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## **Health Care Standards and Practice for Children and Youth in Care**

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### **Purpose**

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The purpose of this Practice Guide is to promote pediatric health and wellness by providing best practice guidelines in the identification of significant health problems; to ensure access to healthcare services; the monitoring for signs or symptoms of abuse or neglect; and the provision of age-appropriate anticipatory health guidance/intervention.

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### **Commitment to Racial Justice**

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The Health and Wellness Division will foster an environment and professional approach that leads to equitable, non-judgmental, and all-inclusive services to improve health outcomes of the families and children served by the department. We recognize the importance of sustaining a racially just Division through advocacy and education of our workforce and community. We remain open-minded and committed to understanding the social and cultural values, experiential contexts, practices, and strengths of families and children served by the department

## Introduction

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### **Introduction to Health Care Standards and Practice for Youths in Care**

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Children and adolescents in the foster care system are a unique population with special health care needs. They experience a higher incidence of physical, developmental and behavioral health conditions than those not in the involved in child welfare system. These can be acute or chronic health conditions that often go under treated and can have an impact on their ability to become happy, healthy adults.

Caring for these children and addressing these unique healthcare needs requires coordination of many disciplines including nursing, mental health, and social workers, and health advocates in collaboration with the community and the child's own primary care practitioner. The division of Health and Wellness within DCF has created this practice guide to assist anyone working with these children navigate the many challenges in meeting the healthcare needs regardless of the setting with which they reside.

There are four main sections to this practice guide.

#### **Children and Youth in DCF Care**

This section covers practice standards for all children or youth regardless of the setting with which they reside. This includes information about health insurance, permissions and authorizations, Multidisciplinary Evaluation and guidelines for hospitalizations.

#### **Children and Youth Placed in Foster Care**

This section covers those practice standards specific to those children and youth placed in a foster placement. This includes requirements for placement and on-going care

#### **Children and Youth Placed in Congregate Care Facilities**

This section covers those practice standards specific to those children and youth placed in a congregate care setting. This includes requirements for admission and on-going care

#### **Medication Management of Youth in DCF Congregate Care**

This section covers those practice standards specific to medication management of children and youth in a congregate care setting including regulatory responsibilities, training and facility implementation guidelines.

## Introduction to Health Insurance

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### Introduction

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DCF is responsible for ensuring that all children in the care and custody of the department have health insurance coverage and that they have access to adequate medical, dental, psychiatric, and psychological services.

To fulfill this mission, caregivers, Social Workers, RRG nurses, Health Advocates, the DCF Medical Assistance Unit, the Department of Social Services and the provider community work together to ensure insurance is active and healthcare services are accessible.

DCF Policy Reference: 16-4 - Medical Coverage; Legal reference: [Conn. Gen. Stat. §17a-6e](#).

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### Health Advocate Role – Removing Barriers to Healthcare Services

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In an effort to ensure DCF children are “healthy, safe, smart and strong”, DCF Health Advocates (HAs) provide direct real-time assistance to DCF Social Workers, RRG Nurses and clinicians, caregivers and community providers for children and families in all legal statuses and phases of the DCF system of care. Health Advocates act to ensure effective connections to healthcare services.

In this role, HAs are the main point of contact for removing insurance related barriers to medical, dental, behavioral, health, transportation and pharmacy services for DCF involved clients. HAs also identify systems impacting health and propose changes in protocols to improve health outcomes.

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### When to Consult with a Health Advocate

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DCF Social Workers and RRG Nurses shall contact their area office Health Advocates when they encounter problems accessing care for children and families on their caseload. Examples of the most common situations that require a Health Advocate consult, include but are not limited to, the items below:

- Problems connecting to services
- Problems getting timely appointments
- No insurance
- Obtaining a child’s insurance number
- Ordering medical cards
- Problems getting medication
- Difficulty finding in-network providers
- Problems securing DME products, in-home nursing or home health aide services
- Facilitating appointments at other MDE sites
- Identifying child’s PCP, dentist, and dates of last exams
- Transportation problems
- Out of state placements

- Bills
- Discharge planning meetings, team case discussions when needed

**Note:** Health Advocates have access to the HUSKY (Medicaid) system but there are limitations regarding the type of information that can be acquired.

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## **Accessing Health Insurance**

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When children are initially involved with DCF, the insurance profile may differ for each child, but will fall into one of four insurance coverage categories. The child will either have:

- active HUSKY (Medicaid) insurance
- no insurance
- private insurance
- private insurance and HUSKY

**Note:** private insurance is also known as commercial insurance

### **Coordination of Private Insurance & Medicaid Coverage Benefits**

Coordination of benefits is the practice of ensuring that insurance claims are not paid multiple times, when an enrollee is covered by two or more health plans at the same time<sup>1</sup>.

If a child in DCF custody has private insurance, HUSKY insurance must still be activated and becomes the secondary insurance. Private insurance is always the primary insurance and must be billed first before Medicaid.

**Note:** DCF cannot cancel private insurance policies – only the policy holder can do this.

Health Advocates may be able to access private insurance information if it is listed in the HUSKY computer system.

Reference: <sup>1</sup> Coordination of benefits (COB) Law & legal Definition. *USLegal.com*, Retrieved October 29, 2018, from <https://definitions.uslegal.com/c/coordination-of-benefits-cob/>

### **HUSKY Health Program Organization**

The HUSKY Health program is Connecticut's Medicaid insurance program. This program is also frequently called "HUSKY", "HUSKY Medicaid", "HUSKY Health Program", "Title 19", "T19", "fee-for-service", or just "Medicaid".

The Department of Social Services (DSS) administers the HUSKY program and contracts with the administrative service organizations below to coordinate the program's medical, behavioral health, dental and transportation services. DSS contracts with DXC Technology to oversee the program's pharmacy services.

**Administrative Service Organizations:**

<b>Medical Services:</b>	Community Health Network (1-800-859-9889) <a href="http://www.huskyhealthct.org/members.html?hhNav= #">http://www.huskyhealthct.org/members.html?hhNav= #</a>
<b>Behavioral Health Services:</b>	Beacon Health Options (1-877-552-8247) <a href="http://www.ctbhp.com/">http://www.ctbhp.com/</a>
<b>Dental Services:</b>	CT Dental Health Partnership <a href="https://www.ctdhp.com/default.asp">https://www.ctdhp.com/default.asp</a>
<b>Transportation Services:</b>	Veyo (1-855-478-7350) <a href="https://ct.ridewithveyo.com/">https://ct.ridewithveyo.com/</a>

**Pharmacy Services:**

- DXC Technology, Customer Assistance line 1-866-409-8430

**HUSKY Health Program Benefits**

The HUSKY Health program is comprehensive and provides a wide range of services including, but not limited to:

- behavioral health services
- preventive care
- vision services
- primary care
- specialist visits
- hospital care
- dental services
- transportation services
- prescription medications
- durable medical equipment
- out of state services emergency room services
- out of state non-emergency services\*

Note: \*HUSKY will pay for out of state non-emergency healthcare services if the provider is enrolled in the HUSKY program.

Follow this link for more information about [HUSKY Health Program Benefits](#).

**Husky Burial and Funeral Benefits**

HUSKY will pay for a portion of burial/funeral costs. There are specific requirements that control the amount of the benefit. To be eligible, an application must be filed with the Department of Social Services (DSS) within one year of the date of death.

DSS has an arrangement with the CT Funeral Directors Association (CFDA) and all participating funeral homes are familiar with this program. To access this benefit please contact any one of the 220 CFDA member funeral homes in Connecticut.

For further information / answers to questions, contact the Department of Social Service Benefit Center at 1-855-626-6632, option "0".

DCF Health Advocates can assist DCF social workers and their clients to access this benefit in the event of the death of a DCF client.

## HUSKY Insurance Activation

### DCF MA-1 Form

Social Workers are responsible for completing the DCF Medical Assistance Form (MA-1) to activate, maintain, update or close HUSKY insurance for children in the care and custody of the department.

Social Workers shall record a child's private insurance information in the "Commercial Insurance" section of the MA-1 Form.

MA-1 forms must be emailed to the DCF Medical Assistance Unit for processing.

Note: DSS should not be contacted to address HUSKY insurance issues when children are placed out of home. Social Workers must contact their area office Health Advocate for assistance.

Cross Reference: DCF Policy 16-4 - Medical Coverage

### HUSKY Medical Cards:

Medical cards provide proof of coverage and they facilitate appointments.

#### HUSKY Insurance Cards

Social Workers shall ensure children in DCF custody have HUSKY insurance cards. Every child in DCF custody needs two HUSKY insurance cards - a grey Connect Card and white HUSKY card:



- **Requesting the grey Connect Card:** The DCF Social Worker shall complete a DCF MA1 form to request the grey Connect Card. At the bottom of the form in the "remarks" section, the Social Worker must indicate that he/she is requesting a medical card. The MA-1 form is forwarded to the DCF MAU ([DCF.MEDICALASSISTANCE@CT.GOV](mailto:DCF.MEDICALASSISTANCE@CT.GOV)) for processing.

The Connect Card must be used at the pharmacy and presented at dental and mental health appointments.

- **Requesting the white HUSKY Card:** Social Workers shall email their area office Health Advocate to request HUSKY cards for children in DCF custody. The Health Advocates contact Community Health Network (CHN) to request HUSKY cards on the behalf of the Social Worker.

The HUSKY card must be presented at Medical and Vision appointments.

Allow 10-14 business days for delivery of the Connect Card and the HUSKY insurance cards.

### **Private Insurance Cards**

If a child in DCF custody has private insurance, Social Workers shall try to obtain the child's private insurance card(s) at the time of removal or as soon as possible after placement.

Children with private insurance will need three insurance cards – the private insurance card, the Connect card and the HUSKY card.

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## **Accessing Healthcare Services**

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Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans <sup>2</sup>.

Reference: <sup>2</sup> Access to Health Services, HealthyPeople.gov, Retrieved 10-29-18, from <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>

### **Issues Effecting Access**

- Lack of availability of Medicaid providers
- Lack of insurance coverage
- Lack of insurance card
- Lack of prior authorization for treatment and/or pharmacy
- Lack of transportation to medical appointments
- Lack of private insurance information

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## **Ensuring Payment for Healthcare Services**

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### **Using HUSKY Providers**

It is recommended that DCF caregivers use HUSKY providers for children in the care and custody of DCF. When a child has both private insurance and HUSKY coverage, HUSKY providers must be chosen who accept the child's private insurance.

HUSKY providers, also called “in network providers”, offer the full array of healthcare services which include medical, behavioral health, dental, vision, pharmacy and transportation services. All HUSKY providers must meet or exceed HUSKY’s standards for care. These providers are contracted by HUSKY to provide care at established rates and to accept these rates as payment in full. HUSKY providers cannot bill DCF for any balances that remain after insurance payment. They must accept the contracted rate as payment in full as required by contract.

HUSKY providers can be located by accessing the HUSKY CT website.

Health Advocates can also assist DCF staff and caregivers in locating HUSKY providers.

### Using Non-HUSKY Providers

There may be situations when it is not possible to use a HUSKY provider(s). When this occurs, it may be necessary to use a non-Medicaid Provider. These situations include, but are not limited to the following examples:

- If there is no provider or specialist in the HUSKY network who can appropriately address the medical or behavioral health needs of a DCF child.
- If there is a court order specifying the use of a particular non-HUSKY provider
- If a child has a history with a provider before coming into care and DCF staff determine it is in the best interest of the child to continue treatment by this provider
- A child is placed out of state and there are no HUSKY providers or no providers are willing to enroll in HUSKY
- If a child is out of state, needs medications and pharmacies do not take HUSKY insurance.

### IMPORTANT

**When seeking healthcare services, use in-network providers whenever possible. If in-network providers can not address a child’s healthcare needs, DCF contracted providers should attempt to be utilized. When DCF contracted providers cannot be used, then DCF credentialed providers should attempt to be utilized. When none of these provider options are available, then as a last resort use a non-HUSKY provider that requires DCF payment. DCF payment should be sought ONLY as a last resort.**

Social Workers shall contact their area office Health Advocate when DCF payment is required. Health Advocates facilitate payment with non-HUSKY providers to control DCF costs.

<p><b>Caregiver Responsibilities:</b></p>	<ul style="list-style-type: none"> <li>• Caregivers shall bring all insurance cards to medical, vision, dental, behavioral health appointments and pharmacy services.</li> <li>• Caregivers shall use healthcare providers who accept their DCF child’s insurance. If a child has both HUSKY and private insurance, the provider chosen must accept both insurance plans.</li> <li>• Caregivers shall contact their DCF Social Worker as soon as possible when they encounter problems with insurance and/or accessing healthcare services for their DCF child.</li> </ul>
<p><b>DCF Social Worker Responsibilities:</b></p>	<ul style="list-style-type: none"> <li>• DCF Social Workers shall consult with their area office Health Advocate to remove barriers to healthcare services.</li> <li>• DCF Social Workers shall include the Health Advocate in team discussions when assistance is needed to remove barriers to healthcare services</li> </ul>
<p><b>RRG Nurse Responsibilities:</b></p>	<ul style="list-style-type: none"> <li>• RRG Nurses shall consult with their area office Health Advocate to remove barriers to healthcare services.</li> </ul>
<p><b>Health Advocate Responsibilities:</b></p>	<ul style="list-style-type: none"> <li>• Whenever possible, assist DCF staff, caregivers and parents by remove barriers to healthcare services.</li> </ul>

## **Discharge from Care – Health Insurance for Former Foster Care Youth**

### **Former Foster Care Youth Eligible for Insurance through Age 26**

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#### **Purpose:**

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The Affordable Care Act (ACA) assures that former foster care youth who meet certain eligibility requirements have the same opportunity for extended medical coverage through age 26 as youth who were not in foster care.

According to DCF Policy 16-4:

All adolescents who were in foster care at age 18 AND who were receiving Medicaid benefits are also entitled to medical coverage through their 26th birthday, whether or not they chose to continue receiving services from DCF.

The DCF Medical Assistance Unit (MAU) shall facilitate the enrollment of these children in Medicaid through close collaboration and communication with the children's Social Workers and the Department of Social Services (DSS).

Cross Reference: DCF Policy 16-4 – Revenue Enhancement: Medical Coverage

To screen for eligibility and maintain coverage until age 26:

- Social Workers shall complete an MA1 Form to close the youth's DCF case
- The DCF MAU shall screen the youth's case and, if eligible, will set the youth up with medical coverage through age 26
- Youth eligible for this extended coverage must inform the MAU (DCF.MEDICALASSISTANCE@ct.gov) of any changes in their address. This notification helps ensure there are no disruptions in coverage.

Note: Youth eligible for coverage through age 26 should not contact Access Health CT or the Department of Social Services for assistance with their insurance. DCF MAU must handle all questions/problems regarding their insurance. Contacting the MAU for assistance will prevent insurance from closure and other problems,

#### **Former Foster Care Children and Youth Not Eligible for Insurance Though Age 26**

Social Workers shall inform parents they need to ensure their child(ren) has medical insurance. Parents must add their dependent on their private or their HUSKY insurance.

Youth who are living on their own or are otherwise independent can apply for their own insurance from an employer or through Access Health CT online or by phone at 1-855-805-4325.

## Discharge from Care – Supports for Youth Leaving DCF Care

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### Supports for Youth Leaving DCF Care with HUSKY Insurance

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The HUSKY program offers many supports to help create stability for youth exiting DCF care. Examples of some of these supports include, but are not limited to:

- Appointment reminders
- Assistance obtaining medical cards and connecting to healthcare services
- Help resolving insurance problems
- Education about health conditions
- Identifying non-traditional supports
- Arranging transportation to medical appointments

To request supports for children and youth exiting care with HUSKY insurance, contact:

<b>Medical Services:</b>	Community Health Network (1-800-859-9889) <a href="http://www.huskyhealthct.org/members.html?hhNav= #">http://www.huskyhealthct.org/members.html?hhNav= #</a>
<b>Behavioral Health Services:</b>	Beacon Health Options (1-877-552-8247) <a href="http://www.ctbhp.com/">http://www.ctbhp.com/</a>
<b>Dental Services:</b>	CT Dental Health Partnership <a href="https://www.ctdhp.com/default.asp">https://www.ctdhp.com/default.asp</a>
<b>Transportation Services:</b>	Veyo (1-855-478-7350) <a href="https://ct.ridewithveyo.com/">https://ct.ridewithveyo.com/</a>

#### Other Supports:

2-1-1 Infoline (dial 2-1-1 or access their website [211 Infoline](#)). These supports are available to all CT residents.

Prior to DCF case closure, consult with a Health Advocate to assist youth in connecting with these supports.

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### Supports for Youth Leaving DCF Care without HUSKY Insurance

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Contact 2-1-1 Infoline (dial 2-1-1 or access their website [211 Infoline](#)) to inquire about supports available in the state of Connecticut. These supports are available to all CT residents.

## Special Health Insurance Topics

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### Non-Emergency Medical Transportation (NEMT)

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#### Purpose:

Non-Emergency Medical Transportation (NEMT) is a limited transportation benefit that is provided to eligible HUSKY A, C and D members in Connecticut who cannot drive themselves, and/or do not have a neighbor, friend, relative, or voluntary organization that can transport them to their appointment<sup>1</sup>.

In Connecticut NEMT services are managed by Veyo.

#### Trip Scheduling:

To schedule rides, contact Veyo at **1-855-478-7350** Monday through Friday between 7:00 am and 6:00 pm. DCF facilities who need to book multiple trips for multiple members, can book rides online using Veyo's [Multiple Trip Scheduling Tool](#).

NEMT callers must allow 48 hours advance notice when making a non-emergency transportation reservation and must also provide the HUSKY Medicaid #, name of the provider treating the DCF client, and any special accommodations needed for the transport (e.g. oxygen tank etc) at the time of the call.

Prior to trip scheduling, travel authorizations and forms may be required for certain transports (e.g. transportation of youth 16 and younger, medically required attendants/escorts, travel greater than 20 miles).

To reduce the possibility of missing a ride, NEMT riders should be ready 15 minutes before their scheduled pickup time.

Note: Transportation out of state may be available if it is medically necessary. Contact your area office Health Advocate for assistance with cases that require out of state transportation

#### DCF Protocol for Handling NEMT Problems:

<b>Caregiver Responsibilities</b>	<ul style="list-style-type: none"> <li>• If the ride is more than 15 minutes late, call Veyo at 855-478-7350, prompt #4 for assistance.</li> <li>• Immediately contact their Social Worker to inform them of any NEMT problems not resolved by Veyo.</li> </ul>
<b>Social Worker Responsibilities</b>	<ul style="list-style-type: none"> <li>• Forward all unresolved NEMT problems from caregivers to the area office Health Advocate to address.</li> <li>• Include the child's name, ems# and brief description of the problem</li> </ul>
<b>Health Advocate Responsibilities</b>	<ul style="list-style-type: none"> <li>• Escalate all unresolved NEMT problems to the Department of Social Services NEMT liaison.</li> </ul>

Source: <sup>1</sup> Veyo Informational Member Brochure, [ct.ridewithveyo.com](http://ct.ridewithveyo.com), Retrieved 10-29-18, from <https://ct.ridewithveyo.com/brochures/>

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## Social Admissions

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### Definition

“Social Admission”: Days in a hospital setting that are not medically necessary but are required for any of the following reasons:

- A child is medically cleared for discharge from a hospital but requires an extended hospital stay because an adequate discharge plan is not in place.
- A child requires a hospital admission for respite care.

Social Admissions are also commonly called “administrative days”, “administrative hospital days”, “medically necessary discharge delay days”, or “non-medically necessary hospital days”. Social admissions are negotiated with the hospital and it is not an expectation that they accept or agree to a social admission.

### Payment for Social Admissions

HUSKY pays for social admissions when children who have a behavioral health diagnosis and require an extended hospital stay because an adequate hospital discharge plan is not in place. The Department of Social Services (DSS) has established hospital specific rates to pay for these admissions and DCF staff shall use them.

DCF is responsible for paying for social admissions when children have medical diagnoses. Funds are remitted from area office budgets to pay for these medical social admissions.

### Process for Securing Payment for Social Admissions

#### Before a Social Admission is Approved:

As soon as there is an awareness a social admission may be required, a discharge planning team meeting shall be set up to secure payment and ensure a safe and timely discharge plan.

<b>Social Worker Responsibilities</b>	<ul style="list-style-type: none"> <li>• The Social Worker shall set up the discharge planning team meeting. At minimum the team should include the Social Work Supervisor, RRG nurse, FASU staff and the area office Health Advocate. The RRG clinician should be included if the child was admitted for the management of a behavioral health condition.</li> <li>• The Social Worker shall assist the RRG nurse in their effort to advocate for children when DCF feels a hospital admission continues to be medically necessary.</li> <li>• The Social Worker, with input from the RRG nurse and FASU staff, shall determine whether a social admission is required.</li> <li>• The Social Worker shall obtain permission from his/her chain of command and, if required, the Area Office Director.</li> </ul>
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<b>RRG Nurse Responsibilities</b>	<ul style="list-style-type: none"> <li>The RRG nurse shall consult with the child’s medical team and CPS team to ensure the child is medically cleared for discharge and an adequate discharge plan is in place to ensure the child receives the appropriate care in a safe environment.</li> </ul> <p><i>If the CPS team and child’s medical team are not in agreement regarding the child being medically cleared for discharge the RRG nurse will consult with their supervisor to determine the next steps.</i></p>
<b>Health Advocate Responsibilities</b>	<ul style="list-style-type: none"> <li>If the hospital determines a child is ready for discharge but an RRG nurse, RRG clinician or other provider feel a longer hospital stay is medically necessary, the HA shall assist DCF in ensuring all levels of insurance appeals are pursued while approval for a social admission is being sought.</li> </ul>

**After a Social Admission is Approved:**

<b>Social Worker Responsibilities</b>	<ul style="list-style-type: none"> <li>Once it is determined a social admission is required, the Social Worker shall contact the area office Health Advocate as soon as possible to ensure all necessary paperwork is completed and payment for the admission occurs.</li> <li>The Social Worker shall follow established documentation procedures and visitation requirements for hospital admissions.</li> <li>The Social Worker shall consult with the RRG Nurse, the CPS team and the child’s medical team to ensure a safe discharge from the hospital</li> </ul> <p><u>Cross Reference:</u> Practice Guide Section - Hospital Support &amp; Visitation Plan</p>
<b>RRG Nurse Responsibilities</b>	<ul style="list-style-type: none"> <li>The RRG Nurse shall consult with the Social Worker, the CPS team and the child’s medical team to ensure a safe discharge from the hospital.</li> </ul>
<b>Health Advocate Responsibilities</b>	<ul style="list-style-type: none"> <li>The Health Advocate shall consult with the DCF Rate Setting Unit to ensure a rate letter is sent to the hospital for medical social admissions or, in the case of a behavioral health social admission, that the hospital bills HUSKY insurance.</li> <li>The Health Advocate shall address insurance related issues that arise during the discharge planning process.</li> </ul>

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**Voluntary Services – Payment for Services**

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**Purpose:**

DCF has partnered with the Office of the Healthcare Advocate (OHA) to assist families who apply for the Voluntary Services Program to access and appropriately utilize available health insurance plans to pay for the services.

Cross Reference: DCF Policy 37-4-2, Voluntary Services-Accessing Insurance

**DCF Health Advocate & OHA Roles**

Social Workers shall **contact DCF Health Advocates for health insurance assistance with cases that are not Voluntary Services** and contact OHA for health insurance assistance for cases that are Voluntary Services.

The following short reference guide provides additional detail to assist DCF staff in knowing which state agency (DCF or OHA) to contact for assistance with insurance issues for non-Voluntary and Voluntary Services cases.

<b>Case Type</b>	<b>Who to Contact</b>
All non-Voluntary Services cases with HUSKY insurance problem	DCF Health Advocate
All non-Voluntary Service cases with HUSKY and private insurance problem	DCF Health Advocate
FAR, adoption, JJ, probate cases with private insurance problem	DCF Health Advocate
CPS case with private insurance problem	DCF Health Advocate
Voluntary Services case with private insurance problem	OHA
Voluntary Services case With HUSKY insurance problem	OHA

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**Out of State Placements – Accessing Healthcare Services**


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**Purpose:**

Changes in HUSKY Health Program policy and the process for identifying payment sources for healthcare services are often barriers that must be addressed when DCF children move out of state. For this reason, special care shall be taken to ensure DCF children placed in out of state foster care or congregate care settings have access to timely and appropriate healthcare services.

Social Workers shall make every attempt to consult with their area office Health Advocate and RRG staff before placement occurs to best ensure there are connections to out of state services and providers.

**Process: Accessing Out of State Healthcare Services**

<b>Prior to Out of State Placement</b>		
1	Complete all DCF paperwork required to place the child out of state.	Social Worker
2	As soon as a decision is made to place a child out of state, arrange to meet with the Health Advocate, Educational Consultant, RRG Nurse and the RRG Clinician (if the child has behavioral health needs) to: <ul style="list-style-type: none"> <li>Identify medical/behavioral health and educational issues that must be addressed prior to and/or after the placement.</li> </ul>	Social Worker
3	Whenever possible make medical, behavioral health, dental appointments while the child is in CT	Social Worker/ Caregiver
4	Whenever possible, ensure prescriptions are filled while the child is in CT. Ask the prescriber to write a 3 month supply of the medication.	
5	Email your Area Office Health Advocate a list of the providers the foster family wishes to use (primary care doctor, medical specialists, Psychiatrist, counselor, dental, vision, pharmacy, local hospital etc).	Social Worker/ Caregiver

<b>After Placement</b>		
1	Complete an MA1 Form when the child has been placed.	Social Worker
2	<ul style="list-style-type: none"> <li>If the child is placed in a congregate care setting, continue with step #3.</li> <li>If the child is in foster care, email the Health Advocate the name/number of the person at the licensing agency responsible for licensing the foster home.</li> </ul> <p><u>Note:</u> Licensing agencies may be able to assist in activating Medicaid</p>	Social Worker
3	Apply for out of state Medicaid.	Licensing Agency, Health Advocate, or Caregiver
4	Contact healthcare providers to enroll them in HUSKY or make DCF payment arrangements when necessary.	Health Advocate
5	Inform caregiver how the providers will be paid.	Health Advocate
6	Contact the Health Advocate as soon as possible when there are problems accessing services and/or problems with payment.	Social Worker/ Caregiver

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## **Adoptions/Subsidized Adoptions – Medical Coverage**

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### **Purpose:**

Children who have been adopted from the Department of Children and Families (DCF) foster care system and/or a private Connecticut licensed child-placing agency who have special needs are eligible for the subsidized adoption program. This program provides a financial subsidy and/or a medical subsidy to the family to provide for the child's needs.

Cross-reference: DCF Policy 41: Post Adoption Services – Financial & Medical Subsidies

When a DCF child is adopted, the DCF Subsidy Unit discontinues medical coverage under the child's biological name and activates new medical coverage using the child's adoptive name. A new HUSKY number is assigned and medical cards with the adoptive name are sent to the adoptive parents.

Establishing medical under the new adoptive name may take more than four months.

For this reason the adoptive parents shall continue to use the medical card with the child's biological name and HUSKY number issued prior to the adoption until the new medical card arrives. Parents shall contact the DCF Subsidy Unit to inquire about insurance cards that have not been received. To avoid problems accessing healthcare services, parents **should not call HUSKY or Department of Social Services to inquire about insurance cards.**

Adoptive parents shall contact the DCF Subsidy Unit or a DCF Health Advocate if they have difficulty accessing healthcare services or other Husky benefits.

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## **Immigrant Families**

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### **Immigrant Families/Undocumented (non-citizen) children**

#### **Purpose:**

DCF provides medical coverage for children in our legal care regardless of U.S. citizenship.

However, supports for immigrant, undocumented and uninsured children who are **not** in DCF legal care are often difficult to find. The Health Advocates can assist DCF Social Workers by helping to identify resources available for undocumented and uninsured families who are involved with DCF but are not in DCF legal care. The DCF Office of Multicultural Affairs is also a valuable resource.

Cross References: Policy 10-1: Multicultural Services - Office of Multicultural Affairs & Immigrant Practice

## Securing Permissions and Authorizations of Specific Health Services

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### Informed Consent

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#### Purpose:

It is the responsibility of DCF to ensure that informed consent is obtained before permitting health care treatment for a child in its custody.

Note: This policy does not apply to the involuntary administration of psychotropic medication. In such cases consult DCF Policy [44-5-2.2, Involuntary Administration of Psychotropic Medications](#).

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### Legal Status of the Child and Consent

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The following chart indicates, according to the legal status of the child, who is responsible for providing consent for treatment.

Note: In some circumstances, as outlined later in this Practice Guide, minors may provide consent for health care treatment.

Important Note: For those children in DCF's care, consent can only be on DCF approved consent forms.

Legal Status of Child	Who Can Give Consent
96-Hour Hold	Parent or Legal Guardian
Order of Temporary Custody	Parent or Legal Guardian
Abuse, Neglect or Uncared-for (CPS) Commitment	DCF Commissioner or Designee
Statutory Parent (Termination of Parental Right Granted)	DCF Commissioner or Designee

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### Authority to Provide Informed Consent

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The DCF designee shall not provide consent for any medical or mental health care for a child without first obtaining an explanation from the health care provider.

When consent is provided by DCF, such consent may be given by the Commissioner or designee at the level of a Social Work Supervisor (SWS) or higher DCF administrator. Once a DCF 460R consent has been signed for routine health care, a foster parent or other agency authorized caregiver (such as a congregate care provider) may sign a provider's consent for

routine care. This excludes genetic/genomic testing and surgeries/procedures. Additionally, caregivers can only consent for children and youth whose legal status falls under those where the Commissioner or their designee can give consent (see chart above).

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### **Social Worker Responsibility: Obtaining Proper Forms**

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The DCF-460, "Informed Consent for Necessary or Emergency Health Care Medical or Dental" shall be used to provide informed consent for all necessary and emergency health care procedures, surgery, and treatment that include use of sedation for children that are legally committed to DCF. Sedation includes general anesthesia, intravenous (IV) sedation and/or nitrous oxide (gas used in dental procedures). The top portion of the DCF-460 is completed by the DCF SW and forwarded to the licensed medical provider to complete the middle portion. Provider notes/summary reports may be requested to capture all information needed for consent. Once reviewed by the RRG nurse, the DCF 460 is signed by the Commissioner or designee at the level of a Program Supervisor (PS) or higher DCF administrator.

**Note:** The above should be completed in advance of a scheduled procedure to allow time for review and approval unless it is an emergency procedure. In this instance, verbal authorization may be needed with written consent completed within 24 hours.

The DCF-460R, "Permission to Deliver or Obtain Routine/Specialty Health Care and MDE" shall be used for permission for routine medical, specialty and mental health screening and care and Multi-Disciplinary Evaluation (MDE). The Social Worker shall provide the foster parent or other DCF-authorized caregiver with the DCF-460R at the time a child enters DCF care. Signing of the form is dependent upon the child's legal status. See legal status chart in the prior section. The form authorizes the foster parent, other DCF-authorized caregiver, and/or congregate care setting to provide informed consent for routine medical, specialty and mental health screening and care and Multi-Disciplinary Evaluation. The DCF-460R shall expire when a child changes placement or 365 days after the date of signature.

At the time of placement on a 96-hour hold or order of temporary custody (OTC) the Social Worker shall request that a parent or legal guardian of the child sign the DCF-460R. The Social Worker shall provide this to the foster parent or other DCF-authorized caregiver so that the caregiver may access routine health care for the child.

The DCF 460R, shall also be used for permission to obtain specialty medical care. The DCF SW shall provide the foster parent or other DCF-authorized caregiver and/or the licensed specialty medical provider with the DCF-460R prior to the scheduled appointment. Signing of the form is dependent upon the child's legal status. See legal status chart in the prior section. If legal guardian is unavailable, Commissioner or DCF or designee at the level of a Social Work Supervisor (SWS) or higher DCF administrator can sign. The form authorizes the foster parent, other DCF-authorized caregiver, and/or congregate care setting to obtain specialty medical care. The form authorizes the licensed specialty medical provider informed consent for consultation, evaluation, and permission for specific testing such as x-rays, ultrasound, and other non-sedated procedures.

**Note:** If a child is subsequently committed to the Commissioner as a neglected, abused or uncared for child, the DCF SW shall provide the caregiver with a new DCF-460R signed by the Commissioner or designee at the level of a Social Work Supervisor or higher DCF administrator.

Note: A separate DCF 460R is required for each Licensed Specialty Medical Provider and is completed per timeframes required by the provider. Additional consent is required for genetic testing.

#### Multi-Disciplinary Evaluation (MDE) Consideration

Consent from a parent is required for any child for whom the Commissioner is not the legal guardian (most children getting MDEs will not be committed to DCF).

The Social Worker who removed the child shall obtain the signed DCF-460R. Prior to obtaining consent, the Social Worker shall provide the parent or guardian with the MDE informational material describing the MDE clinic, its purpose and importance, and discuss any questions.

If a parent is not available to provide consent or will not sign consent at removal, the DCF-460R consent should be reviewed at the ten day hearing in court and consent from the parent or guardian obtained at that time.

If the parents or guardian are still refusing to sign or cannot be located and the OTC is sustained by the court, DCF social worker, social worker supervisor or the program supervisor cannot sign the 460R for MDE visits and routine medical care. The Department must seek permission from the court for the MDE and to obtain routine medical care. In such circumstances, the area office attorney should be consulted.

(See MDE Report section of this Practice Guide for details about adolescent consent required for release of information to DCF about any disclosures of substance use or reproductive health issues.)

#### Immunizations Consideration

Though immunizations are required for school attendance, parents and legal guardians have the right to exempt their children from receiving vaccines. The 460R enables parents and legal guardians to provide their consent for immunizations when their child is removed from their care and therefore indicate their vaccination preference. Parents or guardians will need to consent and sign the immunization provision on the 460R to allow for the child to receive immunizations as recommended by the child's medical provider. Children on an OTC or 96-hour hold should not receive immunizations as part of the EPSDT or other health visit if their parent/guardian have not consent for vaccines. If the child is committed to the Department and the parent or guardian refuses to consent and sign the immunization provision on the 460R, the Department shall offer the parent or guardian a treatment plan hearing before proceeding with any immunizations.

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### Consents Forms from Health Care Providers

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Some health care providers may require that their institutional forms be signed in addition to the official DCF form. Whenever possible, these forms shall be reviewed by a DCF licensed health professional before providing informed consent to ensure that they comport with DCF medical requirements. DCF Social Workers shall confer with the RRG Nurse to review any non-DCF forms prior to signing, except forms related to the provision of psychiatric care.

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## When DCF is Not the Legal Guardian

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Circumstances in which DCF is not the legal guardian or statutory parent but the child is in DCF's physical custody are in the legal status chart. Reasonable efforts to secure consent of the parent or guardian may include but are not limited to:

- attempting to locate a parent or legal guardian by telephone or in person;
- communication with a parent's or legal guardian's attorney;
- sending a certified letter to a parent's or guardian's last known address;
- providing a parent or guardian with the name and telephone number of the qualified health care provider; and
- obtaining an interpreter where appropriate.

If DCF is unable to get permission from a parent or legal guardian, the Social Worker shall seek a court order prior to providing informed consent for any health care, including for routine health care.

**Important Note About Emergencies:** Notwithstanding the general rules set forth above, emergency health care shall never be delayed because of the unavailability of a parent or legal guardian or insufficient time to access the court system. In any case in which the need for health care is an emergency and there is insufficient time to get informed consent from a parent or legal guardian or a court order, the Commissioner or designee shall provide consent using the DCF-460. If a parent or legal guardian subsequently provides consent, a new DCF-460 shall be signed and shall replace the consent granted by DCF.

<b>Caregiver Responsibilities</b>	<ul style="list-style-type: none"> <li>• Caregiver will bring the DCF 460R to all routine medical, dental and mental health appointments for use as consent to treat.</li> <li>• Caregiver will notify DCF SW of any planned procedures that include sedation so a DCF 460 can be completed by the provider and legal guardian/DCF.</li> <li>• Caregiver will notify DCF SW of any planned specialty consultations so a DCF 460R can be completed.</li> </ul>
<b>RRG Nurse Responsibilities</b>	<ul style="list-style-type: none"> <li>• RRG nurse is available for consultation to assist the SW with the DCF 460R.</li> <li>• RRG nurse should be consulted to review and initial the DCF 460 prior to signature by DCF program supervisor.</li> </ul>
<b>Health Advocate Responsibilities</b>	<ul style="list-style-type: none"> <li>• HA is available for consultation to help resolve barriers to care including insurance, transportation and available providers.</li> </ul>

### What to Expect from Health Care Providers

- A health care provider is required to provide information to a patient and the patient's parent or legal guardian about the proposed treatment or procedure, consistent with his or her health care license, including the specifics of the proposed procedure or treatment, reasonably foreseeable risks, and the reasonable alternatives for care.
- A health care provider is required by law to get the informed consent of the patient's parent or legal guardian before any procedure or treatment is provided and to show written evidence of that consent in the patient's medical record.
- When age and developmentally appropriate, assent of a patient who is a minor is recommended and should be obtained whenever possible.

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## **Parental Denial or Rescission of Informed Consent**

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A parent or legal guardian may object to health care for his or her child for any reason, including religious tenets, values or beliefs.

A parent or legal guardian may rescind and revoke any previously-given consent in writing.

If a parent or guardian objects to or revokes consent for health care, the Social Worker shall consult with the Area Office Attorney or Assistant Attorney General to determine if court action is necessary to obtain health care for the child.

Cross reference: DCF Policy 34-12-7, "Religious Beliefs of Parents Preventing Necessary Medical Care."

## Psychotropic Medication Approval

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### Monitoring of and Consent to Prescribe

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#### Purpose:

Medical oversight of the consent to and monitoring of psychotropic medication is required by state law.

DCF has established a centralized mechanism, via a computerized database, to quantify the use of psychotropic medications for children committed to DCF. This database contains all requests, the class of medication, the setting and the decisions made regarding those requests.

The following Practice Guide sections provide a streamlined process through which providers may interact directly with DCF medical and nursing staff who are trained and board certified in psychiatric and behavioral health care.

Legal reference: Conn. Gen. Stat. §17a-21a.

#### Introduction:

DCF requires that prescribing practitioners obtain appropriate informed consent regarding a child in the care of DCF who requires medically-necessary psychotropic medication.

DCF shall make available to practitioners treating children in the care of DCF a copy of the DCF "Guidelines for Psychotropic Medication Use for Children and Adolescents."

#### Definitions:

**"Assent"** means agreement with the medication being prescribed and is required for all youth ages 14 and up. It is the responsibility of the prescriber to document assent and also the risks and benefits of the proposed medication in the medical records.

**"CMCU APRN"** means an Advanced Practice Registered Nurse who serves as the Commissioner's designee in reviewing and approving the use of psychotropic medications.

**"Centralized Medication Consent Unit" or "CMCU"** means a centralized unit that is responsible for the receipt, triage, communication, data collection and decision-making processes used to provide consent to treat children with psychotropic medications. The CMCU is staffed by psychiatric nurses and child psychiatrists, who have been designated by the Commissioner to provide consent for psychotropic medication requests.

**"Chief of Psychiatry"** means the child and adolescent psychiatrist who is responsible for oversight of the Regional Medical Directors and the Centralized Medication Consent Unit.

**"Designee,"** as used in this section, means a representative of the Commissioner who has been given authority to review and provide consent for psychotropic medications. Designees

are the Chief of Psychiatry, Regional Medical Directors, CMCU Nursing Staff, Careline staff and senior medical staff who are on call after hours.

**"Informed consent"** means permission granted by a child's guardian to prescribe psychotropic medication. As part of the consent process, the prescriber shall provide the patient or the patient's representative with the following:

- the nature and seriousness of the diagnosis;
- the nature of the medication;
- the risks of the medication;
- the expected benefits of the medication;
- any reasonable alternative treatments other than medication; and
- the possible common, long-term or infrequent side effects of the medication.

**"Non-business hours"** means Monday through Friday after 5:00 PM, weekends, state holidays, and other times when normal day-to-day business is not being conducted.

**"Psychotropic medications"** means medications prescribed for psychiatric purposes that affect the central nervous system and influence thought processes, emotions and behaviors.

**"Reasonable efforts (to gain consent)"** means the strategies employed by DCF staff to contact and inform a child's parent or guardian, and to inform a child over the age of 14, of the reason for the psychotropic medication and the risks and benefits of the administration of the psychotropic medication. What is "reasonable" depends on the circumstances of the case, including time of day, the condition of the child, whether the child will suffer serious physical or mental harm if administration of medication is delayed and the availability of a parent or guardian. "Reasonable efforts" include, but are not limited to, telephone calls or in-person visits to any person who is likely to know how to contact a parent or guardian.

**"Regional Medical Director"** means a child and adolescent psychiatrist assigned to designated regions, each consisting of a grouping of DCF Area Offices. The Regional Medical Director may act as the Commissioner's designee for purposes of the medication approval process.

**"Request for Review"** means a request made by a provider to the Chief of Psychiatry to review and, if appropriate, overturn the denial of a medication request by a medical designee.

**"Timely manner"** means the expected time frame to obtain consent for medication treatment. Whenever possible, requests shall be processed within 24 business hours if requested from a hospital setting (urgent requests), and within 72 business hours for non-urgent requests. Requests that require consultation with the provider or contain insufficient information may not be completed within that timeframe.

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## Forms

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DCF-465 - The "Psychotropic Medication Consent Request" must be submitted by the provider for each request to prescribe a psychotropic medication. The final outcome of the request is also recorded on the DCF-465 by the Regional Medical Director or CMCU APRN and a copy is returned to the prescribing provider.

**Important:** The DCF-465, "Psychotropic Medication Consent Request," must be used for informed consent to administer psychotropic medication.

DCF 465A – The “Notification – Discontinuation of a Psychotropic Medication” should be completed by the prescribing provider whenever discontinuing a psychotropic medication for which consent has been previously received.

DCF 465B – The “Suspected Adverse Drug Reaction Reporting Form” must be submitted to the CMCU by the prescriber whenever a child has or is suspected of having an adverse reaction to a psychotropic medication.

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## **Protocols for Consent**

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The DCF Commissioner or designee shall make a determination regarding the use of psychotropic medication in a timely manner, consistent with the best interests of the child.

A Regional Medical Director or a CMCU APRN shall review each request for the use of psychotropic medication prior to making a determination regarding consent.

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## **Requests for Review**

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A Request for Review may be submitted to the Chief of Psychiatry:

- when the prescribing provider disagrees with a DCF designee's denial of consent to prescribe a psychotropic medication; or
- when requested by the DCF Commissioner, a DCF Regional Administrator or a DCF Facility Superintendent.

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## **Responsibilities of the Centralized Medication Consent Unit**

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The Centralized Medication Consent Unit (CMCU) shall ensure that requests for consent to prescribe psychotropic medications are received and reviewed and final decisions are sent to the prescribing providers in a timely manner as follows:

- the CMCU shall accept medication requests from the prescribing provider on the DCF-465;
- the CMCU shall verify the child’s demographic information, assigned Area Office and legal status in LINK;
- based on the child’s legal status, the CMCU shall determine the steps necessary to make a decision regarding the medication request; and
- the CMCU shall triage and communicate appropriate decisions regarding each medication request.

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## Legal Status of the Child and Consent

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The following chart indicates, according to the legal status of the child, who may provide informed consent.

Legal Status of Child	Who May Give Consent
Voluntary Services Placement	Parent or Legal Guardian
Family with Service Needs Commitment	Parent or Legal Guardian
Delinquency Commitment (see below for special instructions)	DCF Commissioner (see below for special instructions)
96-Hour Hold	Parent or Legal Guardian
Order of Temporary Custody	Parent or Legal Guardian
Abuse, Neglect or Uncared-for (CPS) Commitment	DCF Commissioner or Designee
Statutory Parent (Termination of Parental Right Granted)	DCF Commissioner or Designee

### Child Whose Legal Status Requires Parental Consent

For any child whose legal status requires parent or guardian consent, the Social Worker shall make reasonable efforts to obtain the informed consent of the child's parent or guardian, and the child if he or she is over 14 years of age.

If the parent or guardian is not available to provide consent, the Social Worker shall:

- ensure that the child is provided with all necessary medical care, which may include an examination by a physician or mental health professional;
- consult with an Area Office Attorney or Assistant Attorney General for further advice regarding reasonable efforts to obtain consent, potential court proceedings to obtain judicial authorization and any other legal issues that may arise;
- when appropriate, seek a court order authorizing the use of psychotropic medication; and
- document all efforts to gain informed consent from a parent or guardian, and a child over 14 years of age, as well as any refusals.

Note: A physician may authorize emergency medical care without the consent of a parent or guardian while the Social Worker continues to make reasonable efforts to inform the parent or guardian. The authorization for treatment during an emergency shall last only as long as the emergency exists.

Note: For after-hours emergencies, consultation with a DCF legal manager is recommended, but not required. However, legal staff shall be consulted the next business day following the after-hours emergency.

### **Child whose Legal Status Permits DCF Consent**

In the case of a child whose legal status permits DCF to provide consent, the CMCU shall:

- enter the medication consent request, and all information related to the medication request, in the computerized database;
- review the medication consent request;
- if additional information is required, request information from the Area Office Social Worker, the RRG Nurse or the provider;
- make and enter the decision into the computerized database and document in LINK the reasons for any denials;
- fax or email the finalized DCF-465 to the prescribing provider; and
- send notification of the final outcome to the CMCU, Regional Clinical Manager, Area Office Social Worker and RRG nurse.

### **Children Committed Delinquent**

In the case of a child who has been committed to DCF as a delinquent, the Commissioner or designee may authorize medical treatment, including medication, of the child without the consent of the parent or guardian as long as DCF makes reasonable efforts to inform a parent or guardian of the need for treatment prior to the treatment being administered.

Following treatment, DCF shall notify a parent or legal guardian in writing of the treatment provided, the necessity for the treatment and the outcome of the treatment.

**Legal reference:** Conn. Gen. Stat. §17a-10(c).

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### **Protocol for Non-Business Hours**

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The Careline Social Work Supervisor shall ensure that reasonable efforts are made to gain consent for administration of medication from the parent or guardian of a child whose legal status so requires.

When DCF is the legal guardian, the Careline Social Work Supervisor shall determine whether the request is an urgent request to start a new medication. If so, the Careline Supervisor will ensure that:

- the requesting prescriber has faxed or emailed a completed DCF-465 to Careline;
- all pertinent and available information regarding the child is gathered prior to contacting the on-call DCF physician; and
- the DCF on-call physician is consulted regarding all new urgent consent requests for psychotropic medication made during non-business hours.

When an after-hours psychotropic medication request to start a new medication is not urgent, the Careline Social Work Supervisor shall inform the prescriber that:

- the DCF-465 should be submitted for processing the following business day;
- all requests to continue previously prescribed medication shall also be processed by the CMCU the following business day; and
- current medications without any changes may be continued until the new request is reviewed by the CMCU the next business day.

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## **Notification of Discontinuation of Psychotropic Medication**

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The prescribing provider is expected to notify DCF whenever discontinuing a psychotropic medication. Notification may be part of other changes already requested on a new [DCF-465](#). However, if the discontinuation is the only change, notification to DCF should be made by faxing or emailing the [DCF-465A](#) to the CMCU APRN.

**Note:** While the prescribing provider is not required to seek informed consent for discontinuation of a medication, the child's parent or guardian and the child, if appropriate, shall be informed of the decision and the reasons, as soon as practical, by the provider or DCF.

The CMCU shall:

- receive the [DCF-465A](#) notification form;
- enter the information in the computerized database and in LINK; and
- send notification of the medication discontinuation to the Area Office Social Worker.

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## **Appeal of CMCU Denial**

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A prescribing provider may request an appeal of a denial made by a CMCU designee.

A review of the decision of a CMCU designee shall be assessed by the Chief of Psychiatry and the decision of the Chief of Psychiatry shall be final.

The CMCU shall:

- send notification of the final decision to the provider and to the Area Office staff.

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## **Adverse Drug Reaction**

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The prescribing provider must submit the [DCF-465B](#) whenever there is a known or suspected adverse drug reaction to a psychotropic medication.

A complete description of signs and symptoms of the adverse reaction, along with treatment received, must be submitted on [DCF-465B](#) for CMCU collection and review.

## Involuntary Administration of Psychotropic Medication

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### Involuntary Administration of Psychotropic Medication

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#### Purpose

The decision to administer involuntary psychotropic medication to a child in non-emergency situations requires weighing the child's right to refuse psychiatric medications against the need to provide necessary treatment to a child with a serious mental disorder. DCF has defined a process that utilizes professional clinical judgment and practice standards to make decisions regarding involuntary psychotropic medications that are then presented to the Superior Court for an independent judicial determination of the necessity for the medication.

#### Background

Involuntary medication treatment by its nature is controversial. When someone considered to be mentally ill disagrees with an assessment of his or her medication needs, the right to refuse medication is sometimes challenged by the treatment provider on the grounds that the illness has robbed the person of the ability to understand the condition and to make appropriate decisions about treatment.

Patients older than age 14 and their parents or guardians have the right, in most cases, to refuse to consent and they must be taken seriously when they express concerns about the need for or the psychological and physical effects of medications.

Pursuant to Conn. Gen. Stat. §17a-543, "No patient shall receive medication for the treatment of the psychiatric disabilities of such patient without the informed consent of such patient, except in accordance with [statutory] procedures ...."

Conn. Gen. Stat. §17a-540(8) defines "**informed consent**" as "permission given competently and voluntarily after a patient has been informed of the reason for treatment, the nature of the proposed treatment, the advantages or disadvantages of the treatment, medically acceptable alternative treatment, the risks associated with receiving the proposed treatment and the risk of no treatment."

The use of involuntary medication, administered against a patient's, parent's or guardian's wishes, shall be fully discussed with all treatment team members, with the child, with parents or guardians, with the Area Office Social Work staff and with legal representatives for the child, parents and guardians.

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### Emergency Administration of Involuntary Medication

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Involuntary medication may be administered to a child in an emergency situation.

"**Emergency situation**" means the circumstance in which a physician determines that treatment, including medication, is necessary to prevent serious harm to a child.

Such emergency treatment may be administered pending receipt of or in the absence of parental consent, for only so long as the emergency lasts.

**Legal reference:** Conn. Gen. Stat. §17a-81

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## **Non-Emergency Medication of Uncommitted Children**

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DCF shall not consider the non-emergency involuntary administration of psychotropic medications to an uncommitted child unless the child is a patient at Albert J. Solnit Psychiatric Hospital.

If the patient is younger than age 14, written consent to administer psychotropic medication is required only from the parent or guardian.

If the patient is age 14 or over, written consent must also be obtained from the child.

If written consent is requested from the patient or patient's parent or guardian, the DCF attending physician shall review with the patient and the parent or guardian:

- the risks and benefits of the psychotropic medication;
- side effects from the medication;
- the preferences of the patient;
- the patient's religious and cultural views about the medication; and
- the prognosis with and without the medication.

In a case in which

- the parent or guardian refuses to consent to medication,  
**or**
- the patient, regardless of age, refuses to take the medication,  
**and**
- the patient is sufficiently ill that the DCF attending physician believes that the administration of the medication is medically necessary and in the best interest of the patient,

the DCF physician shall request a second opinion by a child and adolescent psychiatrist not employed by DCF regarding the need for medication. The DCF attending physician shall also notify the Solnit Medical Director and the DCF Medical Director.

If the independent child and adolescent psychiatrist is in agreement regarding the need for medication, and the DCF Medical Director concurs with the DCF attending physician, Solnit medical staff shall apply to the DCF Medical Review Board for a recommendation.

If the DCF Medical Review Board recommends involuntary medication, Solnit staff shall then contact the DCF Office of Legal Affairs for a legal consultation. If the decision is made to proceed with court action, the Office of Legal Affairs shall contact the Office of the Attorney General to initiate an application to the appropriate court for a court order for the involuntary administration of psychotropic medication against the parent's or patient's wishes.

If there is disagreement among the physicians consulted as to the necessity for involuntary medication, a court order will not be pursued.

If there is agreement between the attending physician and the independent physician, but the Agency Medical Director or the Medical Review Board disagrees, then the DCF Commissioner shall make the final decision whether or not to seek a court order for involuntary medication administration.

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## **Administration of Psychotropic Medication to Committed Children**

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Providers caring for children under the guardianship of DCF shall request consent for psychotropic medication administration from the DCF Central Medication Consent Unit.

A DCF physician shall review with the patient and, where appropriate, the parent:

- the risks and benefits from the medication;
- side effects from the medication;
- the preferences of the patient;
- the patient's religious and cultural views about the medication; and
- the prognosis with and without the medication.

In cases in which consent is obtained from the Central Medication Consent Unit but the patient, regardless of age, refuses to take the prescribed medication, and the patient is sufficiently ill that a DCF physician reasonably believes the administration of the medication is medically necessary and in the best interest of the patient, the DCF physician shall immediately notify the Area Office Social Worker and, additionally, shall request a second opinion by a child and adolescent psychiatrist not employed by DCF. The DCF physician shall also notify the facility Medical Director, if applicable, and the DCF Agency Medical Director.

If the independent child and adolescent psychiatrist, the DCF Medical Directors and the DCF physician are all in agreement that the medication should be administered involuntarily, the recommendation of the DCF Medical Review Board shall be sought.

If the Medical Review Board also recommends involuntary administration, the DCF medical staff and the Area Office Social Worker shall consult with the DCF Office of Legal Affairs. If the decision is made to seek a court order, the Office of Legal Affairs shall contact the Office of the Attorney General to initiate an application to the appropriate court for a court order for the involuntary administration of psychotropic medication against the patient's wishes.

If there is disagreement between the independent psychiatrist and the DCF physician, a court order will not be pursued. If there is agreement between the physicians, but disagreement by the Medical Review Board or the Agency Medical Director, the Commissioner shall make the final decision as to whether to seek a court order for involuntary medication administration.

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## **Documentation for Court Action**

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When the decision has been made to seek a court order to administer medication involuntarily, the Area Office Social Worker and the DCF medical staff, with the assistance of the DCF Office of Legal Affairs and the Office of the Attorney General, shall collaborate to submit to the court,

in support of the motion, affidavits and other documentation sufficient for the court to determine whether:

- the proposed medication is in the best interests of the patient; and
- there is no less intrusive course of treatment available.

The affidavits and documentation submitted shall include, at a minimum, the following information:

- an explanation of the patient's diagnosis and prognosis, or his or her predominant symptoms, with and without the medication;
- information about the proposed medication, its purpose, the method of its administration, the recommended range of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions such as tardive dyskinesia;
- a review of the patient's history, including medication history and previous side effects from medication;
- an explanation of interactions with other drugs including over-the-counter drugs, street drugs and alcohol; and
- information about alternative treatments and their risks, side effects and benefits including the risks of no treatment.

## Request for Medical Information

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### Request for Medical Information

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#### Purpose

Upon a child's entry into care, the intake Social Worker shall obtain a release of information from the child's parent or legal guardian and send to the child's medical provider the "Request for Medical Information" (DCF-2147) with a request for a medical examination of the child.

Cross Reference: DCF Policy 34-11

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### Process

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The Investigation's Social Worker seeks permission for a medical examination and ensures it is scheduled. The examination should be with the child's medical provider who provides regular pediatric care. If not available another provider will be sought.

The medical provider completing the examination will document their findings on the "Medical Request for Information" DCF 2147 form.

On consultation requested by the Social Worker, the RRG nurse reviews of the "Medical Request for Information" DCF 2147. The RRG nurse evaluates the available information and perform any of the following:

- Provides interpretation of medical information to the Social Worker
- Consults with the DCF contracted Child Abuse Pediatrician, if they had not been previously involved
- Contact the medical provider who did the examination for additional information, or per their request to be contacted
- With assistance of the Health Advocate, collaborate with the Social Worker in arranging community medical resources
- If child is medically complex, initiate medically complex processes
- May participate in legal activities, as needed

Cross Reference: see in this Practice Guide section on Children with Complex Medically Needs

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### Release of Medical Information

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#### Purpose

DCF ensures the protection of children's and families' protected health information by following applicable state and federal laws. The department has established protocols for the acquiring and disclosing of health information to other entities and/or individuals. The disclosure of health information is with the child's legal guardian's consent, unless otherwise mandated by statute.

Cross Reference: DCF Policy 34-11, Conn. Gen. Stat. §17a-28

**Process**

The child's Social Worker will initiate the process to seek authorization for release of information to or from DCF through the "Authorization for Release of Information to the Department of Children and Families" DCF-1231 T and/or "Authorization for Release of Information from the Department of Children and Families" DCF-1231 F. The Social Worker may then disclose the medical information received either verbally or in the form of a document in consultation with the RRG nurse, as needed.

**Cases receiving Adoption or Guardianship Subsidy:**

Cross Reference in this Practice Guide - Children with Complex Medical Needs

## Multidisciplinary Evaluation (MDE)

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### Introduction

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Each child (0 through 17 years old) placed in out-of-home care shall, within 30 days of such placement, receive a trauma-informed Multidisciplinary Evaluation (MDE), the purpose of which is to screen the multiple dimensions of a child including the:

- Physical;
- Dental;
- Developmental;
- Educational;
- Behavioral;
- Emotional; and
- Child traumatic stress components.

Children who re-enter care will have another MDE performed unless the Area Office determines that a repeat MDE is unnecessary and an exemption is granted.

Children who are placed through the Voluntary Services Program and for whom parents have given consent will also receive an MDE.

### Purpose:

A complete screen shall be performed by a contracted Multidisciplinary Evaluation site to:

- Identify, assess and recommend treatment for any acute or chronic medical, educational, developmental, dental or behavioral health condition in a child placed outside of his or her home and identify any child who could benefit from a more comprehensive trauma-focused assessment.
- Identify health condition that requires prompt medical attention such acute illnesses, chronic diseases requiring therapy (e.g. asthma, diabetes) signs of infections, nutritional problems developmental or mental health conditions and/or ongoing treatment needs.
- To inform planning and assist DCF in developing case plan to meet the child's acute and chronic treatment needs

### Exemptions

In the case of an exemption, the DCF Area Office is still responsible for collecting information similar to that required of the MDE clinic including information about screens for medical, behavioral health, development, dental and educational issues.

Exemptions:

- May be granted by a Program Manager in consultation with the RRG Nurse; and
- Shall be documented in the managerial conference note as to why the child is exempt. Documentation must also include details of an assessment of potential emotional trauma associated with the child's removal.

### **Exemptions to MDEs being Performed within 30 Days at MDE- Contracted Clinics**

The following children are exempted from having a MDE performed at a contracted clinic within 30 days of placement:

- **NA Code 1** - Newborns placed directly from a hospital
- **NA Code 2** - Children who are placed in detention for more than 30 days
- **NA Code 3** - Children placed directly into or from a DCF facility (Solnit Centers,) and for whom DCF has age appropriate/applicable documented medical, behavioral health, development, dental and educational assessments
- **NA Code 4** - Children placed in group homes or residential settings for whom DCF has age appropriate/applicable documented medical, behavioral health, development, dental and educational assessments and for whom Program Supervisor determines an MDE is not necessary
- **NA Code 5** - Children who are re-entering DCF care, have previously had an MDE, and for whom DCF has age appropriate/applicable documented medical, behavioral health, development, dental and educational assessments and for whom the Program Supervisor determines an MDE is not necessary
- **NA Code 6** - Children who are placed in a long term, (i.e. several months) special hospital setting or other unique setting for whom DCF has age appropriate/applicable documented medical, behavioral health, development, dental and educational assessments and for whom the Program Supervisor determines an MDE is not necessary
- **NA Code 7** – Children in placement who are receiving voluntary services
- **NA Code 8** - Children who were placed in DCF care between the dates of February 15<sup>th</sup> and May 7<sup>th</sup> 2020, at which time the MDE's were postponed due to the COVID-19 Pandemic. In addition when the postponement period was no longer in effect (June 1<sup>st</sup>, 2020) had appropriate/applicable and documented medical, behavioral health, developmental and educational assessments/services in place and for whom the Program Supervisor determines an MDE was not necessary.

### **Delays**

The expectation is that the MDE will occur within 30 days of a child entering care.

In the rare event that a delay of the MDE is needed, the Program Manager shall document in the MDE icon the reason for the delay and projected deadline for its completion.

Updates on scheduling and completion shall be documented in LINK weekly until the MDE is completed.

## Who May Conduct a MDE

Multidisciplinary Evaluations may only be conducted at DCF-contracted MDE sites by licensed DCF-contracted providers.

## Components of the MDE

DCF shall require contracted MDE providers to include the following components in all MDEs:

- Review of all available past medical, behavioral health, social and trauma history at or prior to clinic visit;
- Complete medical examination including vital signs, height and weight, BMI%, hearing and vision screens;
- Developmental assessment that includes the use of approved MDE tools (unless child is already being seen by birth to three or DCF has documentation of recent involvement with birth to three);
- Behavioral health assessment, mental status exam and diagnostic formulation that includes the use of approved MDE tools;
- Complete dental screening; and
- Documentation of any trauma exposure history and any current child traumatic stress symptoms, as well as administration of the Child Trauma Screen (CTS) for those children ages seven and above *or the* Child Trauma Screen for young Children CTS-YC for children ages three to six.

**Note:** The MDE does not take the place of routine EPSDT exams

## Consent

Consent from a parent is required for any child for whom the Commissioner is not the legal guardian (most children getting MDEs will not be committed to DCF).

The Social Worker who removed the child shall obtain the signed DCF-MDE-460R, "Permission to Deliver or Obtain Routine/Specialty Health Care and MDE ."

Prior to obtaining consent, the Social Worker shall provide the parent or guardian with the MDE informational material describing the MDE clinic, its purpose and importance, and discuss any questions.

If a parent is not available to provide consent or will not sign consent at removal, the MDE consent should be reviewed at the ten day hearing in court and consent from the parent or guardian obtained at that time.

DCF social worker, social worker supervisor or the program supervisor cannot sign the 460R for MDE visits and routine medical care when a child is under an order of temporary custody if the bio parent/s have not signed a consent form (**regardless of whether they refuse to consent or are unavailable to consent**). When routine care or an MDE visit is needed for a child whose parents have not signed a consent, the area office attorney should be consulted

(See MDE Report section of this Practice Guide for details about adolescent consent required for release of information to DCF about any disclosures of substance use or reproductive health issues.)

### **Procedure upon Placement**

At the time of placement, the Social Worker shall provide the foster parent or placement provider with the pamphlet describing the MDE and will review the MDE process and its importance. (Education about the MDE should have occurred in PRIDE or other training.)

The FASU matcher (or other designated staff) in the Area Office shall complete Section I - Part A of the MDE Report template (DCF-746).

The FASU matcher shall email the MDE referral (page 1 of the MDE Report) to the MDE clinic and copy the Social Worker, Social Work Supervisor, FASU Support Worker, Healthcare Advocate and RRG Nurse on the email. In the email "subject" line, the Social Worker shall write "[secure] MDE Referral - \_\_\_\_\_ (child's last name), (placement date)."

The Health Advocate shall check the referral (DCF-746) to ensure that Section I - Part B (insurance information), primary care provider information (PCP name, phone number, date of last visit) and dental information (dentist name, date of last exam) are documented on the MDE Report template. The Health Advocate shall provide or correct the child's name, date of birth, and Medicaid insurance information and any missing PCP and dental information in the email.

The Health Advocate shall forward the MDE Report template to the appropriate MDE clinic, assigned Social Worker, Social Work Supervisor and FASU matcher (or other designated staff).

The MDE clinic coordinator or designee will schedule the MDE appointment with the DCF Social Worker or foster parent/caregiver depending on the Area Office's MDE Protocol. The clinic coordinator or designee will review the pamphlet and review purpose of MDE with the foster parent or other caregiver.

When children are placed outside of the Region, the Area Office chain of command, with assistance from the Health advocate *and* in collaboration with the MDE Clinic, shall decide where the MDE will be performed. Once the site is determined, the Area Office will request that the Health Advocate send the referral to the MDE clinic of choice.

The MDE clinic coordinator or designee will send an email to the Social Worker, Social Work Supervisor, RRG Nurse and FASU support worker with the date and time of the MDE and attach the sections to be completed by the Social Worker along with the consent form.

The Social Worker who had the case at the time of removal shall complete section I, Parts C, D, E and F of DCF-746 and fax or email (using the secure email system) the information to the MDE clinic along with the signed DCF-460R at least five days before the MDE appointment.

The RRG Nurse shall assist the Social Worker as needed in obtaining the child's medical and behavioral health history in order to complete the MDE packet (Parts C, D, and E).

### **Day of the MDE Appointment**

A person familiar with the child, preferably the foster parent or assigned Social Worker and, if appropriate, the biological parent, shall accompany the child to the MDE visit and meet with MDE staff

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### **Medical Component of MDE Process**

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**Purpose:** to identify any medical conditions and review any available data and medical history about the child.

**Qualifications of evaluator:** a pediatrician, Doctor of Osteopathy, pediatric APRN, family physician or family nurse practitioner (all are knowledgeable about the unique needs of this population).

#### **Components include:**

- Review of systems including allergies;
- Complete unclothed physical exam (vital signs as appropriate for age including OFC, height, weight and BMI% with graphing on age appropriate charts) that is conducted in a trauma-informed manner.
- **See** Centers for Disease Control BMI calculator:
  - <http://www.cdc.gov/healthyweight/assessing/bmi/>;
- Immunization review;
- Medication review;
- Hearing and vision screening, with referral if needed;
- Anticipatory guidance;
- Review of universal precautions; and
- Recommendations for referrals as needed.

If while examining the child, the provider has questions or identifies urgent or emergent issues, he or she, or the clinic coordinator, will follow up with the child's primary care provider.

Attention will also be paid to identification of children who require immediate behavioral health intervention.

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### **Behavioral Health, Developmental and Educational Component of MDE**

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**Purpose:** To determine whether there is a need for a full examination for disorders common in this population including those relating to:

- Fetal alcohol and drug exposure;
- Substance abuse;
- Trauma;
- Behavioral health; and
- Behavioral challenges.

Attention will also be paid to identification of children who require immediate behavioral health intervention.

**Qualifications of evaluator:** masters-level or above licensed behavioral health clinician with formal training in the administration, scoring and interpretation of the tools being utilized.

An exception may be granted to allow qualified unlicensed individuals (*e.g.*, post-doctoral students) to perform the behavioral health, developmental and educational components if:

- DCF grants an exception;
- The unlicensed provider is supervised by a licensed clinician; and
- The licensed clinician also signs the Summary and Recommendations section of the report.

**Components include:**

- Complete developmentally-based mental status exam;
- Review of trauma history exposure and any current child traumatic stress symptoms;
- Standardized measures as identified by DCF;
- Assessment of school issues to attempt to define whether there is a need for follow up in specific areas (*e.g.*, need for additional information if the problem presents in the school setting, need to request a team meeting or PPT to secure additional support in school);
- Collateral interviews with adults (DCF Social Worker, foster parent, biological parent) in person or on the phone limited to brief questions about strengths and areas of concern; and
- Recommendation(s) for referral(s) as needed.

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**Behavioral Health Developmental  
And Educational Screens to be Conducted**

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Measure	Domain: What needs are being identified	Age Range
Peabody Picture Vocabulary Test-Fourth Edition (PPVT-4)	Cognitive: Verbal	2 years-6 months to adult
Test of Non-Verbal Intelligence-Fourth Edition (TONI-4)	Cognitive: Non-Verbal	6 years to adult
Ages and Stages Questionnaire (ASQ) - 3	Developmental-General	1 to 66 months
Battelle Screen (portions as needed at evaluator's discretion if ASQ not felt to be valid or complete)		0-8 years
Ages and Stages Questionnaire: SE	Developmental Social-Emotional	3-66 months
M-CHAT	Developmental: Autism Spectrum	16-30 months
<i>BASC-3 Parent</i>	Behavioral: Pre-School	2-5 years
<i>BASC-3 Parent</i>	Behavioral: Child	6-11 years
<i>BASC-3 Parent</i>	Behavioral: Adolescent	12-21 years
<i>BASC-3 Self Report</i>		6-25 years

Measure	Domain: What needs are being identified	Age Range
GAIN Short Screener (domain 3 only)	Substance Abuse	12 years to adult
Mental Status Exam	General	All
Child Trauma Screen (CTS)	Trauma History	Ages 7 to adult
Child Trauma Screen Young Child (CTS- YC)	Trauma History	Ages 3 to 6

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### Trauma Screen Component of MDE

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**Purpose:** To identify children who may benefit from a more comprehensive trauma-focused assessment by a trained clinician.

**Qualifications of Evaluator:** a masters-level or above licensed behavioral health clinician with basic training in child traumatic stress, how to use the trauma screen to engage children and caregivers, and how to manage responses and disclosures of trauma.

**Components Include:**

- Child Trauma Screen - Child Report (Age 7+);
- Child Trauma Screen – Young Child (Age 3-6)
- Review of trauma history exposure and any current child traumatic stress symptoms; and
- Recommendation for referral as needed

### Dental Health Component of MDE

**Purpose:** To identify urgent and ongoing dental needs.

**Qualifications of evaluator:** dentist; public health dental hygienist; or a provider certified in the DSS-certified “Open Wide” curriculum.

**Components include:**

- Oral assessment (dental decay, gum health); and
- Recommendation(s) for referral(s) as needed.

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## **MDE Clinic Responsibilities Following the Evaluation**

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Following an evaluation, the MDE clinic will:

- Work with the Area Office to develop a plan for follow up including mechanisms for reviewing decisions about recommendations;
- Hold an MDE team meeting to discuss the child's status and to identify any urgent needs that require immediate attention;
- If emergent needs are identified (while or immediately after attending to the needs of the child), the MDE clinic coordinator or provider will contact the RRG Nurse and utilize the chain of command to alert DCF immediately (an email documenting the emergent need must be sent to the Social Worker, Social Work Supervisor, RRG Nurse and Behavioral Health Program Manager within two hours and must contain specific information about the emergent need and where the child was sent);
- If urgent needs are identified, the MDE clinic coordinator or provider will contact the RRG nurse and utilize the chain of command to alert DCF within 48 hours (an email documenting the urgent needs must be sent to the Social Worker, Social Work Supervisor, RRG Nurse and Behavioral Health Program Manager within 48 hours and contain specific information about the urgent need and any steps taken);
- Fax or email the completed Trauma Screen to the identified fax or secure email contact located at the bottom of the Connecticut Trauma Screen;
- When requested, ensure that the clinic coordinator will be available to attend the Case Planning Conference in person or by phone; and
- At the end of each MDE clinic day, the MDE clinic coordinator will email a list of children who had MDEs completed that day to the identified DCF liaison.

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## **MDE Clinic Responsibilities: MDE Report**

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The completed MDE report will be provided to DCF for each child referred for services. This report will:

- Follow the required DCF template ([DCF-747](#));
- Include a comprehensive summary report of findings for medical, dental, developmental, behavioral health, educational and trauma screen components of the MDE with a "needs" list, recommendations for addressing each problem and timeframes for completion;
- Include guidance around developmental issues for children up to three years of age based on performance on the Ages and Stages Questionnaire and other developmental assessment (if this includes a Birth to Three referral, it should be indicated the "Summary and Recommendations" section of the MDE Report, [DCF-747](#));
- Be submitted to DCF within two weeks of the MDE visit;
- Be emailed by the MDE clinic to the Social Worker, Social Work Supervisor, RRG Nurse, FASU support worker, Behavioral Health Program Director, Quality Assurance Program Director or Manager, the identified DCF MDE liaison and clerical support

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## **DCF Responsibilities Following the Evaluation**

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Following an evaluation, DCF will:

- Follow up on urgent and emergent needs within specified timeframes; and
- Enter the location and date the MDE occurred in LINK within two days of the MDE.
- The assigned Social Worker will print out the electronically-sent MDE report and place it in the case record.

The Area Office will send a copy of the "Summary and Recommendations" sections to the child's primary care provider and foster parent or placement provider within five days of receipt and review of the completed MDE report.

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## **Child Permission to Release Information**

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When a Multidisciplinary Evaluation is performed on a child aged 13 to 17 years, the MDE clinic must obtain a signed DCF-460-MDE-A, Multidisciplinary Evaluation Child Permission for Release of Information.

This gives the clinic permission to disclose to DCF information pertaining to substance abuse (alcohol or drug use and treatment) and reproductive health (sexual activity, sexually transmitted diseases and birth control).

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## **Area Office Follow Up and Care Planning**

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Each Area Office will develop procedures to ensure the following occur:

- There is an identified MDE liaison in each Area Office;
- The MDE reports are reviewed by staff familiar with the child;
- A plan is developed for responding to each recommendation made in the MDE report that includes specific steps, time frames and the name of the persons responsible;
- Immediate referrals to Birth to Three are made if recommended by the MDE clinic;
- A manager reviews the "Summary and Recommendations" section of the MDE report prior to its distribution to the primary care provider and foster parents;
- The "Summary and Recommendations" section is reviewed with the child's foster parent or placement provider;
- The child is referred to an RRG clinician or to DCF Regional Education Services when needed;
- Recommendations that are not accepted are reviewed with the MDE clinic;
- Consultation with the Health Advocate when needed to:
  - Assist in resolving problems that arise which prevent access to timely healthcare services that are needed; and
  - Inform the DCF Social Worker and, when needed, other Area Office staff of the outcomes after the consultation;
- Dissemination of the MDE "Summary and Recommendations" to additional stakeholders as appropriate (*e.g.*, child's attorney);
- Incorporation of the MDE recommendations into the 60 day Case Plan;

- Discussion and documentation of progress on each of the MDE recommendations at the six-month ACR and at subsequent ACRs until the recommendation(s) are completed;
- Consultation with the RRG Nurse and RRG clinician when needed prior to the six-month ACR to review any unmet medical or behavioral health recommendations; and
- Consultation with the Health Advocate when needed prior to the six-month ACR to resolve unmet needs that are due to lack of access to health care services.

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## **MDE Quality Improvement and Evaluation**

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Quality improvement and evaluation of MDEs will occur as part of contracting process at Central Office and at the Regional or Area Office level.

Components of MDE quality improvement and evaluation will include quarterly meetings between MDE providers and the Area Offices, yearly audit meetings, and implementation of tools which will monitor process and outcome measures incorporating Results-Based Accountability (RBA).

Mechanisms for the collection of data will include customer and consumer satisfaction surveys, audits and chart reviews.

**Note:** The MDE liaison acts as the main contact person for MDE questions and concerns for both the Area Office staff and the MDE clinic. This person assists in the development and implementation of the MDE protocol and also provides on-going monitoring of the established process. The MDE liaisons are actively involved in the MDE quality improvement and evaluation process including collection and review of MDE data and coordination of weekly and bi-annual meetings with MDE clinics and the Area Office to discuss quality improvement activities.

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## **Quarterly Meeting with Area Office and MDE Clinic**

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The Area Office shall arrange for quarterly meetings with MDE clinics to discuss issues related to the MDE process to include but not be limited to:

- How the process is going;
- Communication;
- Quality of the reports;
- Outstanding MDE components; and
- Any other issues that require addressing

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## **Yearly Audit Meetings**

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The DCF MDE program leads and the MDE audit workgroup (representatives from the larger MDE workgroup) will arrange for a yearly audit meeting to discuss quality assurance and improvement topics and to review MDE functioning including specific Area Office and MDE roles and responsibilities and components outlined in this Practice Guide regarding performance and practice

## Health Supervision and Well Child Care

### Purpose

Children in out-of-home care shall receive health supervision and well-child care including prevention services consistent with Early Periodic Screening, Diagnosis and Treatment (EPSDT). Immunizations shall be provided consistent with the guidelines and schedules of the Advisory Committee on Immunization Practices (ACIP).

### Components of Care

Standard health supervision and well-child care shall include:

- routine and preventative care consistent with "Bright Futures: Guidelines for Health Supervision of Infants, Children & Adolescents" ([http://brightfutures.aap.org/3rd\\_edition\\_guidelines\\_and\\_pocket\\_guide.html](http://brightfutures.aap.org/3rd_edition_guidelines_and_pocket_guide.html) and [Fostering Health: Health Care for Children and Adolescents in Foster Care](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf), 2nd Edition, Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics (<http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf>)
- immunizations based on guidelines and recommendations of the ACIP (CDC - Vaccines - Immunization Schedules main page)

### Process

- Routine scheduled health supervision and well child care, including an age-appropriate review of systems, screening consistent with best practices and, as needed, physical examination, mental health status examination and anticipatory health guidance, shall be conducted by the child's health care provider.
- The child's foster parent shall accompany the child to each appointment. If the foster parent is unable to attend, arrangements shall be made through the DCF Social Worker.
- The Social Worker or foster parent shall request that the health care provider complete the DCF-742, "Report of Health Care Visit."
- The Social Worker shall ensure that any recommendations are discussed with the child, foster parent and biological parents, if appropriate.
- The Social Worker in collaboration with the foster parent shall ensure that recommended lab studies are arranged and referral appointments or follow-up visits are scheduled.
- The Social Worker and the foster parent shall each retain a copy of the DCF-742.
- The Social Worker shall enter the information into the LINK medical narrative and if needed, update the DCF Medical Alert (DCF-741). A copy of the DCF Medical Alert will be given to the caregiver to add to the child's Health Passport as a health summary. The healthcare elements of the child's case plan will be updated with help from the RRG Nurse if indicated.

Consultation should be arranged with the RRG Nurse and/or Health Advocate as needed.

For information and guidelines for foster parents on the use of Over the Counter (OTC) medication see this Practice Guide, section Medication Monitoring of Children in Youth in Care."

(See this Practice Guide, Health Passport section for guidance.

## Surgeries and Procedures

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### Area Office Approved Surgeries/Procedures

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#### Purpose

The department will collaborate with community medical providers to ensure that children in DCF care who are identified for a surgery/procedure have a safe and optimal outcome. DCF shall ensure that informed consent is obtained and provided prior to a surgery/procedure for any child in custody.

#### Process

The Social Worker shall consult with the RRG nurse when a child's medical provider has identified that the child may need an emergency or non-emergent procedure, surgery, dental procedure or treatment that is invasive and/or may include the use of sedation.

The Social Worker will make every effort to obtain consent from the child's legal guardian and assent from the foster parents for the proposed treatment plan. In those cases where DCF has authority to provide informed consent, the Social Worker initiates completion of the DCF-460, "Informed Consent for Necessary or Emergency Health Care Medical or Dental" by completing the Section I and then forwarding the document to the medical provider to complete Section II. The RRG nurse reviews the form returned from the medical provider and documents their review in Link

If sedation is to be used, a pre-op physical exam must occur. The Social Worker shall communicate with the child's primary care physician as to the treatment plan and seek their input and agreement. The Social Worker documents the PCP's agreement in LINK.

The Social Worker consults with the RRG nurse regarding the hospital plan for visitation and post-operative needs, if applicable. The Social Worker and RRG nurse collaborate and coordinate communication with the medical provider as to the child's response to the procedure and anticipated discharge planning.

RRG nurse in collaboration with SW and provider(s) ensures readiness for discharge:

- Caregivers have been provided discharge medical instructions. If child has complex medical needs, ensure child specific medical training has occurred;
- Medications and medical equipment has been obtained;
- In-home services are arranged and
- Caregiver is aware of post-surgery care expectations, is able to implement the plan and is in agreement.

Cross Reference: see Practice Guide Section:  
Informed Consent and Permission to Treat  
Hospital Support and Visitation Plan  
Children with Complex Medical Needs

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## Genetic/Genomic Testing

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### Purpose

DCF takes our responsibilities seriously regarding consenting for testing involving genetic material for children committed to the Department. Requirements are that there must be clear benefits to the child, that samples cannot be stored or used for research and there is a plan to share the results with bio-family, if indicated.

### Process

Genetic testing identifies abnormalities or predispositions an individual has been born with, and how these might affect their health. It refers to the genetic markers for certain diseases and disorders that may be passed down from parents to children. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder. It can then help guide treatment for symptoms expressed by that genetic condition.

Genomic testing allows the physician to tailor targeted medication treatment appropriate to the particular genetic biomarkers that help predict the response to specific medications. **Pharmacogenomics is the study of how genes affect a person's response to drugs.**

**A third but less common request for genetic testing is seen in clinical trials or studies that are disease based.**

The Social Worker upon obtaining a request for genetic/genomic testing for the purpose of diagnoses and/or treatment from a medical provider shall consult with the RRG nurse. The Social Worker begins the process of filling out the DCF 460, "Informed Consent for Necessary or Emergency Health Care Medical or Dental". The following information should be collected related to genetic/genomic testing:

- Documentation from provider requesting the testing includes:
  - Description of the testing being requested.
  - Detailed rationale for testing from the geneticist or ordering physician.
  - Detailed description of risks and benefits of testing the child.
  - Information about the child's medical history, symptoms, diagnosis, etc. relevant to the testing.
  - Details about the child including: race, ethnicity, familial history and whether these factors genetically predispose the child to their presenting health problems or impact response to psychotropic medications.
  - Details about any implications of the test results for the bio-family and a plan for how results will be handled in the event that there are implications for the bio-family.

Additional information from the medical provider for genomics testing includes the following:

- Describe what meds have been tried previously including doses, timeframes and outcomes.
- Describe prior medication trials:
  - Number of trials
  - Medications used in each (details about maximum doses achieved for each medication)

- Duration/timeframes of the medication trial and the sequence of the trials must be included
- Details of side effects the child has experienced
- When in the course of treatment the side effects occurred
- At what dose of medication.
- Describe the basis for the youth's psychiatric diagnoses and whether or not there are questions about the diagnosis in light of prior medication failures.
- Provide information about what specific symptoms are being targeted with medication.
- The Social Worker shall acquire a copy of the performing laboratory's consent form for the identified tests and consult with the RRG nurse on the following:
  - A review of the consent form for language regarding storing or using samples for research. If there is no language, request a letter from the lab that the specimen will not be stored/banked or used for research.
  - Legal assurance that the laboratory will not use sample for research and will destroy sample after the results of the current testing request are obtained (a defined period of time post testing)
    - Contact laboratory to determine how to legally amend consent.
    - If unable to amend consent form then request a letter from the laboratory stating that they will not store/ use samples for research.

The Health Advocate shall be consulted about insurance coverage for the testing.

The Social Worker shall ensure the PCP is aware and in letter of agreement or disagreement for testing is obtained from PCP. The Social Worker will document this information in LINK.

The Social Worker is responsible for ensuring the bio family, if appropriate, are aware of the testing and whether or not they agree/consent, and document this in LINK. The Social Worker in consultation with the medical provider, will establish a plan on informing the bio family of the testing results. If the involved youth is of the age of assent, he or she need be part of the decision making process.

The Social Worker will ensure the Office Director has been informed. Approval of genetic/genomic testing is by the Area Office Program Supervisor and documentation of support for testing should be entered into LINK.

## Medical Review Board

### Purpose

The Medical Review Board (MRB) is established by the Commissioner of the Department of Children and Families (DCF).

In selected cases, the MRB shall make recommendations to the Commissioner or designee in matters concerning the medical care and treatment of children in the care and custody of DCF when their health situations are exceptionally complex or present other ethical or legal issues.

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### Composition of Medical Review Board

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The Medical Review Board's standing members, appointed by the Commissioner, shall include:

- The DCF Director of Pediatrics (chairperson);
- The DCF Principal Psychiatrist;
- The DCF Clinical Program Director and/or Division Program Director or designee;
- The Agency Legal Director or designee;
- A pediatric intensive care specialist, preferably board-certified in critical care medicine;
- A community-based, board-certified child and adolescent psychiatrist;
- A board-certified pediatrician or APRN skilled in the care of children with complex medical needs;
- A board-certified pediatric neurologist; and
- A biomedical ethics expert.

Note: A single MRB member may fill more than one of the designated specialties. The Chairperson shall designate another DCF medical professional at the Director level, or another alternate, to act as the chairperson in the chairperson's absence. Reasonable efforts shall be made to ensure MRB member representation is from throughout the State of Connecticut.

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### Selection of Case-Specific or Ad Hoc MRB Members

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In addition to the standing members of the Medical Review Board, the chairperson may, as necessary for a specific case, add case-specific or ad hoc members to the MRB to inform the specific individualized questions relevant to the case being considered.

The designation of Medical Review Board members for any individual case shall be made by the chairperson with consideration of the unique elements of each situation.

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## **Administration**

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The Medical Review Board shall be administered by the DCF Director of Pediatrics. The Medical Review Board shall convene twice a year to review outcomes and, if needed, address any needed changes to policy and procedures. Following each semi-annual meeting, the Director of Pediatrics shall send a report to the Commissioner which shall include statistics and recommendations for improvement of policy and procedures.

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## **Authority of MRB to Review Cases**

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The MRB shall review cases involving any child committed to DCF as abused, neglected or uncared for and any child for whom the Commissioner is the statutory parent that meet the criteria outlined in this Practice Guide.

The MRB may review cases involving a child who is committed delinquent or Family with Service Needs, or is in the care and custody of DCF as a Voluntary Services client or on an Order of Temporary Custody that meet the criteria outlined in this Practice Guide.

Note: If the MRB declines to review the case of a delinquent, FWSN committed, Voluntary Services client or child on an OTC, the Chairperson shall so inform the requestor and provide guidance regarding the requestor's next steps.

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## **When to Make a Referral to the MRB**

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The Area Office Social Worker in consultation with the RRG nurse may refer a case to the Medical Review Board when:

- Authorization is being sought for medical or surgical treatment of a child that is exceptionally complex, high risk, unusual or complicated by ethical or legal issues, as determined through consultation with the RRG Nurse;
- A medical or surgical remedy with a high likelihood of long-term or irreversible life-altering implications is being proposed such as, but not limited to, chemotherapy and organ transplants;
- Authorization for organ donation is being sought;
- the case involves questions regarding religious and cultural practices that have an impact on medical or psychiatric care (e.g., children who are Seventh Day Adventists or Christian Scientists);
- A medical, surgical or psychological procedure that is considered non-traditional is being proposed;
- A psychiatric treatment that is exceptionally complex, unusual, controversial, experimental or complicated by ethical or legal issues is being proposed;
- Electroconvulsive therapy is being proposed;
- Authorization for a child's inclusion in a drug trial or medical study is being sought or
- Life plans or end-of-life decisions are being considered.

Note: The Social Worker shall consult with legal staff for children who are in DCF custody pursuant to a 96-hour hold or Order of Temporary Custody because it may be necessary to

obtain a court order. If any party objects to the medical plan, the Social Worker shall consult with legal staff to determine whether a court order is necessary to proceed.

The Social Worker shall consult with the regional Health Advocate if there is a question about Medicaid coverage, especially if the procedure is new or experimental.

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## **MRB Referral Process**

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Area Office Social Worker who refers a case to the MRB shall consult with the RRG nurse in completing the DCF-785, "Medical Review Board Referral."

The Social Worker shall attach all documentation necessary to fully inform the MRB of the circumstances.

The Social Worker shall work with the RRG Nurse to make personal contact with the parents or legal guardians and the parents' or legal guardians' attorneys, the foster parents (if appropriate), and the child's attorney and GAL to ensure they each understand the medical plan and the risks and benefits and are in agreement with and consent to the plan. Documentation of these contacts must be attached to the DCF-785.

Note: the attorneys of the parents will confirm their clients' consents, as opposed to consenting themselves.

The DCF-785 Medical Review Board Referral shall be signed by the Social Worker and the RRG Nurse. The RRG Nurse will submit the MRB packet to their supervisor for review before it is submitted to the MRB chairperson.

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## **Reviewing the Referral**

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Upon receipt of the referral, the chairperson or designee shall review the material for completeness and assist the requestor, when necessary, in identifying additional necessary documentation or determining if additional ad hoc committee members will be needed to assist with the review.

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## **Response Time**

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The chairperson or designee shall begin reviewing and gathering information for all completed referrals within a maximum of ten working days for non-emergency cases.

Emergency cases shall be reviewed immediately.

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## **Review and Recommendation**

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The chairperson may convene a Medical Review Board meeting at his or her discretion. A minimum of four MRB members shall meet to develop a recommendation to the Commissioner. At least one of these MRB members shall be a board-certified pediatrician who is a standing member of the MRB.

In evaluating the referral, it may be necessary for the MRB chairperson to contact case-specific attorneys, medical providers, mental health providers, primary physicians, parents, caregivers, foster parents, the child or others to obtain additional information and clarification regarding the child's current status which should include any potential impact of the medical treatment on the child's mental and emotional health.

Whenever possible, recommendations of the Medical Review Board shall be made by consensus. If consensus cannot be reached, the MRB Chairperson or designee shall develop a specific recommendation for review by the Commissioner or designee.

The Medical Review Board Coordinator shall complete the applicable sections of the DCF-786, "Medical Review Board Recommendation: Commissioner's Decision." The chairperson or designee shall sign and date the DCF-786 and forward it to the Commissioner or designee with the MRB's recommendation and supporting documents, if requested, including other opinions, if any, expressed by MRB members.

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## **Decision by the Commissioner**

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The decision of the Commissioner or designee shall be recorded on the DCF-786 which shall be returned to the chairperson.

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## **Distribution and Filing of the Decision**

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The chairperson, designee shall provide the Commissioner's decision to the requestor. The DCF Social Worker in consultation with the RRG Nurse will recommend the completion of the DCF 460 based on the decision of the Commissioner. The DCF 786 is an internal document, it does not provide consent and should not be shared with outside providers.

A copy of the decision shall be retained by the chairperson. In all cases, a copy of the DCF-786 and accompanying documentation shall be filed in the medical section of the child's Uniform Case Record.

The requesting Social Worker shall inform the Area Office Director, the parents, the parents' and caregivers' attorneys, the child, the child's attorney, any guardian ad litem and the foster parents of the decision of the Commissioner's.

If any party objects to the medical plan, the Social Worker shall notify the MRB and consult with legal staff to determine whether a court order is necessary to proceed.

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## **Follow Up on Referrals**

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Follow up on each case referred to the Medical Review Board shall be provided.

Within two weeks of the medical intervention approved by the Commissioner, information from the RRG Nurse responsible for the case shall be provided to the Medical Review Board chairperson. This information shall include but not be limited to:

- The child's response to the intervention;
- Whether the intended goal of the intervention was achieved; and
- The child's current medical and mental condition.

Once a referral is initiated, and especially for end-of-life interventions, the Medical Review Board shall be kept abreast of any changes or new information regarding the case.

The RRG Nurse or Nurse Practitioner shall be responsible for providing follow-up information to the Medical Review Board chairperson as requested.

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## **Guidelines for the Development of a Life Plan**

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### **Definition of a Life Plan**

A Life Plan:

- is an individualized set of decisions expressing appropriate agreed-upon levels of medical intervention or care limitations for a given child at a given time;
- contains interventions that are individually evaluated for the benefit and burden they present to the child;
- may be considered for children with a life-limiting condition (one for which there is currently no cure available and the likelihood is that the condition will lead to the child dying prematurely);
- evolves over time through shared decision-making;
- is a written, dated document that summarizes the demographics, family members, legal status, history of DCF involvement, medical history, health care providers' recommendations and the results of all discussions by relevant parties that have previously taken place;
- is a document that allows parents or guardians, and perhaps the child, to make decisions and express their wishes in a way that will facilitate decision-making in the event of an emergency or an acute worsening of the child's chronic condition (advanced directive); and
- may be revised at any time but must be reviewed every six months by the Social Worker in consultation with the RRG Nurse. If changed, the Medical Review Board must review and approve.

A flexible and person-specific Life Plan stating what interventions may be initiated *e.g.*, airway clearance, facial oxygen, trial of bag and mask ventilation, is preferable to a Do Not Resuscitate (DNR) order which is an "all-or-nothing system" and can seem very negative to families.

Similar documents may be referred to as Advance Care Plans, End-of-Life Plans and Wishes documents. Each represents a person-specific plan.

### **Life Plan Guiding Principles**

- There is a general presumption that all children in the custody of DCF will be fully resuscitated.
- There are times, however, when aggressive treatment of children with terminal or degenerative illnesses may be inappropriate and there may be times when a different approach is desirable.
- Seriously ill children with life-threatening conditions or facing terminal stages of an illness, and their families, have a variety of needs that require a collaborative and cooperative effort from many disciplines.
- The dignity of children and their families and caregivers is respected.
- The wishes of children and their families are approached with sensitivity.
- The alleviation of pain and suffering is the primary goal (palliative care).
- Individualized and compassionate care is delivered with consideration to cultural and religious beliefs.

### **End-of-Life Planning and the Initiation of a Life Plan**

Discussions about end-of-life planning generally begin with the child's primary medical providers.

When the child is committed to DCF, these discussions initially involve the child's Social Worker who will then consult with the Regional Resource Group Nurse.

Decisions about limitations or withdrawal of therapy should take place in a non-crisis situation so that the health care providers and families can discuss the medical realities and the available choices without the emotional burden of an urgent life-threatening exacerbation or impending death.

The discussions and plan development should be led by the child's Social Worker and the child's health care team. They should include the input of biological parents and their attorneys (unless TPR'd), the child's attorney and GAL, foster parents, the Regional DCF team and the DCF Director of Pediatrics.

Biological parents who have not been TPR'd and other relatives should be encouraged to participate in these discussions and their wishes should be respected at every stage of the process.

An ethicist or hospital ethics board should be consulted.

Others familiar with the child may also be invited to participate including the child's specialty health, mental health or developmental providers, teachers, physical and occupational therapists, religious leaders and other significant community providers.

### **Referral (DCF-785) to the DCF Medical Review Board to Approve or Review a Life Plan**

The MRB must be involved in reviewing and making recommendations for the approval of a Life Plan.

The referral packet must contain:

- documentation of the child's medical condition and overall prognosis provided by the child's medical provider including specifics about a child's health condition(s) leading to life planning;
- a comprehensive medical evaluation and opinion about current level of functioning including description of behavior being interpreted as indicating pain or discomfort and successful strategies for relieving this pain or discomfort;
- a description of the child's level of functioning including objective information about the child's life, *e.g.*, whether he or she interacts with peers or adults, whether he or she enjoys certain things of interest, whether he or she recognizes people;
- a brief overview of the child's circumstances including social background, caregivers, why he or she entered care, placement history;
- additional documentation as needed from the child's specialty providers and those individuals who are most familiar with the child such as teachers, physical and occupational therapists and other caregivers;
- a brief description of the child's current health circumstances and probable prognosis;
- specific wishes of the family and child; and
- a draft Life Plan outlining medical intervention(s) that are felt to be appropriate as well as treatments or interventions that have been determined to be associated with unnecessary pain and suffering, significant burden on the child or not in his or her best interests.

**Note:** Comfort measures, including nutrition and hydration parameters, must be included in the Life Plan.

### **Review of the Referral**

Members of the MRB shall review the referral packet and make a recommendation to the chairperson of the Medical Review Board within 72 hours.

When necessary, the MRB chairperson will convene a meeting or conference call to permit MRB discussion. The MRB chairperson may invite others (such as Area Office staff, care providers, family members) to participate, as requested by the MRB.

Urgent reviews of referrals for Life Plan initiation or revision will take place within 24 hours.

MRB members may request additional information from the MRB chairperson or the RRG Nurse.

A [DCF-786, "Commissioner's Decision,"](#) will be prepared and signed by the chairperson of the MRB before it is forwarded to the Commissioner or designee for review.

A quorum of MRB members is necessary for a recommendation for approval to be formally made and forwarded to the Commissioner or designee.

### **Approval of the Life Plan**

Upon approval by the Commissioner or designee, the DCF-786 will be signed and provided to the MRB chairperson.

The Area Office will be informed of the Commissioner's decision and provided a copy of the DCF-786.

The Social Worker collaborating with the RRG nurse is responsible for communicating the Commissioner's decision to medical staff caring for the child.

If approval of the Life Plan is denied, the Commissioner or designee will document the denial and rationale on the DCF-786 and communicate that to the MRB chairperson,

### **Routine Renewal of Life Plan**

A referral (DCF-785) should be made for review and renewal of the Life Plan. The process as described above should be followed.

Changes in the child's condition and current clinical status must be documented by the medical provider caring for the child.

The providers shall communicate any desire to revise or modify the Life Plan in any way.

Comfort measures must always be addressed.

The child's biological parents and their attorneys (if not TPR'd) and the foster parents must be consulted by the Social Worker regarding their wishes to continue or modify the Life Plan.

### **Discontinuation of Life Plan**

Under certain conditions, such as remission of symptoms or the changed wishes of the parent or child, discontinuation of the Life Plan may be considered.

### **Do Not Resuscitate (DNR)**

When a child is terminally ill and prolongation of life would only cause further pain and suffering, the legal guardian may agree to allow the physician to write a medical order that states "Do Not Resuscitate" (DNR).

This order must have clear details that specify the level of intensive intervention permitted.

The American Heart Association standards require that a DNR order is:

- in writing;
- signed by the patient's attending physician; and
- based on documentation that the patient is irreparably, irreversibly and terminally ill.

A DNR order might be written for:

- a child receiving palliative or hospice care;
- a terminally ill child on a ventilator in the ICU;
- a child determined to be brain dead; or
- a terminally ill child in a chronic care facility.

Comfort and pain alleviation, as well as nutrition and hydration, shall be provided in every situation.

DNR orders are clinically and ethically appropriate when the burdens of resuscitation exceed the expected benefit.

A DNR order precludes resuscitative efforts being undertaken in the event of cardiopulmonary arrest and does not have implications regarding the use of other therapeutic interventions that may be appropriate for the patient. When anticipated, decisions regarding these other interventions should already be addressed in the Life Plan.

### **Required Reconsideration of Life Plan or DNR Orders for Operative Procedures**

Life Plans and DNR orders should be reevaluated for a child who requires an operative procedure. This process is called "required reconsideration" and should be incorporated into the informed consent process for surgery and anesthesia.

If DNR orders are suspended during surgery and anesthesia, it is important to define the duration of suspension.

The American Academy of Pediatrics recommends that suspension of DNR orders should continue until the post-anesthetic visit, until the patient has been weaned from mechanical ventilation or until the primary physician and the family agree to reinstate the DNR order.

## **Medical Marijuana**

### **Purpose**

There will be occasions when a child's medical provider(s) may recommend medical marijuana for a child in DCF's care. This will require approval from the DCF Area Office, Medical Review Board, and Commissioner. The Area Office should review the Department of Consumer Protection (DCP) Medical Marijuana Program website and familiarize themselves with the process and components.

Pharmacists at Medical Marijuana Dispensaries are responsible for prescribing medical marijuana based on the recommendation of a child's medical provider. Marijuana is unique in that the medical provider does not prescribe the medical marijuana rather he/she recommends and certifies the child on the DCP website. The pharmacist at the DCP licensed Medical Marijuana Dispensary is responsible for determining type and dose of medical marijuana.

**Note:** Medicaid and other third party insurances do not cover the cost of medical marijuana products. The Area Office must therefore make arrangements to pay for the Medical Marijuana, which is a cash only payment. Payment is required at the time that the certified caregiver receives the medical marijuana from the Medical Marijuana Dispensary.

## **Process**

Steps in the process include:

- The identification of the primary caregiver who will register as the DCP certified caregiver and is responsible acquiring the medical marijuana from the dispensary, for administering the medical marijuana to the registered child and for safe storage of the medical marijuana;
- Submission of the referral to the Medical Review Board (MRB) for review and approval;
- Primary caregiver registration of the child/youth as patient on the DCP website;
- Primary caregiver registration as the DCP certified caregiver; and
- Supporting the caregiver in accessing, administering and storing the medical marijuana.

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## **Identification of the Primary Caregiver Who will Register as the DCP Certified Caregiver**

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To begin the process, the Social Worker, in consultation with their Supervisor, the RRG nurse, and the foster family must identify the primary caregiver who will be the Department of Consumer Protection (DCP) certified caregiver.

**Note:** Per state statute, an applicant is prohibited from becoming certified by DCP if they have been convicted of a violation of any law pertaining to the illegal manufacture, sale or distribution of a controlled substance. A person ever convicted of a violation of any law pertaining to the illegal manufacture, sale or distribution of a controlled substance will not be approved.

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## **Medical Review Board**

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Once the primary caregiver who will be serving as the DCP certified caregiver is identified, the Area Office should proceed with the MRB referral.

In addition to the submission expectation for an MRB referral, the MRB referral for medical marijuana should include:

- The identified need for treatment
- Medical Review Board Referral DCF- 785 referral form should be completed and include the following information:
  - The Connecticut licensed physician, who must certify the patient has an approved debilitating condition by Department of Consumer Protection (DCP) will submit a letter which will provide:
    - Written documentation of the child's current health status, recommendations regarding the rationale, risks, benefits, alternatives and prognosis.

- That the certifying provider agrees to take the lead in monitoring the child during the prescribed period.
  - The certifying provider identifies that they will follow-up with the pharmacy and other providers regarding the dose and type of medical marijuana dispensed and the child's response to the medical marijuana.
  - The certifying provider will collaborate with the child's other providers including specialists to coordinate decisions about ongoing interventions for the condition/s for which the medical marijuana was recommended.
  - The certifying provider should also have plan for following up with AO and this should include identification of a primary Area Office contact.
- The Social Worker document in LINK that the foster home and/or facility have been informed, involved, and in agreement with the plan and able to provide identified care. Identify any barriers and the plan to resolve them.
- The name of the primary caregiver who will be registering as the DCP certified caregiver.
  - Submit a written monitoring plan.

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### **Considerations for Individual Medical Marijuana Monitoring Plan**

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When a minor child committed to DCF is recommended for a medical marijuana treatment a written monitoring plan is developed by the Social Worker in collaboration with the RRG nurse and certified caregiver that describes the plan for monitoring the child while s/he is on medical marijuana. The plan should include:

- The child's certified caregiver
- The Social Worker, RRG nurse and caregiver plan to communicate with and/or visit the dispensary to talk with the pharmacist about the child's needs
- The Social Worker will communicate with the caregiver to monitor and collect information related to: form of medical marijuana used, route, dose and effects. The Social Worker will review this tracked information, received from the caregiver during every child in placement visit. The caregiver will share this information with the child's treating physician and the Social Worker will document the information in LINK. The documentation should include form of medical marijuana, route, dose and effects.
- Timeframes for routine communication to ensure collaboration between the certifying provider, the child's PCP, the medical marijuana dispensary, the primary caregiver, and Social Worker. This includes regular updates to the Social Worker from the child's treating physician.
- The Social Worker will accompany the caregiver to the dispensary for the initial appointments, and then as needed.
- An initial joint child in placement visit by the RRG Nurse and the Social Worker shall occur within one month after initiation of treatment. The Social Worker and RRG nurse will routinely visit per the visitation guidelines or sooner in response to changes in the child's clinical condition. The RRG nurse will document the child's response to the medical marijuana and any adjustments/changes to the treatment plan for the condition/s for which the medical marijuana was dispensed.
- The Social Worker will update LINK with current prescriptions and anytime there is a change.
- FASU (or TFC Support Worker) will continue to conduct monthly support home visits that include monitoring the safe storage of the medication.

- A letter is sent by the Social Worker to the pharmacist stipulating that changes in cannabis dosage outside of the initial treatment plan parameters must be approved by DCF.

The DCF Director of Pediatrics shall be updated at least quarterly of the child's progress by the Social Worker. Any changes to the treatment plan may require a re-referral to the MRB.

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## **Applying for DCP Patient Registration**

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Following MRB approval, the primary caregiver identified to be the DCP certified caregiver must begin the DCP registration process. The first step is to register the child:

- The primary caregiver must complete the DCP patient registration for patients under 18.
- The Social Worker and primary caregiver should confirm the certifying provider has certified the child through the DCP process. The physician recommending the medical marijuana should have already certified the child through the DCP process so the child should have a record in DCP's medical marijuana registration system.
- There is an application fee and a dispensing cost. The Social Worker consults with DCF Central Office Fiscal and Child Welfare Accounting. It is important that the Director of Fiscal in DCF's Central Office is notified so they can alert Child Welfare Accounting of this payment.

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## **Applying for DCP Caregiver Certification**

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After registering the child on DCP's website, the primary caregiver identified by DCF must apply to be a DCP certified caregiver:

- The identified primary caregiver must complete the online caregiver certification process. The certification process can take up to 14 business days.
- In order to complete the process, the individual applying has to upload documentation of proof of the relationship to the qualifying patient. The Social Worker shall ensure that the identified applicant has the legal paperwork to complete the process. Documents the Social Worker needs to provide include:
  - A copy of the commitment order;
  - A copy of the foster care license; and
  - A letter from the commissioner/designee that states that the child has been placed with the foster parent by the commissioner.
- The primary caregiver must submit to a criminal background check (state, local and FBI). This background check is a requirement of DCP and must occur regardless of DCF's having completed a prior background check.
- Approved caregiver certifications are in place for one calendar year. Applicants must reapply annually.
- There is an application fee and the Social Worker shall arrange payment. The application process is completed on line and the primary caregiver will be reimbursed by DCF.

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## **Roles/Responsibilities for Children and Youth in Placement**

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### **Role of Foster Parents**

Consistent with current practice and regulations (Section 17a-145-151) and in partnership with the Social Worker and the child's certifying physician, the foster parent will assure that medication is administered as directed, stored safely ensuring that children cannot access the medical marijuana product, and that the child is monitored per the physician's schedule to assure the child's needs are met.

Once identified, the foster parent who is the DCP certified caregiver is responsible for:

- Securing the medical marijuana product from dispensary, (medical marijuana is dispensed in a one-month supply)
- Having the medical marijuana product available to the child and administering,
- Ensuring the safe storage of the medical marijuana product. Safe storage includes: medication is kept in its original container with label, safely stored out of the reach of children, secured, and in a medication lock box.
- Following the documented plan for monitoring of the child while he/she is on medical marijuana

### **Role of Congregate Care Providers**

In the event that a provider is recommending medical marijuana for a child in congregate care, DCF will work with DCP on processes for registration. Social Worker in collaboration with the RRG nurse, will work with MRB chairperson, DCF Licensing Unit, DCF Nurse Consultant to the Licensing Unit and the congregate care facility to develop a plan for administration of medical marijuana and the monitoring of the child while he/she is in that facility.

Child caring facilities will maintain the same standards as outlined in the Child Caring Facility licensing regulations 17a-145-75: Health and Medical Treatment. This includes practice consistent with the DCF Medication Administration (see section – Medication Management of Youth in Congregate Care within this practice guide).

### **Role of the Area Office (AO)**

The AO needs to ensure that the medical marijuana monitoring plan is developed and provided to the MRB and that the plan is followed as approved by the MRB. Once the medical marijuana is started, a schedule of updates to DCF Director of Pediatrics is required. Updates should include information about the child's response to the medical marijuana and details about the type and dose of medical marijuana dispensed, any changes or recommendations from the certifying provider, and any plans for other interventions targeting the condition for which the medical marijuana was begun. Updates should be developed by the Social Worker and the RRG nurses from information provided by the certified caregiver and medical provider. Updates must be entered into LINK under the medical icon.

**IMPORTANT REMINDERS:**

Travel out of state and hospitalizations: While the use of medical marijuana is legal in the state of Connecticut, at the federal level, it is classified as a Schedule 1 controlled substance and remains illegal. It is a federal crime to transport it from one state to another, including when both states have legalized use of marijuana. Entities that receive federal funding are also at risk of losing such funding if the use of marijuana is permitted and thus are likely not to endorse its use in their settings.

It is therefore important to ensure that there is conversation in advance of any travel out of state of children who are receiving medical marijuana. And it is important to understand that hospitals have varying approaches to the use of medical marijuana and that the AO will need to work directly with the hospital in the event that a child who is receiving medical marijuana is hospitalized.

## MRB Review of Therapeutic Procedures for Gender Dysphoria

### Purpose

The DCF is dedicated to support youth who identify themselves as Transgender. The department strives to ensure fair, equal and non-discriminatory treatment of all individuals. To that end DCF provides supports to youth who seek corrective procedures to address gender dysmorphia.

### Process

Physical interventions for adolescents fall into three categories or stages:

1. Fully reversible interventions. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestin's such as medroxyprogesterone, or other medications, such as spironolactone that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives or depot medroxyprogesterone may be used to suppress menses.
2. Partially reversible interventions. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).
3. Irreversible interventions. These are surgical procedures.

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### MRB Referral

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The MRB referral requirements are the same as other procedures that require MRB approval. The Social Worker in consultation with the RRG nurse completes the "Medical Review Board Referral" DCF- 785 and provides other documents identified the MRB. DCF follows guidelines set forth by World Professional Association for Transgender Health in their "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People". The following additional consideration have been added to the MRB referral requirements:

- Mental health professional: Child must be connected with a therapist skilled in working with gender congruent adolescents and the WPATH Standards of Care. Prior to medical intervention initiation, therapist should discuss options to preserve reproduction. Documentation should include: Youth's gender identity, social history, mental health history, gender identity history, social transition, goals, patient supports, patient strengths, patient stressors, and the provider's assessment.
- Pediatric Endocrinologist: An essential member of the team to coordinate appropriate care for corrective procedures. Prior to medical intervention initiation, the endocrinologist should discuss options to preserve reproduction.
- Reproductive Endocrinologist: Prior to medical intervention initiation referred for an evaluation for preservation of fertility before initiation of hormone therapy

- Surgical team: Plastic surgeon, as needed for corrective surgeries
- DCF Health Advocate: Consult with health advocate regarding insurance coverage, finding providers and/or banking of biologic reproductive material.

## Hospital Support and Visitation Plan

### Purpose

On the occasion that a child is hospitalized, it is essential that he or she receive support from individuals with whom the child has a relationship. DCF is responsible for partnering with foster families, biological families, caregivers and other resources to develop an ongoing plan for visitation and support responsive to a child's individual needs.

Goal: Provide children in DCF care with the support they need during hospitalizations and ensure that appropriate documents are entered in the child's LINK record.

Whenever a child in DCF's care is hospitalized, a formal plan for support and visitation must be developed and implemented within two business days of admission for unplanned or emergency admissions and at the time of admission for planned admissions.

The plan will be informed by appropriate medical, mental health and clinical consults involved in the child's care and the nature of the child's primary relationships and existing supports. The assigned Social Worker and Social Work Supervisor are responsible for the formulation, execution and documentation of the plan (DCF-462, "Hospital Support and Visitation Plan").

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### Planned Hospitalizations

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A Hospital Support and Visitation Plan should be developed in advance of the hospitalization and implemented upon admission.

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### Unplanned and Emergency Admissions

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A DCF Social Worker should go to the hospital to see the child at the time of admission but no later than the end of the same day. (This applies to emergency admissions and not to the Emergency Department itself where a child must have supervision and support at all times.)

A "Hospital Support and Visitation Plan" (DCF-462) must be developed and implemented within two business days of admission.

Upon receiving the information of an **after-hours admission** to the hospital (weekends and holidays), the Careline will contact the foster parents or facility where the child is placed to ensure that the child is provided with adequate support and visitation during the hospital stay. If no supports are available at the time of admission, the Careline will dispatch an on-call Social Worker to visit the child.

Further visits will be determined by the Careline after an assessment of available resources. The Careline will also promptly inform the Area Office Director of the child's admission. The Area Office will begin development of the Hospital Support and Visitation Plan the next business day.

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## **Process for Developing a Hospital Support and Visitation Plan**

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The Social Worker and Social Work Supervisor, FASU Social Worker and Supervisor and RRG staff will meet to discuss the child and the current hospitalization. The child's attorney should be invited. Topics should include:

- reason for admission and anticipated treatment or procedure;
- child's needs (both emotional and safety);
- child's baseline medical and mental health;
- anticipated duration of stay;
- available resources including foster and biological family members, other significant people in the child's life, DCF and other professionals known to the child;
- any visitation restrictions;
- legal status; and
- plan for continuation of child's pre-hospitalization medication regimen, including continuation of psychotropic medication and a plan for support of the child if medication is discontinued during hospitalization.

The RRG Nurse or clinical social worker should speak with the hospital medical provider to gather details including the extent of treatment or procedure and post-operative and hospital course.

Following this meeting, designated staff will follow up with the specific resources identified. Resources will vary depending on the specific needs of the child. (Assessment of the needs of the foster family or other caregiver should also occur if there are other children in the home. Those children's Social Workers should also be involved to support the caregiver.)

The biological family should be involved in the development of the visitation plan if appropriate. If not, the Social Worker will determine how the biological family can be included (*e.g.*, visits, phone contact) and the need for supervision of the visitors.

Resources to consider for visitation and support include:

- the foster parents or other caregivers and their extended families;
- biological parents and their extended family; and
- other significant people in the child's life (*e.g.*, mentors, coaches, teachers, supports through church, baby-sitters, daycare staff, DCF).

The hospital social worker, nursing and medical providers must be consulted and their input included in the development of the plan.

The plan will establish the amount of visitation required each day for the child based on his or her needs and wishes.

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## **Process for Implementation of the Completed DCF Hospital Support and Visitation Plan (DCF-462)**

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The completed written plan (DCF-462, "DCF Hospital Support and Visitation Plan") will be:

- documented in LINK in the medical narrative and the supervisory note;
- provided to the hospital and placed in the child's chart;
- reviewed with the hospital social worker, nursing manager and medical provider;
- sent to the DCF Chief of Pediatrics (email or fax); and
- made available to the child's foster parent or other caregiver.

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## **Components of the Written DCF Hospital Support and Visitation Plan (DCF-462)**

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The DCF Hospital Support and Visitation Plan (DCF-462) shall include:

- the schedule for visitation (*e.g.*, daily, every other day);
- the DCF staff scheduled for visitation (*e.g.*, Social Worker, RRG Nurse);
- foster parents', biological parents', siblings' and other resources' schedule for visitation;
- DCF daily phone contact plan (this will occur at an agreed-upon time with the hospital provider to receive updates about the child's status);
- a list of individuals other than DCF who can visit;
- a list of individuals who cannot visit;
- any restrictions on visitation and, where needed, a plan for accompanying individuals during supervised visits;
- any restrictions on telephone contacts;
- plan for continued mental health treatment, if necessary; and
- contact information for Social Worker, Social Work Supervisor, RRG Nurse, Program Manager, Area Office Director, foster parent or other caregiver, biological parent, child's attorney and the DCF Chief of Pediatrics.

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## **Planned Admissions to St. Vincent's Special Needs Services (SVSNS)**

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Admission to St. Vincent's Special Needs Services (SVSNS) are for a planned placements and respite admissions.

SVSNS provides pediatric care for children, ages three through twenty one, with complex medical needs such as children who are non-ambulatory with physical disabilities and intellectual disabilities

SVSNS has their own state approved special education school program

Admissions are best arranged between Mondays - Thursday's. SVSNS is not staffed to take emergency placements.

**Process for Placement Approval:**

Contact is made with SVSNS' Case Management to inquire if a bed is available. If a bed is available, they will arrange for a team from SVSNS to visit your child. Area Office Social Worker will participate in this meeting

If determined by SVSNS that placement is appropriate, they will contact DCF Director of Pediatrics to discuss possible placement. If DCF Director of Pediatrics agrees with placement, SVSNS will contact the Area Office Social Worker and/or RRG Nurse involved in the case to begin placement proceedings.

**Process for Placement:**

The child's DCF Social Worker will arrange for a pre-placement conference call meeting with the DCF Team and SVSNS. SVSNS requires the following documentation prior to admission:

- Medical orders
- Most recent PPT
- Most recent IEP
- Copy of immunization records
- Copy of last physical exam
- Copy of any recent radiological exams or scans
- Prescriptions (meds, diapers for incontinence care, DME, etc.),
- Medication prescriptions should be obtained in advance so pharmacy can prepare them in blister-packs.
- Obtaining Medical Equipment:
  - A letter of medical necessity for a hospital bed and a prescription for the hospital bed is required

DCF Licensing Unit needs to be contacted if a placement will result in going over License Bed Capacity (LBC). A DCF-2153 is required and submitted to DCF Licensing Unit. The form will be initiated by SVSNS and Area Office Management will need to sign.

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**Planned Hospitalizations to Hospital for Special Care (HSC)**

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Admission to Hospital for Special Care (HSC) are for planned placements and respite placements.

HSC is a long- term acute/sub-acute -care hospital that provides services to children and adults.

Admissions are best arranged between Mondays - Thursday's. HSC is not staffed to take emergency placements.

**Process for Placement Approval:**

Contact is made with HSC Admission's office to inquire if a bed is available. If there is a bed available there will be an assigned admissions coordinator to assist. Placement must occur from an acute or sub-acute care facility.

Legal guardian must sign a release of information for HSC to obtain medical information to determine appropriateness for placement.

**Process for Placement:**

Placement will be coordinated by HSC and the acute/sub-acute care facility.

Legal guardian will need to sign admission paperwork at the time of placement.

For respite placements HSC requires the following documentation prior to admission:

- Medical orders
- Copy of immunization records
- Copy of last physical exam
- Prescriptions (meds, diapers for incontinence care, DME, etc.),

## Discharge from Care

### Purpose

Prior to discharge from DCF care, a child and his or her parents or legal guardian shall be provided with an up-to-date DCF Medical Alert (DCF-741) (health summary) including recommendations for ongoing medical and mental health care and contact information for the primary care provider or medical home (referred to as the "health care provider" in this Practice Guide) as well as any specialty providers who will be providing ongoing care to the child after discharge.

### Who Develops the Discharge DCF Medical Alert

The Social Worker in collaboration with the RRG Nurse, the child, their health care provider and the parents or guardian shall update the child's DCF Medical Alert.

### Process

The Social Worker shall inform the child's current health care provider of the plan to discharge the child from DCF care.

Reasonable efforts shall be made to maintain the same health care provider if appropriate. If the health care provider needs to change, the child's case plan shall be shared with the current health care provider so that a new provider can be identified, in consultation with the parent or legal guardian to whom the child will be discharged. DCF staff shall encourage current and successor health care providers to communicate directly about concerns or ongoing medical or mental health care needs whenever possible. An appointment should be scheduled with the successor health care provider prior to or soon after the child is discharged from care. In all communications the team needs to be aware of privacy and adolescent rights.

The Social Worker, with assistance from the RRG Nurse and the Health Advocate, if appropriate, are available to assist the family or youth in identifying a new provider. A summary of the child's health care and recommendations shall be forwarded to the successor health care provider.

For adolescents who are transitioning based on age, this process should start at age sixteen and be reviewed annually.

Once updated, the medical and mental health information and recommendations shall become part of the child's case record, entered into LINK and the DCF Medical Alert.

Cross references: DCF Policy 42-7  
Practice Guide Section: Health Insurance – Discharge from Care

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## **Healthcare Proxy**

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A healthcare proxy is a legal document with which an individual appoints an agent to legally make healthcare decisions on their behalf when he or she is incapable of making and executing healthcare decisions stipulated in the proxy. A healthcare proxy (also referred to as a durable power of attorney for healthcare) is a document that appoints someone to make medical decisions for you, if you are in a situation where you can't make them yourself.

Youth exiting DCF care should be advised to consider identifying an individual who can act as their healthcare

## Special Health Topics

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### Religious Beliefs of Parents Preventing Necessary Medical or Mental Health Care

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#### Requirement to Investigate

A DCF investigator shall investigate reports alleging that a child is suspected of not receiving necessary medical or mental health care because of the religious beliefs of the parents or other caregivers when the child:

- is in a life-threatening condition;
- is suffering harm;
- is suffering pain;
- will suffer increased seriousness of a medical or mental health condition.

#### Definition

**Necessary health care** means medical, mental health or dental care that is not necessarily emergent but that would adversely affect the child's health if not provided within a reasonable time, as determined by a qualified medical provider.

#### Medical Consultation

The investigation shall include consultation with the medical or mental health providers who are treating the child and any other medical or mental health experts as needed to adequately investigate the case.

#### Religious Consultation

The investigation shall include developing an understanding of the religious beliefs relied upon by the parents or other caregiver for the denial of medical treatment, a discussion with the parents about those beliefs and, if approved by the parents, a consultation with their clergy or religious advisor about alternatives to treatment that are approved by the family's religion.

#### Findings of Medical Neglect

If medical neglect is substantiated, the investigator shall:

- work with the family to obtain permission for treatment if the child is not in a life-threatening condition; or
- file a Motion for Order of Temporary Custody immediately if the child is in a life-threatening condition.

Prior to filing an OTC, the investigator shall obtain affidavits from two physicians (which may include psychiatrists, if applicable) that describe the child's condition, the need for treatment,

the urgency of the treatment and what would happen to the child if the treatment is delayed or denied and the parents' or caregiver's refusal to authorize treatment after being fully informed of the child's conditions and need for treatment.

### **Procedures for Cases of Denial Based on Religious Beliefs**

Connecticut Practice Book §33a-8 sets out the procedure for obtaining an order from the Superior Court whenever there is an emergency life-threatening situation.

The investigator shall consult with the Area Office Attorney or Assistant Attorney General to determine the procedure to be followed.

### **Jehovah's Witnesses' Refusal to Permit Blood Transfusion**

In a case in which the issue is the ability to obtain permission for a blood transfusion for a child who is a Jehovah's Witness, the investigator shall ascertain that:

- the parents or caregiver have denied permission based on religious beliefs;
- non-blood medical alternatives and treatment have been discussed between the parents and the caregiver and physicians;
- contact has been made with the Hospital Liaison Committee of Jehovah's Witnesses; and
- necessary medical care cannot be managed without a blood transfusion.

## Termination of Pregnancy

### Introduction

Connecticut law states that the decision to terminate a pregnancy shall be solely that of the pregnant woman in consultation with her doctor. The law requires youth under 16 years of age to receive specific pregnancy information and counseling from their health care providers before terminating a pregnancy.

Temporary caregivers, statutory, natural, foster and adoptive parents and guardians have no legal role in the decision and do not have to be consulted with or notified of the decision. DCF may assist young women by providing access to appropriate medical and counseling services.

Legal reference: Conn. Gen. Stat. §19a-600, §19a-601 and §19a-602.

### Definition

**Counselor** means a psychiatrist, licensed psychologist, licensed clinical social worker, certified guidance counselor, certified marriage and family therapist, ordained member of the clergy, certified physician's assistant, licensed nurse-midwife, and licensed registered or practical nurse.

### Pregnancy Information and Counseling

Pregnancy information and counseling prior to an abortion must be provided by a physician or counselor.

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## Counseling Requirements

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Physicians and counselors shall:

- explain that the information is intended to neither persuade the young woman to have an abortion nor to carry the pregnancy to term;
- explain to the young woman that if she does decide to have an abortion, she can change her mind at any time before the abortion;
- explain that if she decides not to have an abortion, she can change her mind at any time during which she can have a legal abortion;
- explain the alternatives to having an abortion including informing the young woman of the possibility of having the child and keeping it, putting the child up for adoption, or placing the child with a relative or in foster care;
- inform the young woman that public and private agencies are available to assist her with the alternative she chooses and that she can have a list of these agencies and their services;
- explain to the young woman that she can get birth control information from public and private agencies and that she can have a list of these agencies;
- discuss with the young woman the possibility of involving her parents, guardian or other adult family members in her decision about the pregnancy;

- discuss with the young woman whether she thinks involving her parents or guardian would be in her best interests;
- give the young woman a chance to ask questions about pregnancy, abortion and child care; and
- give the young woman the information she wants or inform her where such information can be obtained.

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### **Affirming Receipt of Information and Counseling**

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Following the receipt of information and counseling, the physician or counselor and the young woman must jointly sign and date a form attesting to the fact that the counseling requirements have been addressed to the satisfaction of the young woman. The physician or counselor's business address and telephone number must be included on the form.

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### **Counseling Forms and Counseling Services**

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Counseling forms developed by the Department of Public Health (DPH) are available at health clinics under the jurisdiction of DPH. Counseling services, prior to an abortion, must be provided by counselors in those facilities.

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### **Emergency Exception**

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Counseling procedures and forms are not required in medical emergencies that, for the young woman's safety or well-being, require an immediate abortion. A doctor performing such an abortion must indicate the medical emergency in the medical records.

## Children and Youth Placed in Foster Care

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### Initial Medical Screening

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#### Purpose

Each child placed in an out-of-home placement shall, within 3 business days of removal, receive an initial medical screening to identify if he or she has an acute medical, dental or mental health care need or has a chronic medical or mental health condition which requires medication.

The purpose of the initial health screen is to:

- identify any acute medical, dental, or urgent mental health needs and to assure the timely provision of necessary treatment;
- ensure the child has medications and/or treatments needed for any chronic medical or mental health conditions;
- identify signs and symptoms of maltreatment including physical, sexual and emotional abuse and neglect, and child traumatic stress symptoms;
- assess for any infections or communicable diseases

#### Exemptions

Exemptions may be granted by a Program Supervisor in consultation with the RRG Clinical Team and shall be documented in the managerial conference note as to consideration why the child is exempt.

- A child who is placed directly from a hospital setting or a physician's office where a comprehensive initial screen was performed does not require an initial health screening provided that he or she has received all necessary treatments for acute problems during this period. Records of these treatment encounters shall become part of the child's DCF medical record.
- A child who has completed a forensic interview and/or evaluation by a CAPS team physician where an acute medical, dental or mental health need was not identified.
- A child who has completed a well child exam within 30 days of entering care with no change in condition or outstanding/chronic medical, dental or behavioral health concerns.

#### Social Worker Responsibilities

The SW shall, with the assistance of the caregiver, relatives, SWS, congregate care providers, RRG nurse, health advocate and providers:

- Complete DCF-460R, "Permission to Deliver or Obtain Routine/Specialty Health Care and MDE"
- Complete DCF 2131(T), "Authorization for Release of Information To DCF" and complete DCF 2131(F), "Authorization for Release of Information From DCF"
- SW will obtain the child's health insurance card
- Consult with the RRG nurse as needed

- Consult with the Health Advocate as needed
- Consult with the RRG mental health clinician as needed
- Ensure the child has all medications, treatments and durable medical equipment available and the caregiver is trained to administer.
- Ensure that the initial health screening appointment is made within the above prescribed timeframe, ideally with the child's primary care provider.

### **Placement Responsibilities**

- It is the expectation that the care giver will make every attempt to attend all medical, dental and behavioral health appointments of the children in their care.
- The caregiver will participate in child specific medical training as indicated.

## Health Passport

### Purpose of Health Passport

The purpose of maintaining health information in the Health Passport is to assist in the care, coordination and management of a child's medical and mental health care needs. The Health Passport contents comprise the information that should be entered into the LINK Medical Icon. The Health Passport shall be provided to the caregiver at the time of each placement and should accompany the child to all medical appointments. Health history that is not available at the time of placement shall be provided to the caregiver ASAP.

### Contents of the Health Passport & LINK Medical Icon

All children in an out-of-home placement shall have a Health Passport which has information necessary for the care of the child that includes:

- DCF Medical Alert (DCF-741) form (LINK Medical Icon) – This contains medical, mental health history and current health status.
- DCF Report of Health Care Visit (742) form the caregiver completes for each medical appointment. A copy of the provider's electronic patient summary report can be substituted.
- DCF Caregiver Log of Visits to Provider (DCF 2127) form or a copy of the electronic patient summary report that contains the appointments.
- Child's Medical insurance card whether this is through Medicaid or private insurance. At a minimum, a member insurance number should be provided.

### Medical Records

Prior to obtaining any medical and/or mental health records, a RRG Nurse and/or RRG mental health clinician consult should occur.

### Social Worker Responsibilities

The Social Worker is responsible for creating and distributing the Health Passport.

- This can be done in conjunction with the caregiver, relatives, the Social Work Supervisor, congregate care providers, RRG Nurses, and the identified medical and mental health care providers
- Completing and updating the Health Passport/LINK Medical Icon
  - Every time a child enters a new placement
  - When there are changes in the medical and/or mental health plan of care.
  - When medication changes occur
- Review the information on the DCF-741/LINK Medical Icon, DCF-742, and Caregiver Log DCF-2127 with the caregiver and answer any questions. Ensure the caregiver has copies to maintain in the Health Passport.
- Contact DCF Health Advocate if Medical insurance card and/or member insurance number is needed.

- Consult with the RRG Nurse and/or RRG mental health clinician as necessary.
  - The medical and mental health records of children are confidential and may only be shared with caregivers and other providers as necessary with an appropriate release of information in place. The Social Worker shall explain to the caregiver that this information shall not be shared without DCF consent.
- All children in DCF care must have up-to-date immunization records and a current well child exam on file.
- Information concerning a child's HIV and AIDS status may be released on an as-needed basis when DCF has legal guardianship. When DCF does not have guardianship, a written release for disclosure of information from the parent or guardian must be obtained prior to any disclosure. Cross reference: DCF Policy 26-3, "HIV Testing."
- SW will ensure all children in DCF care have up-to-date immunization record and a current well child exam in the case record.

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### **Placement Responsibilities**

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It is the expectation that the caregiver will report all medical and mental health changes to the DCF Social Worker and appropriate provider in a timely manner and attend all medical and mental health appointments.

The caregiver shall with the assistance of the Social Worker and identified medical and mental health care providers:

- Maintain the DCF Caregiver Log of Visits to Providers (DCF-2127).
- Ensure DCF Report of Health Care Visit (742) form is completed by the provider for each medical appointment. A copy of the provider's electronic patient summary report can be substituted.

The caregiver must notify the DCF Social Worker when:

- The above is not possible.
- The medical and mental care provider has indicated on the DCF-742 that he or she needs to speak to the Social Worker.

<b>RRG Nurse Responsibilities</b>	<ul style="list-style-type: none"> <li>• Available to consult upon request.</li> </ul>
<b>Health Advocate Responsibilities</b>	<ul style="list-style-type: none"> <li>• Assist SW to obtain the child's Medical insurance card whether this is through Medicaid or private insurance. At a minimum, a member insurance number should be provided.</li> </ul>

## Placement

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### Foster Care

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#### Purpose

To ensure that children safely transition into foster placement, DCF will provide the foster parents medical information, medications, medical equipment and medical training. Through the signed DCF-460R, " Permission to Deliver or Obtain Routine/Specialty Health Care and MDE " the foster parents have authority to approve routine medical care.

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#### Process

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Prior to the placement of a child in a foster home the foster parents must receive trainings to prepare them to manage the child's medical needs. The following required trainings are:

- Fostering Health for Children in Foster Care - This training is based on the health standards in the practice guide: "Standards and Practice Regarding the Health Care of Children in DCF's Care". The focus of the training is to instruct foster parents on DCF standards and practices as it relates to the health and wellness of DCF children in their care (e.g. MDE, safe sleep, etc.). This training is part of pre-licensure training for foster parents.
- Cardiopulmonary Resuscitation (CPR) – The following are CPR recommendations for foster parents. Recommendations for laypersons are based on 2010 ILCOR's recommendations.
- DCF requires the following CPR standards:
  - Foster parents must be certified in CPR (age-appropriate).
  - CPR certification course must include a demonstration of skills competency that is observed by the certifying agency's authorized instructor. A written test is not required.
  - The following CPR certifying organizations offer trainings for laypersons consistent with DCF's expectations:
    - The American Red Cross, the American Heart Association, the National Safety Council, American Safety and Health Institute or Medic First Aid International, Inc.
  - CPR certification cards must be provided as documentation of course completion.
- Medication Safety for Foster Parents – this training is optional, except for foster parents of children with complex medical needs classification 2-4. The goal of the training is to inform foster parents how to safely manage medications for the children in their care. The training also offers the foster parents information about classes of medications and safe medication administration practices.

DCF's expectation is that children in care are placed in homes where the foster family is fully immunized consistent with ACIP/AAP guidelines and the recommendations. The department will not place children in homes where the foster parents and/or their children are unimmunized or under immunized. The Social worker shall consult with the RRG nurse on cases where placement is considered in an under immunized or unimmunized home. An assessment will be made based on the child's age, immunization status, length of time in placement, and potentially other case permanency related issues. Conversely, children

entering foster care who are not immunized will not be placed in homes where there are infants or immunocompromised children. The RRG supervising nurse, DCF Director of Pediatrics and the DCF Legal Director will be consulted.

At the time of placement of a child into the foster home, the Social Worker provides the foster parent with a copy of the child's health passport containing any current medical information as to medical treatments and medications (e.g. information received on the "Request for Medical Information" (DCF-2147). The Social Worker provides the foster parents with medications and medical equipment that the child needs. The Social Worker will inform the foster parents who are the child's primary care physician, dentist and other providers are, if applicable. The Social Worker will give the foster parent the dates of last medical appointments and a copy of the child's immunization record, if available. DCF encourages foster parents to maintain the child's prior medical provider(s) for continuity of medical care. Any request to change a child's existing medical provider must be made to the Social Worker who shall consult with the RRG nurse. The Social Worker will inform the foster parent that it is their responsibility to take the child to medical appointments, if the foster parents are unable to bring the child they need to work with the Social Worker to make alternate arrangements if appropriate.

Cross Reference: See in this Practice Guide sections on:  
Inform Consents and Permission to Treat  
Children with Complex Medical Needs  
Request for Medical Information  
Initial Health Screening  
Health Passport  
DCF Policy 44-4-1

## Children with Complex Medical Needs

### Purpose

Children with complex medical needs are particularly vulnerable and therefore require medical oversight and monitoring consistent with their level of complexity and risk. This will be done by the DCF Social Worker, a Regional Resource Group (RRG) Nurse and, as needed, DCF's Chief of Pediatrics and his or her staff.

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### Classification

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Whenever possible assignment should be to Social Workers with expertise working with children with complex medical needs would be preferred unless it's not in the child's best interest due to the stability of the relationship with the current social worker or for the near-term accomplishment of permanency.

Monitoring and oversight of children who are designated as Classifications 3 and 4 will include scheduled RRG nurse consultation and visitation as per guidelines.

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### Classification Identification

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"**Child with complex medical needs**" means a child who has one or more of the following:

- a diagnosable, enduring, life-threatening medical condition;
- a medical condition that has resulted in substantial physical impairment;
- a medically-caused impediment to the performance of daily age-appropriate activities at home, school or in the community; or
- a need for medically-prescribed services as identified on the DCF-2101, "Certification of a Child with Complex Medical Needs."

Children with complex medical needs shall be classified into one of four classifications:

- 1. Potential Condition-Related Risk** means a child who has a chronic health condition which is under good control but requires an educated caregiver. Chronic diseases in this classification include but are not limited to mild or moderate persistent asthma, cancer in remission until the child is medically cleared by the medical provider, chronic infections such as Hepatitis C and latent tuberculosis which require monitoring but no treatment, well-identified allergies which require Epi-pen use, or a newborn with perinatal substance exposure requiring medication upon discharge.
- 2. Medically at Risk** means a premature infant (born at less than 32 weeks gestation) or a child who has a chronic health condition which may periodically become life-threatening such as well-controlled insulin-dependent diabetes, a well-controlled seizure disorder requiring medication, moderate-to-severe asthma that has not resulted in a pediatric intensive care (PICU) or acute hospitalization in the last six months or a chronic infection

such as hepatitis C or latent tuberculosis for which the child is receiving treatment. (**Note:** Conditions resulting in repeated hospitalizations shall be classified as Level 3.)

**3. Intensive Medical Needs** means a child with a chronic condition that is not well-controlled or which requires daily or regular intensive medical follow-up or treatment, including severe forms of chronic disease such as poorly-controlled insulin-dependent diabetes, diabetes that requires the use of an insulin pump, a poorly controlled seizure disorder, hemophilia, an immune disorder, or severe persistent asthma which requires intensive and ongoing medical follow-up or has required an acute hospitalization or PICU admission in the past six months.

**4. Technology-Dependent or Medically-Dependent:**

**Technology-Dependent** means a child who requires a mechanical device or special technological intervention to maintain or sustain life. Children in this classification require routine or periodic assistance from trained and licensed nursing personnel and the availability of professional skilled nursing personnel for assessment of the child's medical status. Examples of children who are technology-dependent are those who require substantial assistance with activities of daily living, those who are unable to ambulate independently due to cerebral palsy or developmental disabilities, and those who may be temporarily unable to ambulate independently due to an injury or surgery, but who are expected to remain in this status only temporarily.

----- **OR** -----

**Medically-Dependent** means a child whose medical status requires specially-trained personnel immediately available to attend to the child, for whom a skilled nursing assessment may be needed as frequently as every two hours or for whom round-the-clock nursing care is required. Children who are medically-dependent may be able to live outside of a medical care facility, but are dependent upon a high level of care and assessment in order to sustain life, such as children with tracheostomies or on ventilators.

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## **Process for Establishing a Child as Having Medically Complex needs**

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DCF Social Worker obtains information from any number of sources which suggests that a child in DCF care may have complex medical needs-

After review of the information, the Social Worker shall:

- consult with the Regional Resource Group (RRG) Nurse to make a preliminary determination as to whether or not the child is medically complex.
- complete Section I of the DCF-2101, "Certification of a Child as Having Complex Medical Needs;"
- forward the DCF-2101 to the child's primary health care provider for completion.
- upon receipt of the signed DCF-2101 from the provider, submit the form to the RRG Nurse for review and signature. Then to Supervisor and Program Manager for review and signatures.
- document the child's complex medical needs status in the LINK medical profile, and document any consults and the completion of the DCF-2101 in the LINK medical narrative;
- file the original DCF-2101 in the child's case record;
- send a copy of DCF-2101 to the RRG Nurse; and
- notify FASU of the child's medically complex designation. FASU will notify Central Office Medically Complex Program Clinical Nurse Coordinator if the foster parents need Medically Complex Certification Training

- notify the area office Health Advocate for outreach to the HUSKY (Medicaid) program to determine what level of supports this program may be able to offer.

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## **Change in a Child's Medical Conditions**

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Whenever there is a change in the child's medical condition which would cause a change in the rate, a new DCF-2101 must be signed by the primary health care provider and submitted for review and approval.

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## **Disagreements with PCP**

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If the RRG Nurse and primary health provider do not agree on the child's classification, the Nurse shall review the DCF-2101 with their RRG Nurse Supervisor. If the RRG Nurse Supervisor is in agreement with the classification, the RRG Nurse will reach out to the medical provider and explain why they see the level of medical complexity as being at the different recommended level. If the PCP still disagrees with this classification, the RRG Nurse will reach out to the DCF Chief of Pediatrics or designee to determine the appropriate classification.

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## **Recertification**

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The child's medical status must be reviewed and re-certified by the child's primary health care provider every six months. To obtain re-certification, the Social Worker shall follow the same procedures as for initial certification

To remove a child from medically complex status, the Social Worker must submit the DCF-2101 to the child's primary health care provider for verification that the child currently does not require any of the care listed on the DCF-2101.

The Social Worker shall document the change to the child's status in LINK and inform the foster parent. The Social Worker shall inform the FASU of the change in child's status.

In the cases of subsidized adoption or guardianship, whenever there is a change in the child's medical conditions the following should occur:

- annually, the DCF Subsidy Unit shall send a DCF-2131, "Release of Information," to the adoptive parent or relative guardian;
- the Subsidy Unit staff shall send the completed DCF-2131 and the DCF-2101 to the medical provider for completion; and
- if the child's provider determines that the child should no longer be classified as medically complex, the family shall be contacted by the Subsidy Unit and sent a DCF-800, "Notice of Proposed Denial, Suspension, Reduction or Discontinuance of DCF Benefits."

**Note:** The DCF-2131 allows the Subsidy Unit to contact the provider regarding the child's current medical condition.

The foster care rate is paid monthly and is determined by the medically complex classification of the child. It shall be used to provide reimbursement of costs incurred for those foster or adopted children who meet the complex medical needs criteria on an ongoing basis.

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## **Extraordinary Rate**

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Extraordinary expenses are for items, environmental adaptations, services or equipment which are ordered by the child's primary care provider for the child's care and which would result in an additional cost to the foster family. These expenses include the rental or purchase of special medical supplies or equipment not provided through the child's medical insurance.

To request approval for extraordinary expenses, the child's Social Worker shall:

- consult with the Area Office Health Advocate;
- utilize the DCF-2103, "Extraordinary Expenses for the Care of a Child with Complex Medical Needs," to document the child's needs and all efforts to secure the needed resources through available funding sources; and
- submit the DCF-2103 to the Social Work Supervisor and Program Manager for review and approval.

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## **Medically Complex Log**

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A log shall be maintained of all children with complex medical needs known to the RRG nurse and updated regularly with current medical information. Each RRG Nurse will maintain a log of all children with complex medical needs in their Area Office.

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## **Foster Parent Training Requirements**

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### **Child Specific Medical Training**

Child-specific medical training" or ("**CSMT**") means a 1:1 training given to a caregiver and backup caregiver, prior to or on the day of placement, about the medical and associated care needs of a child with complex medical needs. Training should be given by a health care professional (physician or nurse outside of DCF) familiar with the child's care. This training is not provided by the RRG Nurse. Training will be determined by the child's individual plan of care and is based on their current medical and healthcare needs and licensed practitioners' orders

After training has been completed, the child's Social Worker shall be responsible for documenting the child-specific medical training in the LINK narrative. Documentation shall cover the following topics:

- name and qualification of licensed health care professional;
- components of the child-specific training;

- components of the trauma-specific training;
- location of trainings;
- lengths of training given to the foster parent and back-up caregiver during the child-specific training; and
- confirmation through the trainers that the foster parent and back-up caregiver have demonstrated a good understanding of the child's needs.

Ongoing documentation is required if any additional training has been provided to the parents after the placement, during doctor visits, home care visits, or any other training sessions, using the same criteria as above.

The Social Worker will verify that the foster parents have current CPR certification.

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## **Medically Complex Certification Training Program**

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The DCF Medically Complex Training Program shall provide post-licensing training and certification for families who wish to care for children with complex medical needs.

To become certified as a medically complex caregiver for children in Classifications 2, 3 and 4, the following requirements must be met unless a waiver has been granted (as specified below)

### **Classification 1**

**This includes: *All Foster Parents: DCF Core, TFC, Kinship and Pre-Adoptive, (includes: Backups, & Respite Providers)***

Training requirements:

- Fostering Health for Children in Foster Care
- Medication Safety for Foster Parents (recommended)
- CPR certification (age- appropriate)
- CSMT (Child Specific Medical Training)

### **Classification 2-4**

**Training Requirements for: DCF Core and TFC Foster Parents, (includes: Backups, & Respite Providers)**

- Medically Complex Certified- 1 Full day class and Prerequisites
  - Prerequisites to register for this 1 full day class are:
    - Fostering Health for Children in Foster Care
    - Module 28: Strategies and Resources for Managing Healthcare
    - Medication Safety for Foster Parents
    - CPR certification (age-appropriate)
- CSMT (Child Specific Medical Training)

**Training Requirements for: Kinship and Pre-Adoptive Foster Parents,  
(includes: Backups, & Respite Providers)**

- Fostering Health for Children in Foster Care
- Module 28: Strategies and Resources for Managing Healthcare
- Medication Safety for Foster Parents (recommended)
- CPR certification (age-appropriate)
- CMST (Child Specific Medical Training)

DCF foster parents, back-up caregivers and respite providers shall be paid a stipend of \$250.00 per person upon completion of the certificate training requirements.

Note: Transportation and child care expenses are incorporated into the stipend rate.

These re-certification requirements are in addition to the mandatory post-licensing requirements to maintain foster care licensure.

<b>Time Frame</b>	<b>Re-certification Requirement</b>
<b>Ongoing</b>	Maintain current CPR certification
<b>Biennially</b>	Continuing education related to the needs of this population of children and their caregivers.
<b>Ongoing</b>	Demonstrate consistent, competent ability to care for children with complex medical needs, including needs related to trauma, as determined by medical and trauma treatment professionals.

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**Respite**

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Any person who wishes to provide respite care for children with complex medical needs in Classifications 2-4 must complete the training requirements for that level of classification.

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**Role of the Clinical Nurse Coordinator  
in the Medically Complex Training Program**

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The Clinical Nurse Coordinator in the Division of Health and Wellness and the Office of Children and Youth in Placement shall coordinate the certification program.

The Central Office Clinical Nurse Coordinator shall:

- Coordinate Certification Classes for potential medically complex foster parents including ensuring eligibility for certification based on required pre-requisites
- make the final determination that the foster parent and back-up caregiver have successfully completed all requirements for certification; and
- provide the FASU Program Manager with the names of those foster parents and back-up caregivers who have been certified. The FASU Program Manager shall ensure that the foster parent’s certification status is entered in LINK. The back-up caregiver’s documentation shall be filed in the foster parent’s licensing record.

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## Prior to Placement

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### DCF-2102

The child's Social Worker shall ensure that the DCF-2102 is completed and included with the Health Passport for classifications 2-4 only

The DCF-2102 shall be signed by the health care provider, reviewed by the RRG Nurse and approved by the Program Manager.

The child's Social Worker shall consult with the child's Social Work Supervisor, FASU support worker, FASU Supervisor, RRG Nurse, and Health Advocate to identify the home characteristics needed for the placement and the child-specific medical training required for the caregiver; and any barriers to placement.

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## Foster Care Placement

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### Back Up Caregiver

All persons approved by DCF to care for a child with complex medical needs shall be supported by a back-up caregiver who has received the same level of training.

If there are two licensed foster parents in the home who have been certified to care for a child with complex medical needs, one parent will be considered the primary caregiver and the other will be the back-up caregiver.

If there is only one licensed foster parent in the home who has been certified to provide such care (the primary caregiver), a back-up caregiver must be available to assist the primary caregiver as needed.

The back-up caregiver:

- does not have to be a licensed foster parent, but must meet the same requirements as the foster parent for certification for the care of children with complex medical needs;
- must maintain current CPR certification;
- may live in the foster parent's home;
- if not a licensed foster parent, must provide care to the child in the licensed foster home; and
- must take all of the same training as the foster parent and have completed child-specific medical training and the "Medically Complex Certification" course.

The FASU Social Worker shall determine if the proposed back-up caregiver is an appropriate candidate for certification training and, if so, shall:

- notify the Central Office Medically Complex Unit Nurses, who will arrange for the certification training; and
- file the proposed back-up caregiver's documentation in the licensed foster parent's record.

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## **Emergency Placement**

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In the event that an appropriate home certified as medically complex is not available, and a non-certified resource is identified, then the FASU Program Manager, after consultation with the RRG Nurse, shall follow the principles of matching to:

- ensure that the foster family is willing to become certified as medically complex (not required for children in Classification 1);
- ensure that the foster family will participate in child-specific training and receive age-appropriate cardiopulmonary resuscitation (CPR) certification through an accredited organization;
- ensure that the foster parent has a qualified back-up caregiver willing to receive the same training; and
- notify the Central Office Medically Complex Program Nurses that the parents require medically complex certification.
- consult with the Health Advocate when there are barriers to accessing healthcare services.

The non-certified resource must complete child-specific medical training prior to the placement taking effect, in accordance with the Post-Licensing Certificate Training requirements outlined in this Practice Guide.

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## **Discharge of a Child from the Hospital to a Medically Complex Foster Home**

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If the child is being discharged from a hospital, the child's DCF Social Worker shall:

- make a referral to the RRG Nurse;
- ensure the DCF-2101, "Certification of a Child's Complex Medical Needs," is completed and signed by the child's health care provider
- work with the RRG Nurse and the hospital to ensure that an interdisciplinary discharge planning meeting is arranged that includes the child's medical team and other appropriate participants such as the parents, a managed care representative, a home care nurse, etc.;
- consult with the Health Advocate if needed;
- ensure that coverage of prescriptions, durable medical equipment and home nursing care has been approved prior to discharge;
- ensure that the child's primary care provider is informed of the hospital discharge;
- for a new placement, ensure that primary health care provider has been chosen and has agreed to care for the child after discharge;
- confirm with the hospital staff that the foster parents have received Child Specific Medical Training;
- confirm with the hospital staff or home care nurse that the necessary equipment and medications are available in the home;
- ensure referrals to appropriate clinics and physicians for follow-up care are scheduled;
- ensure emergency plans are in place to address power outages for those children who require electrical power;
- ensure that local emergency medical services are informed of the child's presence in the home;
- ensure that emergency plans for fire, unpassable roads, etc., have been established.

Discharges of children who have been hospitalized for an extended period of time and who will need home nursing care or durable medical equipment should not occur on Fridays, Saturdays or Sundays nor during "off" hours unless otherwise planned and approved by appropriate DCF area office administrative staff.

When DCF is the child's legal guardian, the Social Worker or other representative shall go to the hospital to sign the required discharge forms.

The foster parent(s) should go to the hospital to receive the child being discharged into his or her care.

A contact at the hospital shall be identified to the foster parent(s) to answer questions and assist with problem resolution during the immediate post-discharge period.

The Social Worker shall provide the foster parents with a written summary of the child's medical information and history. This should include the Health Passport and DCF 2101

Cross Reference: see Practice Guide section on Social Admissions

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## Visitation Requirements

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### Social Worker

The child's Social Worker and the FASU Support Social Worker shall make home visits to the home of a newly-placed medically complex child in accordance with their respective practice guide(s). This visit should include:

- follow up on changes in status;
- offer additional supports as needed; and
- collect the DCF-742, "Report of Health Care Visit."

The information shall be documented in the medical section of LINK.

### Regional Resource Group Nurse:

An initial home visit by the RRG Nurse and child's social worker should occur shortly after placement.

Thereafter, visitation requirements are the following

- **for Classification 1**, RRG nurse will make a nursing assessment annually to determine if an in-person visit or phone contact is indicated
- **for Classification 2**, visit annually with additional visits or phone calls if the RRG Nurse deems it clinically necessary based on a review of the DCF-2101 or if a specific concern or question arises;
- **for Classifications 3 and 4** – visit every six months with additional visits or phone calls if the RRG Nurse deems it clinically necessary based on a review of the DCF-2101 or if a specific concern or question arises.
- **As needed** based on a review of the DCF-2101 or if a specific concern or question arises; conduct annual visits with the child if deemed

- The frequency of visits, contact with providers and other activities shall be determined on a case-by-case basis in consideration of the level of complexity and classification.

### **Out of State placement visit**

The RRG Nurse visitation standard shall be met regardless of the location of the child's placement or the type of placement unless a modification is approved by the Director of Nursing following consultation with the DCF Chief of Pediatrics or designee. All modifications shall be documented by the RRG Nurse in the LINK narrative.

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## **RRG Nurse Oversight Activities**

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**The RRG oversight responsibilities include (but not limited to):**

- direct contact, as needed or when requested, with a child's primary health care provider, medical specialist or medical home to discuss the medical plan for care of the child;
- routine placement visits with the assigned Social Worker or other Area Office staff to assess the child's medical and mental health status and quality of care;
- documentation in LINK of the child's medical status, including specifics of care, services received and results of any site visits or medical planning meetings;
- involvement and assistance with permanency planning.
- review all medical documentation including the LINK Medical Alert for accuracy and completeness
- review results of any medical information provided by the Social Worker about a child with complex medical needs and assist in ensuring medical follow-up as needed.

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## **Annual Case Review (ACR)**

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Sixty days prior to the proposed ACR date for a child, the Social Worker and Social Work Supervisor will receive an email notification alerting them that an ACR will be scheduled for a specific case and informing them that they must identify participants to be included in the ACR including the RRG Nurse or Nurse Practitioner if the case involves a child with complex medical needs classifications 3-4. The Social Worker shall send an invitation email to the RRG Nurse no later than 21 days prior to the ACR.

Medical icons and the LINK Medical Profile will be updated by the Social Worker.

The most recent DCF-2101 shall be reviewed at each Administrative Case Review (ACR).

The medical icon and the LINK Medical Alert and shall be updated following the ACR and include plans as developed in the Comprehensive Health Plan portion of the Case Plan.

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## **RRG Nurses Role in the ACR**

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The RRG Nurse will:

- review the child's medical history and develop a summary highlighting on-going or unmet needs which need to be addressed in the ACR, including needs related to any trauma reactions the child may be experiencing related to his or her medical condition;
- consult with the Health Advocate, if needed, to address insurance related barriers to meeting the child's needs;
- highlight unmet needs and outstanding issues requiring follow up by the Social Worker, including the need for EPSDT or dental preventative services; the need for medical follow up with the PCP or a specialist; and recommendations for permanency planning; and
- email the summary to the Social Worker, Social Work Supervisor and Program Director of Clinical Services at least two weeks prior to the ACR.  
(Note: In preparation for a child's first ACR, the MDE report will be sent along with the summary.)

The RRG Nurse shall be notified by the Social Worker of the ACR for all children with complex medical needs in Classifications 3 and 4.

The RRG Nurse will also be notified by the Social Worker to attend the ACR when:

- the RRG Nurse has provided assessment services to the child or family within the six months prior to the ACR; or
- upon reviewing the ACR list, the RRG Nurse identifies a child with significant unmet needs, including needs related to a child's reaction(s) to the traumatic effects of complex medical conditions.

Any questions about the summary should be reviewed with the RRG Nurse prior to the ACR.

## Monitoring and Tracking

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### Healthcare Elements of the Case Plan

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#### Purpose

The case plan shall include healthcare elements that are inclusive of medical, dental, developmental, behavioral and emotional health to ensure that child is receiving appropriate care and services.

#### Process

The healthcare elements of the case plan are developed based on the MDE recommendations and included as part of the case plan at the 45 day treatment planning conference and at each subsequent ACR.

The Social Worker, in consultation with the RRG Nurse as needed, will develop the healthcare elements and integrate them into the case plan.

The healthcare elements of the case plan shall be routinely updated by the Social Worker, in consultation with the RRG Nurse as needed, based on reports of health visits and other information obtained.

## Medication Monitoring of Youth in Foster Care

### Purpose

To ensure that children in DCF's care have appropriate oversight of medications received while in care.

### Process

The child's foster parent or caregiver will maintain a medication monitoring record for the child in their care. That record should include:

- Child's current medications.
- Have there been any medication changes since last contact with DCF
- Were the changes in medication and/or dosage?
- Why did the medication change(s) occur?
- What symptoms are targeted by the medication(s)?
- How is the child doing on the current medications?
- Has the medication(s) had: desired effects, no effect, side effects, and/or adverse reactions?
- Has the foster parent contacted the child's prescriber about the medication(s) and/or no effect, side effects, and/or adverse reactions?
- Does the foster parent demonstrate a level of comfort knowledge of the child's medication treatment?
- Has the child been compliant in taking their prescribed medications?

The Social Worker as part of routine visitation with the child's foster parent or caregiver review the above list pertaining to the child's medication treatment. The Social Worker should also talk directly with the child about the medication(s), if appropriate. The Social Worker may consult with the RRG nurse related to the above medication information. The Social Worker will make changes to the Medical Icon in LINK and document the information on the child's medications and treatments into LINK.

### Foster Parents and the Use of Over the Counter (OTC) Medications with Children and Youth

Foster Parents may seek to use OTC medications for symptoms of illness that can be purchased without a licensed practitioner's order. These medications can cause harm if not used correctly and in consultation with the child's health care provider. DCF requires that foster parents follow the American Academy of Pediatrics (AAP) recommendation that foster parents talk with their child's health care provider before giving any OTC medication to a child or youth especially for the first time. In addition, they also recommend the following:

- Always check the product label for specific age-related dosing information;
- Call the health care provider immediately if there are any suspected side-effects such as vomiting or rash; and
- Consult child's health care provider to determine the best pain relief medication to use for pain and fever. Aspirin should never be administered unless recommended by the child's health care provider.

DCF Social Workers should discuss these recommendations and guidelines with caregivers at each visit and refer them to the child healthcare provider for any further questions about their child's medications.

For more information on safety and medications go to [www.healthychildren.org](http://www.healthychildren.org).

## Children and Youth Placed in a Congregate Care Facility

### Introduction

Licensed congregate care settings are responsible for the health and medical treatment needs of DCF children placed in their care. This is accomplished by having written policies and procedures that speak to delivery of that care for preventive, routine, elective and emergency medical care. Such procedures are reviewed by each facility's Licensed Independent Practitioner. The arrangement for medical services for DCF children in residence also includes medical emergency treatment, on a 24-hour, 7-day-a-week basis. Those child caring facilities licensed by the Department of Children and Families' must follow the care guidelines for the delivery of care in this practice guide.

Nursing services are delivered by nurses at several levels of licensure (LPN, RN, APRN). It is their responsibility to know their own scope of practice and perform within this scope. The goal for nursing standards is to help establish a standardized performance model for nurses that will be safe and effective using current best practice and the nursing process of assessment, planning, implementation and evaluation.

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### Nursing Delegation

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#### Delegation and the Nurses Role in the DCF Medication Administration Program

The Medication Administration Training Program has been developed in accordance with State of Connecticut General Statutes 370 Section 20-14h – j, and DCF regulation 17a-6(g)-12-16, to provide training for medically-unlicensed persons to safely administer medications to children in DCF operated and licensed child care facilities and extended day treatment programs. The assignment of medication administration comes from DCF Regulations and is considered part of the allowed functions of the unlicensed personnel and is not considered a nursing delegated task in DCF Licensed Child Caring facilities, as long as the unlicensed personnel have successfully passed the DCF approved Medication Administration Certification Program.

The primary role of the nurses in our licensed facilities is to have "oversight of the medical care received" by DCF children and youth placed in their facilities. Their role in DCF's Medication Administration Program is not the direct supervision of the facility employees. The nurses provide oversight of the medical care which includes the medication administration program.

Cross Reference: Roles and Responsibilities of Program Staff.

#### Nursing Delegation for tasks outside DCF Medication Administration

If a youth has a medical need (outside of those allowed in the DCF Regulation mentioned above) that requires a nursing activity, a nurse may delegate that task to an unlicensed staff member. The facility must have written Policies and Procedures that addresses the delegation

process and identifies responsibilities within that process. These policies and procedures must address the following:

- Responsibilities of the employer (facility) or nurse leader
- Responsibilities of the delegating nurse
- Responsibilities of the staff with whom the task will be delegated

These responsibilities must also be outlined in the child/youths plan of care as well as the facilities Guidelines to Manage Health Conditions.

Cross Reference: Monitoring and Tracking

For the full Declaratory Ruling go to:

[http://www.ct.gov/dph/lib/dph/phho/nursing\\_board/guidelines/unlicensed\\_ap\\_dec\\_rul.pdf](http://www.ct.gov/dph/lib/dph/phho/nursing_board/guidelines/unlicensed_ap_dec_rul.pdf)

### **Resources for Delegation**

#### **National Council of State Board of Nursing**

<https://www.ncsbn.org/index.htm>

#### **State of Connecticut Board of Nurse Examiners**

<http://www.ct.gov/dph/cwp/view.asp?a=3143&q=388910>

#### **American Nurses Association - Delegation**

<http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Joint-Statement-on-Delegation-American-Nurses-Association-ANA-and-National-Council-of-State-Boards.html>

### **Permissions to treat – 460, 460R, ROIs**

- See Practice Guide: Standards and Practice Regarding the Health Care of Children in DCF's Care for guidance on consents and releases

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## **Admission to DCF Licensed Child Caring Facility**

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- Every effort should be made to provide the Congregate Care Facility pertinent medical and health information. The medical information listed below will aid the child caring agency determine how to best address the youth's healthcare needs in the congregate care setting.
- Once it is determined that a youth will be admitted to the congregate care facility, the Social Worker should provide the Congregate Care Nurse with the following information;
  - Immunization Record,
  - Most recent Physical Exam
  - Date of last Dental Hygiene Exam
  - Date of last Eye Examination
  - Medication information
- In addition, the following documents may be available from the DCF Social Worker:

- The **DCF 469 - Child Placement Agreement** form includes youth's placement information, health issues, health screens/evaluations, and identified special education disability categories.
- The **DCF 2101 - Certification of a Child's Complex Medical Needs** form addresses the youth's medical diagnosis or diagnoses, and healthcare needs.
- The **Child and Adolescent Needs and Strengths (CANS)**, the Health Module section of the form, includes the youth's medical and medication information.
- The DCF 2147- Medical Questionnaire/Request for Information form is sent out to the youth's healthcare providers and will contain the youth's medical information.
- The **Multidisciplinary Evaluation (MDE) Summary and Recommendation (DCF 747)**

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## **Admission Readiness Activities**

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Readiness activities may need to occur to ensure the health and safety of the youth. Readiness Activities may include, but are not limited to the following:

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## **Children with Complex Medical Needs**

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- If the youth has been identified as having complex medical needs or a chronic health condition, Child Specific Medical Training (CSMT) may be needed to address youth's medical needs. CSMT may be obtained from youth's primary healthcare provider, or pre-discharge from a healthcare facility. The Congregate Care Nurse will work with the RRG Nurse and Social Worker to determine educational needs for program staff.
- Staff may need to be trained on how to address a youth's specific medical need(s), or training may be needed regarding how to use and care for medical equipment.
- If applicable, assessing the facilities compliance with ADA requirements and ensuring youth's ability to access the facility and areas within the facility.
- Developing an emergency plan address youth's medical needs in the event of an emergency. This plan must include DCF and healthcare provider's emergency contact information and must be identified prior to admission
- Emergency Medical System (EMS) will need notification of youth's placement if assistance will be required in the event of an emergency.
- The assigned Social Worker and RRG RN are available to assist in arranging for CSMT as needed.

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## **Release of Information**

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**DCF 2131 (F) - Authorization for Release of Information From DCF** and **DCF 2131 (T) - Authorization for Release of Information To DCF** is to be used when obtaining medical

information from the youth's primary healthcare provider, dentist, and / or other specialist(s).  
**Cross Reference** : *Securing Permissions and Authorizations for Specific Health Services*

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## Nursing Assessment

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### Guidelines for Nursing Assessments in DCF Child Caring Facilities

- All nursing assessments are conducted by a registered nurse.
- Nursing **Admission** Assessment is required upon Admission or readmission to DCF Licensed Congregate Care Facility
- Nursing **Admission** Assessment should be conducted if the youth has been away from the facility and unaccounted for any period of time. This assessment must be completed within **24 hours** of child/youth's return.
- A nursing **focused** assessment should be conducted whenever there is a change in an individual's health status.

### Nursing Admission Assessment

The following is required for each admission to a DCF Licensed Child Caring Facility:

1. A nursing assessment of the child needs to be done as soon as possible after admission but no later than 72 hours. This assessment must be documented on either the recommended form in the Appendix section of this guide or on an agency form that includes the following:
  - A review of systems
  - Medical and medication history
  - Vital signs
  - Height, weight and BMI
  - Immunization status
  - Nutritional Status
  - Developmental assessment
  - High Risk Behavior assessment
  - Identification of medical and dental providers
  - Mental Status Evaluation
  - Allergies
2. Collaboration with other care providers and the child's family to obtain health information on the child/youth. This includes
3. An initial nursing care plan within 24 hours of admission assessment
4. A statement about the child's adjustment to new surroundings
5. A statement about the child's emotional well- being
6. A current picture of the child as part of the record.
7. Current Immunization Record obtained by child's PCP or last school child/youth attended.

Written documentation of the assessment will be provided to the child's DCF social worker and Regional Resource Group nurse. Pertinent information will be shared with the child's primary care provider, the Multidisciplinary Evaluation clinic staff before the child's multidisciplinary evaluation and Interdisciplinary Treatment Team (IDT).

### **Nursing Focused Assessment**

Detailed nursing assessment of specific body system(s) relating to the presenting problem or current concern(s) of the patient. This may involve one or more body systems. Nurses should utilize their clinical judgement to determine which elements of a focused assessment are pertinent for their patient. Situations might include (but are not limited to):

- Child presenting with specific medical concern (respiratory, gastrointestinal, neurological, skin condition, fever)
- Change in child's mental status
- Medication side effects/adverse reactions
- Child returning from AWOL
- Child returning from acute/in patient hospitalization – including any changes in medication or treatment plan

Documentation should include history of presenting problem, assessment/inspection of specific concern, care provided, additions/changes to plan of care, notifications to medical provider (if applicable), evaluation and follow-up.

### **Pain Assessment**

- Should be completed when assessing pain. Suggested form located in "Forms" section of this handbook
- Information should be used to inform any changes in the nursing plan of care.

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## **Medications at Placement (Psychiatric, OTCs, Prescription, Supplements, Emergency)**

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- DCF Social Worker is responsible for coordinating all aspect of child admission to facility.
- Social Worker must contact admitting facility to discuss what is required for medication and medical care and make sure all necessary equipment is available upon admission.
  - A written licensed practitioners order for medication must be available before any medication (including over the counter medication) is administered to a child in a DCF Licensed or operated group home, safe home or residential facility including extended day treatment.
  - If the social worker obtains a new written prescription or order from the licensed practitioner, the social worker must contact the admitting facility for direction about whether the prescription should be filled at a pharmacy before bringing the child to the admitting facility. If the prescription is filled at a pharmacy prior to admission - social worker must bring a copy of the prescription. Many admitting facilities will prefer to have the prescription filled at their own affiliated pharmacy.
- DCF medication certified staff and licensed nurses (RNs and LPNs) cannot administer medication to anyone without a current licensed practitioner's prescription or order on hand.

**Sources for licensed practitioner's orders:**

- The licensed practitioner who prescribed the medication. The name of this practitioner may be found on the medication's pharmacy label.
- The child's primary care provider (PCP)
- The pharmacy that filled the medication prescription.
- The health office of the child's school or day care center.
- The child's parent or guardian.

**Resources for assistance with medications and/or obtaining an order:**

- **Health Advocates** - DCF specialists in health insurance who may be able to help with medication issues involving insurance or payment. A current list of DCF Health Advocates is available at: <http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314348>
- **DCF Careline** - 1-800-842-2288

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**Psychotropic Medication at Admission**

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Information on what is required at the time of admission is found on the DCF CMCU Website.

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**When a Child Transfers from One DCF Licensed Facility to Another DCF Licensed Facility**

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For children who are transferring from one DCF licensed program to another, a copy of all current medication licensed practitioner's orders and the corresponding medications must be provided by the discharging program and may be used by the admitting program.

To help ensure a secure transfer of medications from one facility to another, a Transfer of Medication form should be used to document all medications released by the discharging facility to transfer to the admitting facility. This form will indicate who prepared the medications for release, who accepted the medications for transfer and who accepted the medications at the admitting facility. (see Forms Section for an example)

Every time a child/youth changes providers or setting, a new 465 needs to be submitted to the Centralized Medication Consent Unit (CMCU).

Link to CMCU Website: <https://portal.ct.gov/DCF/CMCU/Home>

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**When a Child is Admitted into a DCF Licensed Facility from Home or Foster Home**

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The DCF social worker has the responsibility to obtain signed copies of licensed practitioner's orders for all medications the child is currently prescribed.

If the social workers bring in bottles or containers of medication from the child's home or foster home, the admitting facility may use these medications only after getting permission from a licensed practitioner or pharmacist who can confirm the contents of the medication containers.

Permission to use these medications must be documented in the child's record and include the date and contacts.

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### **After-Hours or Emergency Admissions**

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By law, a child/youth will not be able to be administered his/her medications without current licensed practitioner's orders.

In the event of an after-hours or emergency admission, the DCF social worker must make every effort to obtain licensed practitioner's orders for any medication a child has. Sources for obtaining orders:

- Child's Primary Care Physician
- Dispensing pharmacy – This can/may be in the form of a *medication summary*
- Child/Youth's parent or guardian
- The health office at the child/youth school

There may be circumstances where all orders/prescriptions are not immediately available and this should not preclude admission. If orders are unavailable at the time of admission, the social worker and/or the admitting facility staff must call the DCF Hotline to report the situation. The DCF Careline can contact the on-call Physician to explore options for obtaining orders for the child medication.

The on-call physician will offer direction, but should not be expected to provide orders for the child.

**DCF Careline – 1-800-842-2288**

## Monitoring and Tracking

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### Congregate Care Nursing Care Plan

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Each youth admitted to a DCF Licensed Child Caring Facility shall have a Nursing Plan of Care that is based on the assessment data obtained during the admission process. The RN shall use the Nursing Process in the development of the plan of care and the subsequent provision of nursing care. This plan shall provide guidance to all staff who provide care to the youth and assure continuity of care.

There are many resources available for how to write a care plan as well as a variety of formats for a plan of care. They are generally organized in four main categories:

- Assessment data,
- Nursing diagnosis/problem list,
- Interventions with time frames
- Evaluation

#### Assessment:

The Nursing assessment shall be completed based on the guidelines listed in "Children and Youth in Placed in a Congregate Care Facility – Admission" of this practice guide.

#### Nursing Plan of Care

It is up to the agency to determine the best format to use that works for the nurse and their facility. The RN shall develop the nursing care plan and should contain the following:

- A diagnostic statement: Each diagnostic statement shall include a nursing or medical diagnosis (North American Nursing Diagnosis Association (NANDA I) approved diagnosis optional),
- Definition of the diagnosis
- An assessment which may include health history, physical findings, psychosocial status, data obtained during the assessment, objective and subjective information,
- Expected outcomes (such as the Nursing Outcome Classification -optional )
- Nursing interventions classification and rationale (such as NIC optional)
- Evaluations of expected outcomes.
- Documentation of patient's response to treatment as well as nursing observation

The RN will collaborate with other members of the Interdisciplinary Treatment Team (IDT) while developing the nursing care plan.

It should be incorporated into the treatment plan and updated as needed when health concerns either arise or are resolved. A Nursing Plan of Care should be reviewed quarterly and response(s) to nursing intervention should be noted.

#### Evaluation of the Plan of Care

The RN evaluates the individual's response to the nursing care plan and interventions in order to revise the data base, nursing assessment, and nursing care plan. This evaluation shall be shared with the child's Interdisciplinary Team including DCF Social Worker. Based on the evaluation, the RN shall revise the nursing care plan as appropriate.

Evaluations shall be performed and documented on an ongoing basis. On a quarterly basis the RN will prepare and provide a summary of the individual's interventions and outcomes to the Interdisciplinary Team.

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## **General Rules of Documentation**

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A nurse shall document all nursing interventions and care provided for each client. This includes (but is not limited to):

- Evaluation of identified nursing needs when an individual's health status changes.
- All telephone communications regarding the child/youth with DCF. Use full, proper names and titles when documenting contacts made.
- Communication with community health care providers, (i.e. hospitals, clinics, physicians, and ER's etc.) telephone communications with guardians, DCF social worker(s), pharmacy etc.
- When a client moves to another residential facility and shall include an evaluation of all health care needs, including history, current status and recommendations as part of the transition process.
- To protect children's confidentiality, do not use one child's full name in another child's record.

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## **Legally Accepted Documentation Standards**

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- All entries shall be documented in blue or black ink.
- When documenting, the licensed nurse shall sign off the entry with the date, time, first initial, last name and title (e.g. date, time, first initial, last name, title).
  - January 1, 2007, 10 a.m., J. Smith, LPN
- Charting corrections shall be made by drawing a single line through the incorrect statement/word, writing "omit" and initialing above the statement/word, and then entering the correct documentation.
- When an addendum is needed, the following shall be documented next to the current date: time, first initial, last name and title as follows:
  - Current date and time
  - Addendum to notes of date and time of happening
  - Signature
  - e.g. 1/1/2007 2 p.m. addendum to notes of January 1, 2007, 10 a.m., J. Smith, LPN
- When a late entry is needed, the following needs to be documented:
  - Current date/time
  - Entry with date and time of happening
  - Signature
  - e.g. 1/3/2007 9 a.m. late entry for January 1, 2007, 10 a.m., J. Smith, LPN

## Guidelines for Care of Specific Medical Conditions

When a child has a care need that goes beyond routine well child care – the facility nurse must have specific guidelines for these conditions. These include but are not limited to care plan and specific facility responsibilities and are based on best nursing practice. Below is a template of what should be included in the care planning. Refer to the appendices for sample guidelines

### Guidelines should include:

- Definition of the condition
- Purpose (If applicable)
- Procedure (If applicable)
- Nursing Considerations/Responsibilities
  - Care Planning
  - Medical or Nursing Diagnoses
  - Delegation Considerations
  - Communication
- Facility Responsibilities
  - Staffing Consideration
- Documentation/Forms
- References

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### EXAMPLE:

### Guidelines for Care of the Child with Diabetes

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#### Definition

- **Type I:** Type 1 diabetes is a disease caused by a lack of insulin. Insulin is needed to allow sugar to move from the bloodstream into the cells to be used for energy. Nutrients in food are changed into a sugar called glucose. People with type 1 diabetes cannot make insulin, and without insulin, glucose is "stuck" in the bloodstream, leading to a high level of glucose in the blood. Type 1 can be diagnosed at any age but most commonly diagnosed in children, teens and young adults
- **Type II:** In children with type 2 diabetes, the pancreas does not make enough insulin and the cells don't use the insulin very well.
- **Gestational Diabetes:** Gestational diabetes is high blood sugar that develops at any time during pregnancy in a woman who does not have diabetes

#### Nursing Plan of Care

- Is developed in conjunction with the child and endocrinologist.
- Identifies measures to be taken in the event of hypoglycemia including a follow-up blood glucose measure.
- Identifies measures to be taken in the event of hyperglycemia including a follow-up blood glucose measure.
- Defines emergency measures when the child is out of the facility.

- Defines the supplies the child needs to take when leaving the facility (glucose tabs, glucometer).
- Describes a medical plan in case of the child's illness or non-compliance.
- Describes the prescribed exercise and activity program.
- Addresses nutritional needs
- Addresses use of specialized equipment – i.e. insulin pump, Dexcom Glucose Monitoring system, etc
- Education

### **Nursing Considerations/Responsibilities**

- The nurse will ensure that a record is kept of blood glucose levels and insulin use  
Laboratory reports are available in the child's record  
Diet/carbohydrate compliance is assessed and documented  
Exercise and activities are documented
- The nurse will monitor blood glucose values and notify the physician/endocrinology clinic as indicated.
- At least weekly, the nurse must supervise and document the child performing blood glucose testing and insulin administration independently:
  - Hand washing
  - Site rotation
  - Drawing up the correct dose of insulin into the syringe
  - Storage and handling of insulin
  - Proper disposal of sharps and contaminated materials
  - Calibration of glucose monitor
  - Knowledge of insulin coverage plan
- The nurse will assess the need for the child to be evaluated by a nutritionist.  
The nurse will ensure that the prescribed diet is being provided and will assist the child in making food choices.
- The nurse is responsible for the safe storage of diabetes supplies; supplies need to be available to staff but inaccessible to children.
  - Blood glucose monitor
  - Needles and syringes
  - Glucose replacement product
- The nurse will assess and document the condition and progress of the child as often as necessary, but not less than weekly.
  - Potential complications must be assessed and documented
  - The nurse communicates regularly with the child's physician/endocrinologist
  - The nurse communicates with the child's family and school nurse as necessary
  - The nurse communicates regularly with the DCF area office nurse.

### **Medical or Nursing Diagnoses**

- Risk for Unstable Blood Glucose Level related to insulin deficiency
- Knowledge Deficient (Diabetes Management) related to care of a child with newly diagnosed diabetes mellitus

### **Delegation Considerations**

- Blood Glucose monitoring

### **Communication**

- Program Nurse communicates with the area office nurse.
- The nurse should speak directly to the endocrinologist in charge of the child's diabetes prior to admission in order to obtain a current clinical summary of the child and to become familiar with the child's diabetic treatment plan.
- The nurse arranges for the child to be cared for by an endocrinology clinic that has 24 hour coverage.

### **Facility Responsibilities**

- Policies and Procedures  
The facility must develop policies and procedures that address
- Staffing/Coverage
- The nurse will ensure that medical appointments are scheduled and attended.  
The nurse accompanies the child to medical appointments if possible.  
A report of health care visit is given to document each medical visit.  
A copy of the health care visit report (DCF 742) is sent to the child's DCF social worker.
- The nurse assesses staffing needs  
There is adequate nursing coverage to oversee the diabetes management plan.  
The nurse collaborates with the endocrinologist and the area office nurse to determine a safe level of nursing supervision for the child.  
This collaboration is documented in the child's record.  
Home care nursing is obtained when nursing coverage is required.
- In absence of nursing coverage 24/7, the child must be able to self-administer insulin and perform blood glucose monitoring independently.  
Home care nursing services are obtained if nursing supervision is required

### **Emergency Planning**

- Facility must have an emergency plan in place in the event of a diabetic emergency

### **Training Requirements**

- The nurse makes arrangements for staff training on diabetes. The training:  
Must be provided by a diabetes educator, staff member from endocrinology clinic or Homecare nurse skilled in diabetes training.  
The training must include child-specific interventions.  
Documentation of this training must be kept at the facility.

### **Documentation/Forms/References/Educational Links**

- American Diabetes Association
- Pub Med Health

## **Congregate Care Quarterly Nursing Reports**

### **Purpose**

The purpose of the Quarterly Nursing Report is to provide the DCF Social Worker and RRG Nurse with an update on the health and medical status of a DCF committed child or youth residing in a DCF Licensed Child Caring Facility. The information should be a continuation of the care provided from the previous 90 days.

- AAP/Healthychildren.org

### **Who Completes the Report?**

DCF -2270 "Congregate Care Quarterly Nursing Assessment" must be completed by the congregare care provider nurse

### **Nursing Summary**

The Nursing Summary at the end of the DCF -2270 "Congregate Care Quarterly Nursing Assessment" should only contain a summary of the health issues addressed in the previous 90 days or what has changed since the previous report. This should include (but not limited to): changes in diagnosis or medication, abnormal lab values, significant weight gain/loss, any doctor's visits including well child/dental exams and immunizations received. It should include any updates to the nursing plan of care and progress towards goals.

### **How Often is the Report Completed and Submitted?**

The Congregate Care Quarterly Nursing Assessment is completed every 90 days from the date of admission. This report is sent to the child/youth's Social Worker as well as the Area Office RRG nurse. The Congregate Care Nurse should develop a system for determining review dates and when the reports are to be submitted to DCF. The Social Worker includes a copy of the Congregate Care Quarterly Nursing Assessment in the child's LINK and Case record.

## Discharge

Prior to discharge from a congregate care setting, a child and his or her parents or legal guardian shall be provided with an up to date Medical Alert (DCF-741) including recommendations for ongoing medical and mental health care and contact information for the primary care provider/medical home as well as any specialty providers who will be providing ongoing care to the child after discharge.

Congregate Care Providers are required to complete the Congregate Care Discharge Summary. There should be a copy in the child's record and one provided for the caregiver upon discharge. A copy of this should be sent to the child's Social Worker and RRG Nurse. Upon discharge the following should be included, but not limited to:

- Aftercare planning
- Medication and prescriptions
- Any necessary equipment

## Medication Management of Youth in Care

### Introduction

The Medication Administration Training Program has been developed in accordance with State of Connecticut General Statutes 370 Section 20-14h – j, and DCF regulation 17a-6(g)-12-16, to provide training for medically-unlicensed persons to safely administer medications to children in DCF operated and licensed child care facilities and extended day treatment programs.

Upon completion of DCF approved Medication Administration Certification Program, in the absence of a licensed medical personnel, only certified employees may administer medications

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### Regulatory Responsibilities for DCF and the Congregate Care Facility

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#### DCF Responsibilities in Administration of the Medication Training Program:

DCF Regulation 17a-6(g)-15 (a - g)

1. Provide a training program for unlicensed persons designated by the DCF licensed or operated programs. 17a-6(g)-15 (a)
2. Designate licensed medical personnel to conduct the training or contract with appropriate education agencies. 17a-6(g)-15 (b)
3. Determine the location and frequency of training programs. 17a-6(g)-15 (c)(d)
4. Develop training curriculum as outlined in DCF regulation. 17a-6(g)-15 (e)
5. Maintain a current listing of persons who have successfully completed the training and are authorized to administer medications. The listing will also identify the program or facility in which such persons are employed.  
17a-6(g)-15 (f)
6. Issue and maintain documentation of successful program completion.  
17a-6(g)-15 (g)

The DCF Medication Administration Training Program will also:

7. Collaborate with DCF Risk Management in the monitoring of medication errors.

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### Facility Responsibilities in Medication Administration

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1. Designate and recommend appropriate persons to be trained in medication administration.  
DCF Reg: 17a-6(g)-15(a)

2. Permit only those staff who have successfully completed DCF Medication Administration Certification to administer medications. DCF Reg: 17a-145-75 (d)
3. Maintain a current listing of trained persons and a copy of their certification. DCF Reg: 17a-6(g) - 16 (a) and 17a-145-75 (d)
4. Provide continuing education to trained staff on medication administration. DCF Reg: 17a-145-75 (d) and 17a -6(g) - 16 (c)
5. Order medications in unit doses if available. DCF Reg: 17a-6(g)-16 (d).
6. Provide and maintain proper, safe storage for all medications according to current drug control and pharmacy regulations as outlined in the DCF Medication Administration Program. DCF Reg: 17a-145-75 (f) and 17a -6(g)-16(b) 4
7. Establish and maintain written policies on the following: DCF Reg: 17a-6(g)-16 (b):
  1. the role and responsibilities of medication certified staff
  2. the provision of adequate supervision of or consultation with medication certified staff by licensed medical staff
  3. the provision of adequate back-up by licensed medical persons.
  4. storage, access, administration and documentation of medication
  5. requiring a written prescription or order from a licensed medical practitioner for all medications administered to children in the facility.
  6. procedures to following the event of medication errors or adverse reactions.

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## **Roles and Responsibilities Program Staff**

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### **Program Director (Or Designee)**

- Program Director/Designee supervises the med admin certified personnel.
- Program Director (or designee) recommends employee for med admin certification and in consultation with program nurse is the person responsible for med error reporting and the corrective action plan.
- Program Director (designee) supervises the med admin certified personnel

### **Program Nurse (RN, LPN)**

The nurse in congregate care setting assumes the responsibility of the medication administration program oversight and must be available for consultation to the program managers. These responsibilities include:

- Check monthly that all prescriptions/orders are current, correctly transcribed on the medication record and match the pharmacy labels. Including but not limited to the following:

Orders are not over 90 days

Orders contain the 5 rights and dose is written in a specific amount (e.g. "1or 2 tablets bid" is not acceptable)

Orders contain parameters for administration of PRN medication

- Review medication errors and adverse reactions, identify trends or recurrent problems.
- Ensure the proper storage of medications.
- Submit a **DCF-2272** *Monthly Medication Administration Program Supervision and Review* to DCF Risk Management
- Oversee and consult with facility staff regarding medication administration.
- Maintain documentation of all medication program supervision, internships and annual supervision of medication certified staff. Make this documentation available for review by the Department of Children and Families upon request.
- Annual Observation of Medication Administration Skills
  - Once a year the facility nurse must observe medication certified staff performing the DCF medication administration procedure. This must be documented using the **DCF-2275** *DCF Medication Administration Program Procedure Checklist* and placed in the employees file.
- Quarterly Review of Policies and Procedures
  - Quarterly, the supervising registered nurse or licensed medical person will document a review of the facility's medication policies and a review of the continuing education offered related to medication administration.
    - Forms for documentation of these reviews are available on line and in the Forms section of this handbook (see Quarterly Review of Medication Policy and Procedures by Licensed Nurse and Quarterly Review of Medication Administration Continuing Education).
    - Documentation of these reviews is to be kept at the facility and made available to the DCF upon request.
- The program nurse or licensed medical staff person shall immediately report to the facility director and the DCF Risk Management any significant deficiencies in a facility's medication administration program or in an individual's competency to administer medications.
- Additional responsibilities of the Registered Nurse and Licensed Practical Nurse:
  - RNs must be familiar with and practice within their legal scope of nursing practice.
  - RNs supervise LPNs and oversee medication certified staff in medication administration.
  - RNs may become Endorsed Instructors to teach the DCF medication administration course.
  - RNs may assess the health needs of children in care and evaluate the need for PRN medications. Refer to guidelines on use of Psychotropic medications for clarification of nurse's responsibilities...
  - RNs review orders for any new medication, changes in medication orders or changes in treatment orders on a regular basis.
  - RNs may accept orders from licensed practitioners via the telephone.
  - RNs must provide continuing education related to safe medication administration and maintain quarterly documentation of the continuing education offered.
  - Registered nurses may not dispense medication.

### **Licensed Practical Nurse (LPN)**

- LPNs must be familiar with and practice within their legal scope of nursing practice.
- LPNs must be supervised by a Registered Nurse or Advanced Practice Registered Nurse as per State of Connecticut requirements and as per facility policy and procedure.

- LPNs must consult with the RN supervisor to review verbal orders for any new medication, change in medication orders or treatment orders that represent a change in the child's treatment plan.
- LPNs may not assess for the need for any medication including PRN psychotropic medication.
- LPN's may not dispense medication

**Under the Supervision of a Registered Nurse, LPNs May:**

- administer medications appropriately ordered by a licensed practitioner and dispensed by a pharmacist or licensed practitioner.
- become Endorsed Instructors to teach the DCF medication administration course
- coordinate the internship process for medication certification candidates
- prepare monthly supervision reports on the medication administration system, document the quarterly review of medication policy and procedures and of any continuing education offered with regard to medications.
- provide continuing education related to safe medication administration.
- conduct the required annual skill observation of medication certified staff.

**Advanced Practice Registered Nurse (APRN)**

The APRN may function as the program nurse as well as the Licensed Practitioner.

- Must be familiar with and practice within their legal scope of practice.
- Must meet contractual obligation of their hired role(s)

**Licensed Medical Practitioner**

Licensed Medical Practitioners are individuals licensed by the State of Connecticut to prescribe and dispense\* medications. These include: physicians, dentists, physician assistants (PA), and advanced practice registered nurses (APRN). Licensed Medical Practitioners may provide consultation concerning medication they have prescribed.

Licensed practitioners assess children, make medical and/or psychiatric diagnoses and prescribe treatment including medications.

A licensed practitioner documents quarterly that he or she has reviewed the facility's policy and procedures regarding medication administration and medical care of children.

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**DCF Medication Administration Certified Staff**

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1. DCF medication certified staff medication administration skills must be supervised by a licensed medical staff person as per regulation 17a-6(g)-16(b)(2).
2. DCF medication certified staff may not dispense medication.
3. DCF medication certified staff will attend continuing education offerings related to safe medication administration.
4. DCF medication certified staff must be observed annually by a licensed medical person in their medication administration skills.

5. DCF medication certified staff must recertify every two years, on or before their certificates' expiration date in order to continue to administer medications to children in DCF licensed or operated child caring facilities. Certification becomes ineffective immediately upon failing the recertification exam.
6. DCF medication certified staff may not assess for the need of any medication including for PRN psychotropic medication
7. DC medication certified staff may administer properly dispensed medication according to a licensed practitioner's prescription/order by comparing the five rights (the right person, drug, dose, route and time of administration) using the rule of three (comparing the practitioner's order, the pharmacy label and the MAR) before administering any medication. Medication Certified Staff must follow the established training practices taught in the Medication Administration Program approved by DCF.
8. DCF Medication Certified Staff must follow the Steps of the Med Procedure every time they administer medication. (see below)

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### Steps of the Med Procedure:

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1. Approach the task in a calm manner and allow no distractions.
2. Wash hands before and after medication administration.
3. Assemble appropriate equipment and unlock the Medication Storage Area.
  - 1ST Check** Compare the licensed practitioner's prescription/order with the medication administration record ensuring that the five rights match on both. Right Person, Right Medication, Right Dose, Right Time, Right Route.
  - 2ND Check** Compare the licensed practitioner's order with the pharmacy label on the medication container, ensuring that the five rights match on both. Check the concentration on the pharmacy label.
  - 3RD Check** Compare the pharmacy label and the medication administration record ensuring that the five rights match on both.
4. Pour the right dose of medication.
5. Identify the correct person.
6. Administer the medication properly – utilizing the proper technique.
7. For oral medications, perform a mouth check. Ensure that the medication has been swallowed.
8. Document appropriately on the medication administration record.
9. Return the medication to the locked area and clean up.

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### Pre-Pouring Medications

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- The Department of Children and Families does not permit the practice of pre-pouring medications.
- Only the person who prepared the medication by following the Medication Administration procedure and checking the Five Rights against the licensed practitioner's order, the MAR and the pharmacy label can administer the medication.
- Under NO circumstances can a med certified staff sign off on administering a medication before it has been given.
- Under NO circumstances can an RN or LPN pre-pour a medication for a Med Certified Staff

## Facility Implementation Guidelines

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### Documentation

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#### Licensed Practitioner's Order

##### Acceptable forms of a LP Order

- Original, copy or faxed signed licensed practitioner's order (See guidelines for authenticity of electronic and faxed orders: (Section IV page 21)
- Copy of the original signed prescription from the pharmacy where the prescription was filled
- Doctor's Order Sheet signed by the licensed practitioner
  
- Inter-agency referral form (such as a W-10), signed by the licensed practitioner
- Telephone orders can legally be accepted only by a pharmacist or a nurse.
  - Facility policy must identify the time-frame during which licensed practitioners must co-sign any telephone order. Must not exceed 30 days.
  - A licensed practitioner's written order must include the child's name, the name of the medication, the dose to be administered, the times to be administered and the route or method of administration.
- Electronic Prescriptions
- A copy of a practitioner's telephone order written by the dispensing pharmacist may be used in lieu of an actual practitioner's order. The order must include the child's name, the name of the medication, the dose to be administered, the times to be administered and the route or method of administration.

For PRN or as needed medications, orders must include the indication for use and the interval of time that must occur between doses.

Refer to the sections on **PRN Medications** and on **Standing Orders**
- LPN scope of nursing practice requires the LPN to review any telephone order with the supervising RN before beginning a medication or treatment that reflects a change in the child's plan of care (e.g. new medication). Please refer to the appendix Scope of Nursing Practice, LPN.

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### PRN (as Needed) Medications

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PRN medications are medications administered only on an as-needed basis and are prescribed by a licensed practitioner to be administered only when the youth needs them to treat specific symptoms

- PRN medication orders must be individualized
- PRN orders must be renewed every 90 days
- DCF Medication certified staff and LPNs cannot make nursing/medical assessments about a youth's need for a PRN medication therefore:
  1. Licensed practitioner's orders for PRN medication must include objective indications for use that does not require assessment prior to administration

**Example:** Tylenol 650 mg PO, PRN, Q 4 Hours, *for temp. of 101.0 F or higher* (General statements of "give for pain or fever" require medical/nursing assessment and are **not permitted**)

2. PRN orders MUST contain specific time intervals for administration

**Example:** Tylenol 650 mg PO PRN **Q 4 hours** (Orders must indicate specific time intervals; time frames (i.e. 4-6 hours) are **not permitted**)

- PRN orders must include:
  1. directions about when to contact the nurse and/or licensed practitioner for further evaluation if symptoms persist or get worse
  2. the maximum number of doses that may be administered in a 24 hour period, i.e., NTE (not to exceed) direction
  
- PRN medication administration must be documented on the youth's individual medication administration record (MAR) and it must include:
  1. the date and time the medication was given
  2. the reason (indication) the medication was given
  3. the outcome - the measurable results from the medication

**OTC (Over-the-counter) PRN medications** may only be administered from pharmacy dispensed or manufacturer's dispensed packages. If manufacturing package is used the concentration of the medication must be indicated on the label and must allow for the correct dose to be administered according to the licensed practitioner's order.

Youth may self-administer OTC topical preparations as indicated by the licensed practitioner and facility policy.

- **Over-the-counter Topical Preparations** may be administered to youth according to a facility policy reviewed and approved by a licensed medical practitioner. Some examples of topical OTC medication include:
  - sunscreen
  - antiseptic solutions
  - creams
  
- Facility policy must specifically identify the OTC preparations including strength, indication, frequency of administration, and when to contact the chain of command or licensed medical practitioner for direction
- The OTC topical preparation list and policy must be reviewed and renewed every 90 days by a licensed practitioner
- Facility policy and procedure may permit non-medication certified staff to administer OTC topical preparations according to the manufacturer's directions and/or the licensed practitioner's directions
- OTC topical preparations must be stored so that they are not accessible to youth

**Psychotropic PRN medications** can only be administered upon nursing/medical assessment. No med admin certified or non-licensed medical personnel can make an assessment for the need of the psychotropic PRN medication

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## **Vitamins, Nutritional Supplements and Herbal Remedies**

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Over-the-Counter (OTC) vitamins, nutritional supplements and herbal or alternative remedy preparations require a child specific, current licensed medical practitioner's order that identifies the medication and the dose, the route and time the medication is to be administered to the individual youth

Licensed practitioner's orders for any of the above preparations must be renewed every **90 days**.

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## **Electronic Prescriptions and e-Prescribing**

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E-prescribing, or electronic prescribing is a technology framework that allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy electronically instead of using handwritten or faxed notes or calling in prescriptions. All orders must comply with the requirements stated in Acceptable forms of Licensed Practitioners Order.

Facilities that utilize electronic prescribing must have written guidelines and training for employees on their agency's specific electronic prescribing system that includes:

- How orders are processed and transferred to MAR
- Process to ensure orders for Controlled Medication are in compliance with Federal and State Pharmacy Regulations
- Process to assure the verification of the original order when performing the five rights and rule of three.
- Documentation of administration of medication including scheduled and PRN medication, and refusals

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## **Utilizing Prescription Drug Samples**

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At times, a child may receive sample packages of medication from his or her licensed practitioner. In order for these samples to be administered to the child, the following are required:

- A written licensed practitioner's order or prescription must accompany any medication including samples.
- Individual packages of medication must be labeled with the following:
  - a. Drug name
  - b. Concentration of medication
- The container in which the drug samples will be stored must be labeled by the prescribing licensed practitioner with the following information that corresponds with the practitioner's written order:
  - a. Child's name
  - b. Drug name
  - c. Dose to be administered (including number of pills, etc. to administer)

- d. Time of administration
  - e. Route of administration
  - f. Signature of the prescribing practitioner.
- The sample packs of medication may then be placed into the labeled envelope or pill bottle.
  - When the medication is to be administered, the envelope/bottle's label must be compared to the order and MAR, then the name of the drug and concentration on the individual packages are to be compared to the order and MAR before administering.

CMCU approval is necessary for psychotropic medications prescribed to children for whom DCF is the legal guardian.

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### **Storage of Prescription Drug Samples**

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All medication ordered and administered must be labeled according to the DCF regulations stated on page 27 of this handbook. Only medication that is prescribed and labeled correctly may be accessible to DCF Med Certified staff. Any prescription drug samples not in use and not labeled for a specific child must be stored in an area that is locked and accessible only to Licensed Practitioners or Pharmacists. Any controlled medication must be stored according to the DCF Policy for storage of controlled medication located on page 36.

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### **Stock Medication**

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The use of stock medications purchased by the facility and available for use by all clients, are acceptable for medications that are administered on an as needed basis providing there is a valid order from a Licensed Practitioner. Because these stock supplies will not have an individual pharmacy label for a specific youth, the agency must have written guidelines for verifying the five rights and rule of three when administering these medications. In addition the guidelines should include:

- Where stock medications will be safely and securely stored
- Process for routinely checking the expiration date (at least monthly)
- Process for regularly checking that there is an adequate supply of medication
- Process for reordering stock medications, including who is responsible for maintaining the supply
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Documentation of the administration of medication should be in accordance with the rules of documentation in this guide.

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## Medication Administration Records (MARs)

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### General Rules of Documentation on the Medication Administration Record

1. Use permanent ink pens. Do not document in pencil or erasable pens. Blue or black ink is preferred for medical and medication documentation.
  2. Write legibly.
  3. Use only approved abbreviations. Please refer to the appendix for a list of currently approved abbreviations in medication administration.
  4. Do not attempt to obliterate a documentation mistake. Do not use white-out. If you make a mistake in documentation, draw a single line through the mistake, write your initials and date above it.
  5. Note the date and time on all documents.
  6. Sign all documentation with full name and title.
    - a. The only exception to this is on the MAR where initials are used to indicate that medication was administered at a specific time.
    - b. MAR documentation must include an area where staff may identify their initials with their full name.
- Every child must have his or her own individual MAR(s).
  - All new medication orders must be reviewed and co-signed by a second med certified staff or licensed staff. If there is not a second med certified or licensed staff on at the time the first dose is scheduled to be administered it is the responsibility of the next available med certified or licensed staff to review the order and co-sign the MAR prior to next scheduled dose. As always Registered Nurses are responsible for reviewing all new orders for medication and must also sign the MAR after reviewing the order
  - All MAR's must include following:
    - The Five Rights: the child's name, the drug name and dose, time and route of administration that matches the practitioner's order.
    - The order's start and stop/renewal date.
    - **Co-signatures of Med Certified staff and RN's who have reviewed all new medication orders**
    - Space for staff to identify their initials with their full names.
    - Space for staff to document the date, time, reason and outcome of the administration of PRN medications.
    - Space to note the child's allergies and adverse reactions

- A second identifier (other than the child's name) must be included with the MAR such as date of birth. A photograph of the child must be available for additional safety in identifying the correct child.
- Facilities must have a standard procedure for indicating on MARs:
  - Changes in medication orders
  - Discontinued medication orders
  - Medications to be given for a specific period of time (e.g., an antibiotic ordered for 10 days)
  - How to document a new medication order if MAR had already been initiated
  - Space to document administration of medication including if dose has been missed. Facilities should have standardized way of indicating why medication was missed or not administered (i.e. LOA, refusal)

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## Controlled Medications

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- Controlled medications are those medications that are potentially addictive or abused.
- An inventory of all controlled medications in the facility must be maintained. See section on **Storage and Control** for specific guidelines around documentation requirements for Controlled Medication

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## Prescription Changes

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- When a licensed practitioner makes a change in a child's medication's dosage, time or frequency of administration, a properly labeled supply of medication must be obtained from the pharmacy.
- The old order must be discontinued and a new order must be written
- The order must be taken/sent to the pharmacy for a properly labeled supply of medication

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## Pharmacy Labels

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Only medication that has been legally dispensed and clearly labeled may be administered to children in DCF licensed programs.

- Medication must be labeled by the dispensing pharmacy or licensed practitioner with the Five Rights and match the licensed practitioner's order.\*
- RNs, LPN, and medication certified staff may not dispense medications or label medications.
- The pharmacist may label the medication with additional directions and/or precautions.

\*Definition of Dispensing: Placing a medication into a container and labeling that container for someone else to administer the medication.

## Medication Storage and Control

**Section 17a-145-75 of DCF child caring regulations requires:**

***Medications must be stored so they are accessible only to medication certified and medically licensed staff.***

All medications must be stored in the original container (i.e. bottle, blister pack) received from the pharmacy or licensed practitioner.

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### Medication Keys

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State law and regulation require that medications be locked and only accessible to medication certified staff or licensed medical staff. To ensure the safety of the children in care, the keys to the medication storage areas must be secure.

**At all times**, the medication keys *must* be carried by an identified DCF medication certified staff person or licensed medical person on duty. **ONLY** in the absence of DCF medication certified staff or licensed medical staff may the keys be stored in a secure location that is accessible only to DCF medication certified or licensed medical staff

The person who is carrying the keys has the responsibility to:

- Count the controlled medications with the DCF medication certified person or the licensed medical person who is relinquishing responsibility to him or her for the medications. Count the controlled medications with the DCF medication certified or licensed medical staff person who is taking over responsibility from him or her for medication administration.
- Maintain the security of the medications at all times.
- Carry the medication keys for the duration of the time he or she is responsible for administering medications.
- Medication keys must remain on facility grounds at all times.

***The key to the non-controlled medications must be on a separate key ring from one of the keys for the controlled medications. These keys must be carried separately.***

- Only one set of medication keys is to be available for use on site. For security purposes, any back up keys must be maintained off-site by a member of the senior administration. These keys are used only in the case of extreme emergency when the routine set of keys is unobtainable.
- Under no circumstances is it permissible for any person (nurse or program staff) to obtain and carry their own personal set of medication keys.
- If the staff person with the assigned medication responsibility leaves the program grounds with the keys, he or she must immediately return the keys to the program.
- Only in the absence of DCF medication certified staff or licensed medical staff may the keys be stored in a secure location that is accessible only to DCF medication certified or licensed medical staff.

The facility must have a policy and procedure for storing the medication keys in a secure location when no medication certified or licensed medical staff is on duty. This policy must

explain the circumstances and identify the documentation that must be completed when keys are stored or accessed.

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## **Storage of Non-Controlled Medications**

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Non-controlled medication must be stored in a cabinet or other storage container that is:

- locked and immobile
- accessible only to medication certified or licensed medical staff
- contains only medication and appropriate medical supplies.
- free of clutter and kept clean.
- free of extremes in temperature.

The medication administration certified staff or licensed medical staff person on duty who is responsible for medication administration must carry the medication keys at all times.

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## **Storage of Controlled Medications**

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Controlled medications are considered to be potentially addictive or easily abused. They require additional security measures to ensure children's safety. DCF Medication Administration policy regarding the storage of controlled medication reflects the current best practice outlined by the State of Connecticut Drug Control Laws.

- Controlled medications must be in a locked, immobile storage cabinet or container that holds only controlled medications. This storage container must then be within another locked immobile storage cabinet or container.
- Each storage container must have its own lock that is opened by its own key.
- The keys for the locks must be on separate key rings

The medication certified staff or a licensed medical staff who has the responsibility for medication administration that shift must carry the keys.

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## **Documentation of Controlled Medication:**

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### **Controlled Medication Documentation Terms:**

**Shift count sheet** - document used to record that the controlled medications were counted at the change of shift and/or the transfer of responsibility for medication administration. The date and time that the control medication inventory count was completed is noted and the two staff who performed the inventory count sign that the count is correct: The signature indicates that the actual amount of controlled medication in the controlled medication storage container is the same as the amount noted on the Record of Use or Disposition Sheet.

**Record of Use Sheet or Disposition Sheet** - every controlled medication package must have its own *Record of Use Sheet or Disposition Sheet* that includes the name of the

medication, the amount of medication dispensed, the concentration and the pharmacy controlled medication number. Pharmacies will send such a document with controlled medications. Whenever a controlled medication is administered, the medication certified staff or nurse documents the date, time and amount administered and records the amount of medication remaining in that package.

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### **Controlled Medication Inventory (Controlled Medication Count)**

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- When a controlled medication is administered, the remaining amount of medication must be documented on that medication's disposition sheet or record of use sheet.
- All the controlled medication must be counted each time the responsibility for safeguarding and administering medications is transferred from one DCF medication certified staff person or medically licensed staff person to another.
- Both staff people must count the controlled medications together.
- The documented count is compared to the actual amount on hand for each controlled medication.
- If the documented count and the actual amount match for each controlled medication both staff will sign the shift count sheet and the keys transferred to the person assuming responsibility.
- If the documented amount and the actual amount do not match, the chain of command must be immediately notified and facility policy and DCF reporting guidelines followed.
- Facilities may develop a policy and procedure that allows non-certified staff to witness controlled medication inventory counts in the absence of a second DCF medication certified or licensed medical staff person.
  - Med certified and licensed staff may utilize non-certified staff to be a witness and provide VISUAL VERIFICATION ONLY when doing the controlled drug count.
  - Staff who are not DCF medication certified or medically licensed must not have access to the medication keys or have access to or handle medications.
  - "*Witness Only*" must be written next to the signature of the non-certified staff name.

See "*Reporting a Discrepancy in the Controlled Medications Inventory Count*" for additional information.

- Facilities should develop a policy and procedure on how to identify controlled medications including a list of commonly prescribed controlled drugs.

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### **Reporting a Discrepancy in the Controlled Medications Inventory Count**

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In the event of a discrepancy in the count of controlled medications the following must occur:

- Assure the safety and welfare of the children.
- The staff persons involved must immediately contact the facility chain of command.

- **DCF-2277** Medication Incident Report form must be completed and sent via email or fax to the DCF Risk Management unit within 12 hours of discovering the discrepancy.
  - [DCF.Riskmanagement@ct.gov](mailto:DCF.Riskmanagement@ct.gov) or fax: 860-550-6482
- Send a copy of the incident report to:  
**Drug Control Division of Consumer Protection**  
**165 Capital Avenue, Hartford, CT 06106**  
**860-713-6065**
- Follow facility specific policy and procedure about further required documentation reporting, investigation and corrective actions.

If a DCF medication certified staff person's certification is suspended as a result of the discrepancy, inform the DCF Medication Administration Training Program so that the suspension may be documented in the Training Program database.

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## **Storage of Refrigerated Medications**

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1. Refrigerated medications must be accessible to only DCF medication certified staff or licensed medical staff.
  - If the refrigerator is in a locked room to which only medication certified or licensed medical staff has access the medication refrigerator does not require its own lock.
  - If the refrigerator is in an area to which all staff have access the refrigerator must have a lock. Only medication certified or licensed medical staff may have access to the key for this lock.
  - If refrigerated medications are stored in multi-use refrigerator, the medications must be stored within a locked container permanently attached to the refrigerator. Only medication certified staff or medical staff should have the key for this container.
  - The temperature of the refrigerator must be 36 – 46 degrees F.
  - When refrigerated medications are being stored, the temperature of the refrigerator must be documented every day.
  - The medication refrigerator must be maintained so that it will be immediately operational if needed.

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## **Storage of Internal and External (Topical) Medications**

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Internal medications must be kept separate from External medications:

- Internal medications are kept on a different shelf or in a different cabinet or drawer than the external medications.

OR

- External medications are placed in plastic bins or baskets that are used for external medications only.
- Storage areas for external medications must be labeled, "For External Medications Only".

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## **Storage of Emergency Medications – Epi-Pens and Asthma Rescue Inhaled Medications**

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1. For the purposes of the DCF Medication Administration Handbook, emergency medications are Epi-pen ® auto injectors used for emergency treatment for severe allergic reactions or anaphylaxis and asthma rescue inhaled medications (bronchodilators) that are used to treat a child who is experiencing an asthma attack.
2. Emergency medications must be stored in a secure location where staff can easily access them
3. Pharmacy dispensed emergency medications must be labeled by the pharmacy with the Five Rights.
4. Emergency medications must be stored where they are not accessible to children.
5. Documentation must be completed when an emergency medication has been administered.

## Destruction of Medications

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### Non-Controlled Medications

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- Facilities must have a policy and procedure for the prompt destruction of medications that are no longer needed or have expired.
- These medications must be separated from the routine, daily supply of medications as soon as possible and placed in a secure storage for prompt destruction. Medications removed for destruction must not be used for any other youth.
- Two DCF medication certified staff, two licensed medical staff or one certified and one licensed staff to destroy non-controlled medications.
- A medication destruction log must be maintained that includes the following information for each medication destroyed:
  - Child's name
  - Pharmacy
  - Date prescribed or dispensed
  - Prescriber's name
  - Name and dose of medication
  - Amount destroyed
  - The prescription number
  - Signatures of the two staff (as allowed) who destroyed the medications
  - Date of the destruction.
- Facilities must have a safe and environmentally sound policy and procedure for the destruction of non-controlled medications.
- Refer to the current recommendations from the State of Connecticut Department of Environmental Protection for current direction about methods for the safe destruction of medications: <http://www.ct.gov/dep>
- Contact the dispensing pharmacy for guidelines for destroying inhalers, aerosols and topical medications.
- Never destroy or dispose of vaccines at the facility. Contact local health department or dispensing pharmacy for instructions.
- Non-controlled medications that have been removed from the daily supply must be stored in a locked area that is labeled "*For Destruction*"

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## Controlled Medications:

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- For security and liability reasons, controlled medications that have been discontinued or are otherwise no longer needed must remain in the controlled medication storage container and **counted** in accordance with DCF Medication Administration Guidelines until arrangements are made for their proper destruction.
- Discontinued/expired controlled medications should be separated from the current controlled medications but stored within the controlled medication storage container.
- Immediately contact Drug Control at the Department of Consumer Protection when controlled medications must be destroyed.
- Licensed medical staff and DCF medication certified staff may not destroy controlled medications *except with direct and explicit permission from a State of Connecticut Drug Control Division representative.*
- Contact the Drug Control Division of the State of Connecticut Department of Consumer Protection when controlled medications need to be destroyed.
- Controlled medications that are pending destruction must be stored as any other controlled medication and be counted every shift.
- If specifically directed by a State of Connecticut Drug Control Division representative to destroy a controlled medication, DCF medication certified or licensed medical staff is responsible to provide and maintain copies of any and all documentation required by Drug Control Division. Documentation must include the name of the Drug Control representative who directed staff to destroy the controlled medication.
- Phone number: (860) 713-6065. <http://www.ct.gov/dcp>

## Providing Medication During Facility Sponsored Outings

Facilities must have a policy and procedure about how to safely manage medications for children during facility sponsored outings off grounds. The policy and procedure must at a minimum include the following guidelines:

- The following are acceptable options for providing medication to children during facility sponsored outings:
  - Schedule activities so that medications can be administered before leaving the facility and/or after returning. Medications may be administered one hour before or one hour after the scheduled medication time.
  - Consult with the licensed practitioner as per facility policy about adjusting the medication administration times to accommodate the off-grounds event.
  - The licensed practitioner may change administration times to accommodate the event.
  - Any such direction must be in writing from the licensed practitioner. All contacts must be documented.
  - Properly dispensed medication from the pharmacy.
  - If the pharmacy cannot dispense the medications, the medication certified staff who will be administering medications must be the person who prepares the medication for the trip and must be the person who will document upon return that the medications were administered.
  - Medications must be clearly labeled with child's name, the medication and dose, the route and time of administration.
  - Medication must be kept secure, locked and inaccessible to children and non-med certified staff
  - The medication certified staff responsible for administering the medication on the trip must also be responsible for maintaining the security of the medication during the outing - keys to the medication must be held by the med cert staff at all times.

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### LOA/Visit Medication

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Facilities must develop a policy and procedure for providing medications to children who are preparing for a Leave of Absence.

- The following are guidelines for the development of such procedure:

1. A licensed practitioner or pharmacist must properly dispense medications for visits. **Under no circumstances shall medication certified staff or facility RNs or LPNs dispense LOA medications.**

Definition of *Dispense*: To place a medication into a container and label that container for someone else to administer. The practice of dispensing medications is closely regulated by law and is limited to specific licensed practitioners and pharmacists.

2. The facility supply/blister pack should not be routinely sent home with the exception of the following:
  - Topical medication
  - Inhalers
  - Time limited antibiotics
  - Birth control pills
  - Epi-pens
  - Liquid medications dispensed in such a way that the pharmacy cannot dispense a limited number of doses accurately.

If any facility supply of medications is sent home, it is imperative that the child and/or responsible adult understand that these must be returned with the child to the facility. The facility should have documentation signed by the parents that addresses the following:

- What medication was sent home?
- How the medication is going to be kept secure at home.
- Assurance that the medication will be returned with the child.

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## Controlled Medication

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- Facility supplies of controlled medications must never be sent on visits. Controlled medications must be properly dispensed with the limited amount of medication necessary for the length of the visit.

Methods for obtaining medications for visits include:

- The pharmacy dispenses LOA medications from either the facility stock or as “extra medications”. Pre-authorization from the insurance company may be necessary to ensure payment for these medications.
- The pharmacy may be able to divide the medication into two packages when the medication is initially dispensed. One pack is dispensed for the facility and one pack to take on home visits.
- Licensed practitioner dispenses medications from the child’s facility supply into containers and labels the containers with the Five Rights.
- Licensed practitioner writes an order for a limited supply of medication to be dispensed at the child’s local pharmacy.

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## **Self-Administration of Medications**

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At times it may be appropriate for children or young adults to self-administer medications especially when they are preparing for independent living. Careful consideration must be made to ensure the safety and well-being of all the children and young adults in the program and to allow for adequate staff supervision of self-administration. Facilities that allow self-administration of medication must have a written policy and procedure regarding self-administration that has been approved by DCF. Facility policy may prohibit self-administration.

Self-Administration Policy must at the minimum include the following requirements:

- The licensed practitioner must write a specific order for a child or young adult to self-administer and/or carry medications.
- Documentation of all self-administered medications must be maintained including current licensed practitioner's orders, MARs and pharmacy prepared labels.
- All medications that are self-administered must be properly dispensed and labeled by a licensed pharmacist or licensed medical practitioner.
- The safety of all the children in a facility must be maintained.
- Medication must be kept inaccessible to other clients but be accessible to medication certified staff and licensed medical staff.
- Self-administration must be suspended at any time safety is compromised.
- Topical medications containing alcohol are not appropriate for self-administration and should be stored in a locked area accessible to staff only.
- Facilities that allow self-administration must develop an educational program in conjunction with a licensed practitioner to provide the children with information about their medication including:
  - reason for taking medication, side effects to report, identification of medication
  - proper administration technique. This should include the child giving return demonstration
  - contact information if questions or concerns arise.
  - how to get prescriptions renewed.

All education provided must be documented.

## Emergency Medications

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### Emergency Inhalers and Epi-Pen Auto Injectors/NARCAN

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Facilities are to develop policy and procedure that allow for immediate availability for emergency medications, specifically asthma emergency medications and epi-pens used to treat serious allergic reactions.

1. All facility staff with possible child-caring responsibilities and regardless of whether they are medication certified must be trained to administer epinephrine (Epi-pen auto injectors) and inhalers in the event of an emergency.
2. A licensed medical professional must provide the training and personally assess the competency of individuals to administer emergency medications.
3. Documentation shall be maintained listing staff who have been successfully trained and deemed competent to administer Epi-pens and emergency inhalers.
4. Facilities must ensure that an adequate number of trained staff are available to provide emergency treatment with Epi-pens and/or inhalers on all shifts and outings.
5. Whenever appropriate, children should be taught to properly self-administer these emergency medications. The prescribing practitioner may write orders to allow responsible children to "self-administer" and "self-carry" these medications. The safety of the individual child and the rest of the children must be considered.
6. Emergency inhalers and Epi-pens must be stored in a secure location which is easily and quickly accessible by staff but inaccessible to children.
7. Facilities must have an annual plan for Epi-pen and emergency inhaler training.
8. Documentation must be completed when an emergency medication has been administered. Facility policy and procedure must outline how this documentation is to be done.

## The DCF Medication Administration Training Program

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### Eligibility for Certification

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- Participants must be employed by a DCF licensed or operated child caring facility or extended day treatment center.
- Participants must be recommended by their facility director or designee as indicated by a completed, signed course recommendation form.
- Participants must have a high school diploma or equivalent; in the absence of a diploma or equivalent, the director of the employing facility must approve the person's eligibility. A copy of this approval must be placed in the employees file and available upon request.
- Participants must be capable of reading and understanding complex information and be able to perform basic math calculations

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### Endorsed Instructor

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The DCF Medication Administration Training Course can only be taught by a certified Endorsed Instructor. Licensed nurses (LPNs, RNs, and APRNs), pharmacists, or physicians who have completed the Endorsed Instructor Training Program and have been approved by DCF may teach the DCF med admin certification course at their employing facility or a contracted DCF licensed facility. The Endorsed Instructor training is offered periodically through the year on an as-needed basis by the DCF Medication Training Program. Announcements of upcoming EI training classes are sent via email to nurses and program directors.

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### Endorsed Instructor Training

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Endorsed Instructor (EI) training is a one day training for nurses and other medical professionals allowed by Connecticut law to become instructors for the Medication Certification training. The training includes:

- Adult Learning Principles
- Effective presentation and training skills
- Overview of the Learning Objectives and Skills Verification of the Basic Certification Course
- Practice and a return presentation of training skills (practicum)

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### Basic Medication Administration Training Course Components

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Four Steps of DCF Medication Certification Process

#### Step One

Recommendation by Congregate Care Program's Program Director or Designee (On-line *password protected* recommendation form)

#### Information required for recommendation

Employee's legal name (no nicknames allowed)  
Employee's email address  
Employing Facility  
Name of Supervisor recommending employee for certification

### Step Two

Successful completion of DCF Basic Medication Certification Course which consists of Course/curriculum and Skills Verification

- **Course/curriculum – 10 Units**
  - Basics for Safe Medication Administration
  - Medication Terminology
  - Know the Medication
  - Medication Administration Documentation
  - Math for Medication Administration
  - Asthma
  - Medications to Treat Medical and Psychiatric Conditions
  - Safe Storage and Control
  - Medication Errors
  - Medication Administration Techniques
- Students must pass quizzes at the end of each unit (100%) and a Cumulative **Mandatory** quiz at the end (pass at 85%) to move to Skill Verification
- **Skills Verification (see description below)** completed and verified by DCF Endorsed Instructor

### Step Three

Successful passing of Medication Certification Exam (85%) All tests proctored by DCF at Central Office Training Academy

### Step Four

Successful Internship at employing facility

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## **Approved Methods Employees to Receive the Course/Curriculum**

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- **In-person** with an Endorsed Instructor. Includes teaching the class using the approved curriculum and training materials and conducting the **DCF-2274 DCF Medication Administration Program Skills Verification** (see below for description)
  - EI's are provided with all training materials necessary for teaching the class
    - PowerPoint Presentation
    - Copies of Quizzes to administer (with answer keys)
    - Hard copies of the Skills Verification
  - Endorsed Instructors who decide to teach the class in person with their employees will be responsible for:
    - Arranging the location
    - Communicating with DCF regarding results of training and skills verification
    - Communicating with employees requirements of the certification process
- **Combination** of on-line training (see below) and in-person Skills Verification.
  - Self-directed on-line learning of Basic Medication Administration Curriculum

- Skills Verification completed by Endorsed Instructor (see below for description)

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## Online Training Format

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The on-line format is a self-directed training that can be completed on a computer, smart phone and other electronic devices. There are securities put in place to assure completion of the entire online course – one must pass the unit quizzes in order to proceed to the subsequent units. Only after completion of the entire on-line course an employee will be eligible for the skills verification. Employees must provide proof of successful completion of the on-line course before advancing to the Skills Verification Portion. – These verifications can be;

- A printed certificate of course completion (this is not the medication administration certificate; an employee cannot administer medications yet)
- A screenshot of the certificate of course completion
- An automatically generated email of course completion

**Under no circumstances an employee can start the Skills Verification based on a verbal guarantee of course completion from the employee or the employee’s supervisor/program manager.**

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## DCF Medication Administration Program Skills Verification

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Only nurses who are endorsed by the DCF med admin program are eligible to provide the Skills Verification; programs without an Endorsed Instructor (EI) should contact the Med Admin Program for options to complete the practicum.

The practicum includes the following:

At a minimum the practicum must include the following:

1. Opportunity for review of material covered in the Medication Administration Course (Optional based on student need)
2. Demonstration of skills by the EI: (required)
  - 5 Rights and Rule of Three
  - Steps of the Medication Administration Procedure
  - Techniques taught in the Medication Administration Training Course Curriculum
3. Opportunity for employees to practice demonstrated skills (required)
4. Successful “return presentation” of all listed techniques by student/employee (required)

Upon successful completion of the skills verification both, the nurse and the student/employee must sign and date the **DCF-2274**, *DCF Medication Administration Program Skills Verification Form*. This form must be then placed in the employee’s training file and made available to the DCF regulatory/nurse consultants upon request.

In addition, the Endorsed Instructor must submit the online **DCF-2274** to DCF Medication Administration Program. This online form is located on the DCF medication Administration Program Website and provides a confirmation to the DCF Medication Administration Program that the employee successfully completed the practicum.

**Once submitted, the employee becomes eligible for the exam.**

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## **DCF Written Exam**

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### Registering for Exam

- Employees are not eligible for a medication administration certification exam until they have received confirmation from their facility nurse that they have successfully completed their practicum.
- Upon receiving notification employees must consult their direct supervisor to determine a testing date that meets the need of the facility and the employee
- Employees or their supervisor register for the exam using the on-line registration system
- If any cancellations or changes must be made to the exam registration employee or their supervisor must contact the DCF Medication Administration Program
- If DCF needs to cancel or change an existing exam (for a non-weather related event) an email notification will go out to all employees registered. For weather related events see *DCF Inclement Weather Policy (link)*

All exams are proctored at the DCF Training Academy, Central Office, Hartford CT.

A score of 85% or better is required to pass. Employees who passed the exam cannot start the internship until the results notification from the Med Admin Program is received by the program supervisor.

Exam venue driving, parking and sign-in directions are attached to the exam confirmation email.

All visitors to the DCF Central Office are expected to follow professional conduct policy that includes appropriate dress code and behaviors.

- Employee who exhibit hostile, angry and/or aggressive behaviors to any person on site will be turned away.
- Anyone suspected of being under influence of alcohol/drugs will be asked to leave.
- We reserve the right to turn away anyone who's dressed inappropriately, for example:
  - any clothing with lewd graphics and/or language is considered inappropriate
  - tight, form-fitting, see-through, low-cut or too short
  - apparel that is considered inappropriate

**Employees are expected to arrive on time. No admits after posted time of exam.**

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## **Facility Internship**

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Upon successful completion of steps 1, 2 and 3 participants must complete an internship. This step is performed under the supervision of the facility director (or designee) and a program nurse. The purpose of the internship is to provide the participants with the opportunity to practice and apply the skills learned in the Medication Administration course in their own work setting. It also allows them to strengthen those skills and gain the confidence

they need to competently and safely administer medications. The facility will provide the staff adequate time to complete this internship.

### Requirements of the Internship

1. A thorough orientation to facility medication policy and procedure.
2. Observation of experienced medication certified staff or program nurse during at least two complete medication passes
3. The program nurse will determine if the candidate may progress to the next step of the internship; complete the steps of the med admin checklist
  - For the purposes of the internship, *a complete medication pass* refers to the time period during which medications are routinely administered to all the children at a given medication pass - preferably a medication pass that the medication certified staff will routinely be conducting after they become certified. For example: If, when the employee becomes certified, he/she will be responsible for 7:00 am medication passes, the internship shadowing experiences should be for an entire 7:00 medication pass and include all the children receiving medication during that pass.
4. Performing two complete medications passes with direct, immediate supervision by the program nurse or an experienced medication certified staff person. The medication passes must be documented on the **DCF 2275 – DCF Medication Administration Program Procedure Checklist**.
5. The internship must be successfully completed within 90-days of passing the written exam.
  - a. **Candidates who do not successfully complete the internship within the 90-day timeframe must re-take the entire Medication Administration training and pass the written exam before attempting the internship again.**
6. Successful completion of the Internship is indicated by the signatures of the candidate, the program nurse and the program director on the Internship Verification Form. Incomplete forms will not be accepted
7. Internship must be documented on the **DCF-2276 DCF Medication Administration Program Facility and Internship Objectives and Criteria** form. This form is located on the DCF Website.
8. All training related documentation must be kept in the employee's file and made available upon request.

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### **Awarding of Medication Administration Certificate**

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Upon receipt of the Internship Verification Form the DCF med admin certificate will be issued and emailed to one, designated person in the employee's program. Program managers/supervisors are responsible for making copies of the certificate for the personnel file and for giving the certificate immediately to the employee. **No employee is allowed to administer medications until in possession of the med admin certificate.**

**DCF Medication Administration Program will not replace any lost certificates**

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**Recertification**

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Recertification for medication administration is required every two years. Medication certified staff currently employed at a DCF licensed or operated child caring facility *and* whose certification is in good standing may recertify. Staff may recertify any time before or, on the certificates expiration date.

All recertification eligible employees must be recommended by the facility program director/designee before testing. This recommendation can be found on the DCF medication Administration Website.

- Staff whose DCF Medication Certification is under suspension may not recertify until the suspension is lifted. If the certificate expires while under suspension, the employee is no longer medication certified and must retake and pass the entire Medication Administration Training.
  - **Employees** are expected to prepare themselves for the recertification exam. Materials are available on the DCF Medication Administration webpage. Endorsed instructors and supervising nurses are encouraged to offer comprehensive reviews for their staff needing recertification.

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**Recertification Exam**

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All tests are proctored at the DCF Training Academy, Central Office, Hartford CT. Employees who are eligible to test must register online for the test of their choice. A link to the registration can be found on the DCF Medication Administration Website

A score of 85% or better is required to pass. A new certificate effective for two years will be issued to those who pass the Recertification exam. The original certificate is to be given to the staff person after copies are made for facility records.

**Failing a Recertification Exam or allowing certificate to expire:**

A DCF Medication Certified staff person who fails the Recertification Exam or who allows his or her DCF Medication Certification to expire is no longer certified as of the date of expiration or failure of recertification exam and may not administer medication.

Employee must go through the entire Medication Administration Certification Training if they wish to become medication certified.

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## **New Employees with Current DCF Medication Administration Certification**

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If a newly hired employee presents a DCF Medication Administration certificate, the facility **MUST** verify the status of that certificate, and provide a thorough orientation to the facility's medication administration policies and procedures before the new employee is permitted to administer medications independently.

Facility Responsibilities:

- Obtain a copy of the employee's current DCF Medication Administration Certificate for facility records.
- Contact the Medication Administration Program to verify the status of the certificate. Written confirmation of the employee's certification status is available from the DCF Medication Program.
- Conduct an internship.
- Maintain documentation at the facility of the orientation and internship. Do not send this documentation to the DCF Medication Administration Training Program.

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## **Special Accommodations**

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The Department of Children and Families recognizes its legal obligation to meet the learning needs of medication certification candidates who have disabilities including documented learning disabilities or special needs. Participants requesting special accommodations must submit to the Medication Administration Training program appropriate documentation as required by law. Training program representatives will consult with DCF specialists in the requirements and applicable laws regarding the American's with Disabilities Act.

Submit requests and documentation as soon as possible so that timely responses can be made.

For further details and information please refer to the following statutes:

Section 504 of the Rehabilitation Act of 1973.

42 U.S.C. Section 12101 et seq. of the Americans with Disabilities Act of 1990.

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## **Mandatory and Continuing Education**

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DCF regulation requires the facility licensed medical professional (RN, LPN, APRN, PA or MD) to provide specific training for both non-certified and DCF Medication certified staff.

### **Mandatory Training for All Staff**

- Annual Emergency Medication Administration - Epi-pens and Asthma Rescue Medication.
  - This training must be provided at least annually and whenever necessary to maintain a safe environment for children.

### **Continuing Education for Medication Certified Staff**

***DCF Reg: 17a-145-75 (d): "There shall be periodic reviews and updating of staff's knowledge about medications and other treatments and their administration."***

***DCF Reg: 17a-6(g) -16 (c): "Day programs and residential facilities shall provide continuing education on administration of medication to trained person staff members."***

Facility nurses and/or appropriate personnel must offer continuing education opportunities for DCF medication certified staff. The facility nurse must document on a quarterly basis all continued education opportunities offered in the past 3 months. See Forms section for suggested form to document quarterly offerings.

DCF Medication Certified staff has an obligation to maintain their skills and knowledge in safe medication administration and are expected to attend facility sponsored continuing education offerings whenever possible.

Facilities must maintain documentation and attendance of trainings.

- Quarterly trainings should be related to safe medication administration and should include (but are not limited to):
  - Properly accessing the chain of command and when to do so
  - Correct medication administration procedure
  - Proper documentation
  - Medication administration techniques
  - Updates in practice including new medications
  - Ordering and receiving medications from the pharmacy
  - Storage and documentation of controlled medications
  - Specific areas identified by Risk Management and/or quality assurance reviews.

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## **Training for Program Supervisors and Managers**

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There is a mandatory training for Supervisor and Managers of Licensed Child Caring/Congregate Care Facilities. This is available as an online training and consists of:

- Overview of Medication Certification Process
- Program Responsibilities
- Supervisory Responsibilities
- Contact Information

## Disciplinary Action for Performance Issues in Medication Administration

Facilities must adopt written policies and procedures including disciplinary actions in the event that the performance of a medication administration certified staff puts children and youth at risk.

- Medication certified staff should be informed during orientation of the facility policy and procedure in regard to disciplinary actions in the event of medication incidents
- The safety and well-being of the children and youth must always be the first consideration in determining corrective action.
- **The facility nurse and or director may suspend an individual's medication certificate whenever there is a concern over the safety and welfare of the children.**
  - Any suspension must be reported promptly to Medication Administration Program.
  - Revocation of an individual's certificate may be ordered by the Commissioner of DCF and/or his or her designee.

Circumstances to be considered in determining corrective action can include:

- Impact on child safety
- Facility policies
- Individual's record related to medication administration
- Extenuating circumstances

## Medication Error Reporting

Agency policies regarding medication administration errors shall include:

1. the mechanism for reporting to supervising nurse or physician and other designated individuals;
2. procedures for obtaining treatment for involved client;
3. corrective action to be taken if three (3) errors are made within 30 days
4. the method for tracking employees' errors and corrective actions taken, from the employee's date of certification to his or her annual certification evaluation and biennial recertification.

Documentation of Medication Administration Errors

- The staff involved must complete a **DCF-2277 Medication Incident Report** by the end of the shift on which the error occurred or was discovered. The staff person involved must also write in the child's record an objective description of the event including the child's condition and any treatment.
- Addendums to this report should be made as warranted to provide a complete record of the event and its outcome.
- Incident reports are to be kept in a quality assurance file, not in the child's personal or medical record.
- The *Medication Error/Incident Report* must be sent to DCF Risk Management within 12 hours of the event.
  - Risk Management Fax: 1 860 550 6482
  - Risk Management Email: [DCF.Riskmanagement@ct.gov](mailto:DCF.Riskmanagement@ct.gov)

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### DCF Reporting Guidelines for Medication Errors

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The DCF licensed child caring or day program shall adopt a written policy which specifies the procedure for reporting errors in medication administration. The policy shall require that any medication error be reported immediately to the supervising nurse or prescribing physician. Policy shall also specify the procedures to be followed if medical treatment is required due to the error. Facility policy must also describe the corrective procedures to be followed if a medication certified staff person makes more than three (3) medication administration errors in a one-month period. These policies shall be approved by DCF.

## Discussion

Agencies shall develop policies and procedures which specify personnel actions to be taken in addressing errors in medication administration in the following classes:

### **Class A - Documentation, security and supply errors**

- Failure to document according to procedures
- Failure to secure/maintain keys according to established procedures
- Failure to submit required documentation relative to medication errors
- Failure to order/document all medications ordered from pharmacy
- Failure to follow procedures to maintain an adequate supply of medications and required documentation

### **Class B - Violation of the Five Rights or use of prohibited techniques:**

A **Class B** error has occurred if any of the following has been violated:

- Correct person
- Correct medication
- Correct dose
- Correct time
- Correct route

### **Class B Errors also include:**

- Use of prohibited techniques such as but not limited to medication certified staff accepting telephone or verbal medication orders, improper storage or destruction of medications, etc.
- Transcription errors resulting in the violation of one of the five rights.

### **Class C - Serious Errors**

- Errors resulting in death or serious injury to client, e.g. hospitalization, injury requiring treatment in a medical facility such as ER, clinic, or physician's office
- Errors resulting in the need for medical monitoring.
- Errors resulting in the need to adjust or change medications, doses or times of administration.

#### **Prohibited practices such as but not limited to:**

- Falsification of medication administration records
- Falsification of certification paperwork
- Administration of medications without a valid medication certificate (e.g., certificate was suspended, revoked, expired, etc.)

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## **Documentation and Reporting Medication Administration Errors:**

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1. Any error in the administration of medication shall be documented in the client's record and an incident report completed by the end of the shift during which the error was discovered or occurred.

2. Class A errors are reported via the DCF Monthly Medication Administration Summary reports sent to DCF Risk Management (see Forms Section of the Handbook or the DCF Webpage)
3. The following errors require that a DCF Significant Event Report Form be filed with the DCF Risk Management unit within 12 hours of the event or its discovery:
  - a. Any medication error requiring a 911 call and the need for emergency medical treatment.
  - b. Any medication error resulting in the death of a child
4. Class B or C must be reported to the DCF Risk Management Unit:
  - Call the DCF Risk Management Unit at (860)560-7095.
  - Email the completed Significant Event Report form to DCF Risk Management ([DCF.RiskManagement@ct.gov](mailto:DCF.RiskManagement@ct.gov)) within 12 hours.
  - Fax related incident reports to DCF Risk Management (860)550-6482.
  - The child's social worker and legal guardian (if after hours, contact the DCF Hotline at 1-800-842-2288) must be notified. If appropriate the child's parent(s) should be contacted.
  - Suspected abuse/neglect must be reported the DCF Hotline - 1-800-842-2288.
  - Errors resulting in serious injury or death (Class C Errors) must be immediately reported to the DCF Medical Director and to the DCF Risk Management Unit.
  - A thorough review of the event must be made and the facility's corrective action plan is to be forwarded to DCF Risk Management Unit within one week of the incident.
  - Facility director or nurse must immediately suspend the medication certification of staff people involved in a Class C Medication Error pending final evaluation and resolution of the event in question.

Report any suspended certifications to the DCF Medication Administration Program.

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### **Corrective Action for Medication Certified Staff Involved in Medication Errors**

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Facilities must have policy and procedures that describe the corrective action plan for medication certified staff who are involved in medication errors.

Considerations in determining corrective action:

- a. The impact the error made on the children's safety.
- b. The individual's performance record related to medication administration.
- c. Any contributing circumstances.

Medication certification must be immediately suspended for any staff person involved in a Class C medication error pending the results of the investigation.

The DCF Medication Administration Training Program must be notified immediately of any suspensions, and when suspensions are lifted.

Corrective action plans should include:

Explanation of Class A, Class B and Class C errors.

1. How the corrective action plan will be determined and implemented
2. Re-training plan appropriate to the level of error.
3. The expected performance outcome and/or skill to be demonstrated by the medication certified staff before certification can be expected to be reinstated.
4. The time frame of the re-training.
5. Ramifications if the expected performance outcomes are not met within the time-frame.
6. A review of the corrective action should be part of the internship orientation for medication certification candidates and of the annual onsite supervision by the program nurse