th>
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**PURPOSE:**
To establish an internal system of review and evaluation of incidents and situations affecting the quality and appropriateness of patient care in accordance with SCDMH Directive No. 898-10, Quality of Care Review Boards.

**POLICY:**
Berkeley Community Mental Health Center will convene a Quality of Care Review Board (QCRB) when incidents occur which adversely affect patient care or safety. Selection, operation and documentation of these boards will adhere to the following procedures.
PROCEDURES:

I. CONVENING QCRB - Center QCRB will be convened to review and evaluate incidents by:
   A. Executive Director or designee, upon daily review of all adverse and unusual incident reports, will designate those necessitating review.
   B. Office of Performance Improvement (OPI)/QA of SCDMH, upon receipt of adverse and unusual incident reports, will indicate to Executive Director or designee incidents requiring a QCRB.

II BOARD MEMBERSHIP/CENTER REPRESENTATIVES - Executive Director or designee will appoint at least three staff members to serve on QCRB. If the QCRB does not include a physician as a member, a physician must consult with the QCRB, review its findings and recommendations, and indicate any recommendations to the QCRB. Employees directly involved with the incident being reviewed will not be appointed to the QCRB. Composition of the board will be appropriate to the incident under review.

III TIME LIMITATIONS - QCRB members will regard the board's agenda with urgency. Case Review reports must be completed and submitted to OPI/QA within thirty (30) calendar days of the incident leading to the review. In certain urgent situations, a Case Review may be ordered to be completed in less than 30 days.

QCRB reports must be completed and submitted to OPI/QA within 45 (forty-five) calendar days of the incident. In certain urgent situations, a QCRB may be ordered to be completed in less than 45 days.

90 (ninety) days after submitting the completed QCRB report, the Center will submit to OPI/QA an addendum to the QCRB report that gives the status of implementation of the corrective action plan.

IV QCRB REPORT – QCRBs of singular adverse or unusual events will be written in the Root Cause Analysis format and will include an action plan. A form for this action plan is provided by OPI/QA.

For QCRBs dealing with broad topics, other formats as specified by OPI/QA may be used.

In addition, the QCRB report will include:
   A. List of names and titles of QCRB members
   B. Signatures of QCRB members
   C. A minority report if necessary
   D. Cover letter signed by Executive Director or designee providing an assessment of QCRB findings and recommendations

V CONFIDENTIALITY - All proceedings of QCRBs and all information and documents generated for or by QCRBs shall be confidential.

VI RETENTION – The Center, OPI/QA and SCDMH General Counsel each will retain one copy of the QCRB report for five years. After that time, all copies will be destroyed.
SAFETY DATA SHEETS (SDS)

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<tr>
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PURPOSE: To provide guidelines for obtaining SDS information on all chemicals used at the Berkeley Community Mental Health Center.

POLICY: It is the policy of the Berkeley Community Mental Health Center to obtain SDS information as required by OSHA for the safety of persons served, visitors and employees.
PROCEDURES:

I. Safety Data Sheet (SDS) - detailed information bulletin describing physical and chemical properties, physical and health hazards, results of exposure, precautions for safe handling and use, emergency and first aid procedures and control measures.

II At the time of purchase of all chemicals, SDS is obtained:
   A. If SDS information is not readily available, one is requested verbally or in writing.
   B. May be received by fax, with merchandise at time of shipment, or via Internet sources.

III Safety Data Sheets are filed in SDS Book; located in workroom.

IV Quarterly audits are conducted to ensure compliance with OSHA requirements.
PURPOSE: To establish guidelines for security/fire alarm system and guidelines for staff responding in event of activation of security/fire alarm system.

POLICY: It is the policy of the Berkeley Community Mental Health Center to have building monitored for security/fire and to respond promptly in the event of security/fire alarm activation. The following procedures will govern staff responses.
PROCEDURES:  

Security Alarm Operation: Security sensors are located throughout the buildings. Motion picked up on one of these sensors once the alarm is armed is the trigger for the siren. There is a 45 second delay from the time motion is picked up on a sensor before the alarm sounds. This means that as you enter the building, you have 45 seconds to turn off the alarm system. You have 45 seconds to exit building after arming the system.

Building Entry: Entry to the building during non-business hours, and entry of the first employee to arrive at the beginning of the business day, shall be restricted to the Doctor’s Wing. Upon entering the building, check the status of the ARMED light on the security alarm control panel. If the red light next to ARMED is illuminated on the control panel, the alarm MUST be de-armed before proceeding into the building. All staff are provided training on alarm operation procedures during orientation.

Alarm Activation: The security/fire alarm will be armed at all times when the building is unoccupied. The staff member assigned to close the building will be responsible for ensuring the security/fire alarm is armed at the end of each day.

Alarm Code: The alarm code is to be kept confidential - please don’t record it in accessible places. The alarm code will be changed every six months. All staff will be notified and given the updated code.

To Silence Alarm:
1. Security Alarm - enter the alarm code on control panel located at Doctor’s Wing entry door.
2. Fire Alarm - control panel located in reception area. Press “Alarm Ack” once; “Trouble Ack” once; “System Rest” twice. Instructions are also located on the alarm panel.

Responding to Alarms: Whenever the alarm is activated, a staff person must follow-up to end the alarm status. After-hours, someone is required to come from home to secure building. When responding to alarm:
1. Do not enter building until police or fire officials have arrived on the scene (unless you are CERTAIN the alarm was activated inadvertently).
2. Call 911 immediately if alarm is triggered inadvertently to prevent authorities from responding to alarm.
4. Call monitoring company: Simplex, at 1-888-746-7539
5. The monitoring company must speak directly to a staff member. They will continue in order of contact list provided until someone responds.

**Contact List for Moncks Corner location:**
- Ben Woodlief
- Lamar Butler
- Debbie Calcote

All staff on contact list will be provided with a wallet-size card with appropriate phone numbers, codes and passwords necessary to terminate alarm, along with phone numbers of appropriate personnel.

**Resetting Alarm:** If the red light next to ARMED on the control panel is blinking, the alarm has been activated. Once the alarm has been activated, it must be reset. To reset alarm, press * on the control panel.

**Documentation:** An incident report and/or safety report must be completed in the event of an actual or false alarm. If alarm is triggered inadvertently, the employee responsible and their supervisor will give verbal explanation of events to Executive Director.
RED CROSS FIRST AID AND CPR TRAINING

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<th>Section Number: VIII – HEALTH AND SAFETY</th>
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<td>Approved by:</td>
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PURPOSE: To provide staff the skills to provide basic first aid and cardiopulmonary resuscitation in the Center and its programs.

POLICY: CPR training will be provided by Red Cross certified trainers during employee work hours. All Center employees will receive training as indicated by Red Cross requirements. First Aid training will be provided by Red Cross certified trainers during employee work hours for all licensed nursing staff as indicated by Red Cross requirements.
PROCEDURES:

Training records will be kept to document training time frames for each employee.

Documentation of successfully completed training for all employees will be maintained.

At the discretion of the Executive Director, staff may be exempted from their scheduled training if job duties dictate.
SECLUSION, RESTRAINT AND EMERGENCY INTERVENTION

**PURPOSE/POLICY:** Berkeley Community Mental Health Center does not practice seclusion or restraint intervention procedures. Emergency interventions are used only as the last recourse in an emergency situation to de-escalate aggressive or life-threatening behavior toward self or others. This policy applies to all persons, including those with special needs.
PROCEDURES:

BEHAVIORAL EMERGENCY STABILIZATION TRAINING (BEST)
BEST training will be provided to all Center employees to learn de-escalation and protective skills. Trainers are certified in BEST instruction by the South Carolina Department of Mental Health. The curriculum for training is based on the South Carolina Department of Mental Health’s Behavioral Emergency Stabilization Training course. BEST emphasizes prevention, so the curriculum offers numerous strategies and skills in prevention techniques and nonphysical interventions. Physical intervention skills are not to seclude or restrain the person served, they are for the purpose of protection and release (such as when the person grabs, chokes, or strikes at another patient or staff). These skills are used only when other less restrictive measures have been found to be ineffective to protect the person served or others from injury or serious harm. This training is competency based with testing of knowledge of nonphysical interventions and demonstration of physical skills. The curriculum is designed to address the needs of new employees as well as training every other year of staff that have previously completed BEST training. In crisis situations that involve persons being aggressive or severely agitated, the BEST techniques will be the foundation for staff response and intervention.

EMERGENCY INTERVENTIONS
Adults or Adolescents: Should a situation arise where the preventive techniques for de-escalating aggressive behavior are not effective or the behavior is too violent for these strategies, staff will call for assistance. A violence emergency code will be initiated for immediate response from other staff. Law enforcement will be summoned anytime the clinician deems necessary, taking into consideration the patient’s past history, presenting symptoms, information received from family, etc. Law enforcement will also be summoned for all commitments.

Staff are not to block the exit of the aggressive adult or adolescent should he/she choose to leave the Center. If the patient leaves against medical advice, staff will note the direction of the person’s exit and note a detailed description for law enforcement, and request law enforcement assistance. Staff will keep themselves and others safe by leaving the area. If leaving the area is not feasible, staff may use the most reasonable and least restrictive skills taught in BEST to protect themselves and others until support arrives.

Children: Should a situation arise where the preventative techniques for de-escalating aggressive behavior are not effective or the behavior is too violent for these strategies, staff will call for assistance. A violence emergency code will be initiated for immediate response from other staff. Law enforcement will be summoned anytime the clinician deems necessary, taking into consideration the patient’s past history, presenting symptoms, information received from the family, etc. Law enforcement will also be summoned for all commitments.

If a child needs an emergency intervention involving the use of a physical hold to prevent harm to him/her self or others, the hold should be applied by the parent or guardian. The clinician and/or the physician shall be present and a violence emergency code initiated. If the parent/guardian is incapable of holding the child, staff may use the most reasonable and least restrictive physical hold only with the parent/guardian’s permission and supervision. If the parent/guardian is not present, the hold may be administered until the parent/guardian and/or other assistance arrives. Physical holds will only be used as a time-limited emergency measure until the appropriate law
enforcement, safety, or other emergency service providers arrive. No hold shall last more than 15
minutes without a review for continued need. Physical holds will not exceed 45 minutes. At least one
other staff member will be present for observation of the person in the physical hold to ensure the
earliest possible release. The intent of these interventions is not to inflict serious or lasting injury or
harm to the aggressive individual, but to protect self and others from injury.

CHEMICAL INTERVENTION
On the infrequent occasion that chemical intervention may be needed, it shall be used at the discretion of
the physician for the safety of the person served and the law enforcement officer transporting the person
to a hospital. Medication will be offered to the person if the physician deems the necessity for chemical
intervention. If the family is present, they will be consulted and explained the reason for the need to
medicate the person. If a physical hold is necessary to administer medication, law enforcement will
administer the hold.

REPORTING OF EMERGENCY/CHEMICAL INTERVENTIONS:
Every incident of emergency and/or chemical intervention is documented according to BCMHC Policy
S052, Reporting of Adverse and Unusual Incidents. All incident reports will be submitted to the
Executive Director for review and signature.

QUIET ROOM
The Center has a “Quiet Room” voluntarily available to persons served needing a space away from other
activities in the Center. This room is offered as a more private, quieter alternative to other office spaces.
At no time will Center staff lock the door or obstruct a person from leaving the Quiet Room. Law
enforcement personnel have the authority to lock the door when a person is in their custody. The law
enforcement officer is responsible for supervising the person in the room. Clinical assessment
/interventions are expedited to reach a disposition for the patient.

Center administration and staff are sensitive to the rights of persons served to receive services in a safe,
dignified environment. As much as possible, environmental factors will be controlled and adjusted to
meet each person’s needs. If control of the environment includes the restriction of the person served
being in the milieu, that person restricted shall be treated with respect and dignity and offered an
appropriate treatment milieu to meet his/her needs. The primary clinician and psychiatrist, along with
the treatment team, will monitor and review the situation and restore the person back to the group or
former treatment milieu as soon as possible or ensure that the person served has the treatment that meets
his/her needs. The purpose of the restriction will be documented in the medical record.
PURPOSE/POLICY: It is the policy of Berkeley Community Mental Health Center to provide services for all citizens of Berkeley County. In order to make our services more accessible for deaf or hearing impaired patients, Relay service is available to enhance communication and promote treatment with respect and dignity.
PROCEDURES:

To access services, Relay service for three way TDD calling is available by calling 711. This information is included with all directory assistance listings for BCMHC. This service allows staff to verbally communicate with an operator who types via TDD to the hearing impaired patient. The patient’s typed TDD communications are interpreted verbally for staff.
URGENT CARE FOR PATIENTS, EMPLOYEES AND VISITORS

PURPOSE: To establish guidelines for providing emergency medical services to patients, employees and visitors who become ill or injured on Center premises.

POLICY: It is the policy of Berkeley Community Mental Health Center to safeguard the health of patients, employees and visitors by establishing procedures to respond promptly to illness or accident occurring on Center property.
PROCEDURES:

I. Patients
If a patient becomes ill or is injured on Center property, this will be reported immediately to the Program Director and/or Executive Director, or their designees. A Center physician will see the individual and make recommendations for treatment. If the illness or injury is serious or may be life threatening, “Code Blue” will be initiated according to BCMHC policy S037.

The patient’s medical record will be provided to the physician as he/she assesses patient’s condition. Staff will offer to call the patient’s emergency contact person. Emergency contact persons may be notified as indicated by the patient’s medical condition and follow-up recommended by the physician.

An adverse incident report will be filed the same day by the staff attending to the patient’s illness or injury.

II. Visitors
If a visitor becomes ill or is injured on Center property, this will be reported immediately to the Program Director and/or Executive Director, or their designees. A Center physician will see the individual and make recommendations for treatment. If the illness or injury is serious or may be life threatening, “Code Blue” will be initiated according to BCMHC policy S037.

Staff will offer to contact family, significant other, friend, etc. for the visitor. Given the visitor’s medical condition and nature of follow-up recommended by the physician, staff may attempt to identify and contact someone on the visitor’s behalf.

An adverse incident report will be filed the same day by the staff attending to the visitor’s illness or injury.

III. Employees
If an employee becomes ill or is injured on Center property, this will be reported immediately to the Program Director, Human Resources Representative and/or Executive Director, or their designee. The supervisor will have Report of Injury (Form P-16) completed and faxed to CompEndium. The supervisor will then call CompEndium for instructions regarding the management of the care of the employee. An adverse incident report will be completed the same day by the ill/injured employee or by the staff attending to the employee.

If the illness or injury is serious or may be life threatening, “Code Blue” will be initiated according to BCMHC policy S037. Emergency information for the employee will be available. Staff will offer to contact the emergency person indicated for the employee. Emergency contact persons may be notified as indicated by employee’s medical condition and follow-up recommended by CompEndium.
EMPLOYEE INJURY PROTOCOL

1. Employee reports all injuries immediately to supervisor.

2. Supervisor and employee complete the front of the Report of Injury (SCDMH Form P-16).

3. Supervisor will fax the P-16 report to CompEndium (877) 710-2667.

4. Supervisor calls CompEndium on behalf of employee (877) 709-2667.

5. CompEndium will instruct supervisor and employee regarding the management of the care of the employee.

6. Supervisor will give employee a Worker’s Compensation information package, with both the supervisor and employee signing the package verifying receipt of the package by the employee.

7. CompEndium will send a fax to the supervisor on the work status medical event.

8. Supervisor will fax Employee/Supervisor Notification (ESN) form to CompEndium.

9. Supervisor will forward all injury information not later than the next business day to the Center personnel representative/timekeeper.

10. Supervisor must state on the SCDMH Form P-14 (Application for Leave), Section 14 (remarks) whether the injury was due to assault by a patient and the date of the injury.

11. All Worker’s Compensation information is filed separately in the medical field file folder.

12. Each time an employee returns to work and then subsequently loses time due to the injury, the supervisor and employee must report the lost time. Fax an ESN to CompEndium and forward to the personnel representative.
HEALTH AND SAFETY

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<td>Approved by: <strong>Deborah Calcutt</strong></td>
<td>Date Approved by Board: September 1997</td>
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PURPOSE/ POLICY: Berkeley Community Mental Health Center is responsible for providing an environment that promotes and protects the health and safety of its patients and employees. The health and safety of patients, visitors, and employees drives the operational policies and procedures of the Center. Mechanisms are in place throughout the organization to address this obligation to those persons who seek treatment at the Center and to the employees who comprise the organization (See BCMHC Policy and Procedure Manual, Section VIII).
PROCEDURES:

The following policies and procedures serve to protect and promote the basic health and safety of patients and employees:

1. Externally conducted safety inspections
2. Documented self-inspections
3. Center Safety Committee
4. Emergency plans for fires, medical emergencies, natural disasters, bomb threats, power failures, and aggressive behaviors
5. Staff education on emergency plans
6. Tests of emergency plans with analysis of effectiveness
7. Emergency information for patients and employees
8. Policy and procedure for reporting adverse/unusual incidents
9. Tobacco policy
10. Policy and procedure for Infection Control and Bloodborne Pathogens
11. Procedures for routine cleaning of toys
12. Red Cross CPR and first aid training
13. Policies and procedures for medication storage and control
14. Emergency lighting
15. Fire detection and warning system
16. Preventive maintenance on heating/air systems
17. Preventive maintenance program for vehicles
18. Transportation policy and procedure
19. First aid supplies, OSHA supplies/clean-up kit, fire extinguishers and cellular phones in vehicles along with procedures for handling emergencies in vehicles
20. Drivers license checks/verification of employees
22. Policy and procedures for serving seriously mentally ill adults whose names appear on the SC Sexual Offenders Registry
23. Policy and procedures for armed intruders.

Employees are expected to be aware of safety and health issues. Patients and visitors are encouraged to give feedback and observations. As health and safety issues are raised, actions are taken to address these.
SAFETY PROTOCOL FOR SMI PATIENTS ON THE SC SEXUAL OFFENDER REGISTRY

Section Number: VIII - HEALTH AND SAFETY

<table>
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<tr>
<th>Policy Number: S105</th>
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<tr>
<td>Revision Number: 02</td>
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<td>Approved by:</td>
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PURPOSE/POLICY: Berkeley Community Mental Health Center has an obligation to assess and/or serve patients with serious mental illnesses who are also listed on the SC Sexual Offender Registry. The Center has the responsibility to maintain a safe, therapeutic environment for patients and visitors of all ages.
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PROCEDURES:

I. **Sexual Offenders Treatment Services.** Berkeley Community Mental Health Center (BCMHC) does not offer sexual offenders treatment. Individuals seeking sexual offender treatment are referred to a qualified provider or another source (i.e. TUW 211 Hotline).

II. **Persons with Serious Mental Illness and Listed on the SC Sexual Offender Registry.** Individuals, who have a potential chronic mental illness, that are seeking services at Berkeley Community Mental Health Center (BCMHC) and are registered sexual offenders will be screened to see if they qualify to receive treatment services from BCMHC for their mental illness. Their status relative to treatment for the sexual offense will also be explored.

   A. If a phone triage received by BCMHC Access unit seems to indicate from conversation that an individual could be a sexual offender, the sexual offender database will be checked. The individual will be asked about past and/or current treatment and/or supervision related to the sexual offender behavior/offense.

   B. The BCMHC reception area will check the Sexual Offenders database on all new admissions to the Center as new patients access care.

   C. BCMHC patients who are registered sexual offenders will be annotated with an alert within the EMR system. The code will indicate that the patient “needs supervision”.

   D. Patients identified as being on the sexual offender registry will not be left in the main lobby or unsupervised in the Center.

   E. Clinicians will address safety expectations while in the Center and on Center grounds with patients who are on the registry.

   F. As for all patients, consideration will be given to scheduling therapy and medical appointments conjointly.

   G. The Access Center space is available for patients needing to wait on transportation after appointments have been completed.