Section: Crisis/Emergency Services
Policy: Emergency/Crisis Contact Summaries
Policy No: CES 01
Effective: 12/19/1994
Revised/Approved: 06/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) that staff members will complete an emergency services report for all emergency contacts.

PURPOSE: To ensure that services provided to people on an emergency basis are documented appropriately and maintained in the medical record for people receiving services.

PROCEDURE: A Crisis Contact Summary as described in the DMH Record Guide will be completed by the staff member responding to a crisis/emergency situation, whether he/she is a Primary or Secondary Emergency On-Call staff member, an M-CeRT team member, or any service provider providing crisis response service.

The Crisis Contact Summary will contain identification of people involved in the emergency/crisis, time and date contact was made, type of contact (face-to-face and/or telephone contact), the location of the contact (if face-to-face), presenting needs, initial behavioral observations, and actions taken by responding staff. In addition, disposition or resolution of the emergency/crisis which will include the condition of the person(s) at the conclusion of the contact and services to which the person and/or family was referred. If warranted, documentation of notification and involvement of significant others should be included. If contact is warranted but not provided, indication of why there was no notification should be reflected. The name and credentials of staff member(s) addressing the emergency/crisis and completing the Crisis Contact Summary will also be included.

If the person who is in an emergency/crisis situation is a recipient of services at CCS, the staff member completing the Crisis Summary Report will submit documentation for inclusion in the medical record and notify a member of the person's treatment team so follow-up contact/support can be arranged. If the person is not a recipient of CCS and the call was addressed by the On-Call staff member assigned, the Crisis Contact Summary forms should be sent to the HR Department, where they will be reviewed and copies of appropriate reports forwarded to the Executive Director. The HR Department will maintain a file of all Crisis Contact Summaries completed by staff serving as Primary/Secondary On-Call. If a member of the M-CeRT team responded to the call, the Crisis Contact Summary will be sent to the M-CeRT Coordinator, who will review them and will forward copies of appropriate reports to the Executive Director. The M-CeRT Coordinator will maintain a file of all Crisis Contact Summaries for the M-CeRT team. Information from all staff providing crisis services will be collected monthly by the M-CeRT Coordinator for submission to DMH as required.

Mississippi DMH Operational Standards addressed: Rule 19.2

Section: Crisis/Emergency Services
Policy: Emergency Services
Policy No: CES 02
Effective: 3/1/1980
Revised/Approved: 06/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) that professional crisis response/intervention services shall be available to the entire region (both CCS clients and non-CCS clients) on a twenty-four (24) hour-a-day, seven (7)-day-a-week basis. These services will be provided through our Crisis/Emergency Hotline and Mobile Crisis Response Teams (M-CeRTs). Two teams will be established, one covering the Eastern and one covering the Western counties served by CCS. The M-CeRT Team (Eastern) will serve Clay, Lowndes, and Noxubee counties. The M-CeRT Team (Western) will serve Oktibbeha, Webster, Choctaw, and Winston counties. Crisis/Emergency services are available in every county served by CCS.

PURPOSE: To ensure that all people needing emergency/crisis services are able to access them in an effective and timely fashion.

PROCEDURE:
General Information
A mental health crisis can be defined as behavioral, emotional, or psychiatric distress in which the person perceives a sudden loss of his/her ability to use effective problem solving and coping skills. These services are provided to children and adults who are experiencing a significant mental health crisis and in the opinion of the mental health professional assessing the situation, the person's mental health and/or behavioral needs exceed the person's resources. All staff delivering emergency services will receive necessary training to ensure essential skills are available to adequately triage and make appropriate clinical disposition decisions, including the capability to access the need for inpatient services or identify less restrictive alternatives.

CCS maintains a Memorandum of Understanding (MOU) with other Crisis Stabilization Units (CSUs) throughout the state. This MOU defines the working relationship between Regions and their respective CSUs. This agreement will clarify the collaborative roles and responsibilities of each Region with respect to admission, discharge, treatment and referrals within the statewide network of CSUs. Through this MOU, each Region agrees to accept referrals and admit individuals to their respective CSU who live in another Regions' catchment areas. In addition, CCS attempts to secure agreements with licensed hospitals within its catchment area to ensure emergency room availability (when deemed appropriate) to people within a reasonable period of time. Through its Crisis Response Services, CCS will make available face-to-face contact (if warranted) with a mental health professional, including specifically the availability of mental health professionals to provide consultation in the care of people admitted to the hospital for medical treatment of suicide attempts or other psychiatric emergencies, as well as, offering training of emergency room staff members in handling mental health emergencies

Both telephone crisis intervention and face-to-face crisis intervention are provided in the following ways:

During the Business Day: (8:00 a.m. - 5:00 p.m., Monday - Friday)
People can contact the crisis hotline at 1-888-943-3022 or walk in to any CCS office. The hotline number is posted on the CCS website (www.ccsms.org), recorded on office answering machines, as well as, local phone books and promotional materials. The M-CeRT Coordinator will be issued a cell phone in order to receive calls made to the crisis hotline during the business day. Emergencies may also be identified through referral from other agencies or from people who walk in to any CCS office. If a person calls the crisis hotline, it will be the responsibility of the M-CeRT Coordinator to assess the given situation and if determined to be a "crisis situation" as defined above, will utilize an assessment tool as required by the Department of Mental Health (DMH) in order to determine the individual's risk. Areas assessed will include, but not be limited to, suicide/homicidal ideation, substance abuse history/current use, mental status, current/past mental health diagnoses and treatment, coping skills, medical conditions, and available resources/support systems. If after assessing the situation over the phone, it is determined that a face-to-face contact is deemed appropriate, members of the respective M-CeRT teams (Eastern/Western) will be contacted. If the person receives services at CCS, the M-CeRT Coordinator will reach out to a member of the person's treatment team to assist in the response since he/she will have first-hand knowledge and an established relationship as the primary treatment provider. If a person walks in to a CCS office or calls the front desk of a CCS office and the Office Manager determines it is potentially a crisis situation, the Office Manager will be responsible to contact the County Administrator who will assess the situation and coordinate response/support from clinicians/team members in the county office. If the County Administrator determines additional support and resources are needed, he/she will contact the M-CeRT Coordinator for assistance.

People must be seen within one (1) hour of initial time of contact in urban settings and within two (2) hours of initial time of contact if in a rural setting. Based on data from the USDA, all counties served by CCS are categorized as rural. Every emergency contact, whether telephone or face-to-face, shall be documented by the clinical service provider handling the emergency. Documentation is provided by completing the Crisis Contact Summary. Submission of the report will follow the procedure outlined in ES 01: Emergency/Crisis Contact Summaries.

After the Close of the Business Day: Weekends and Holidays
Emergency mental health services are provided when deemed necessary to the entire service area whenever the offices of CCS are closed. It is anticipated that by providing immediate services, many persons who may otherwise be handled through other community institutions may more appropriately be helped by mental health professionals. In addition, immediate consultation and education services to other community agencies (police, health and human services, clergy, etc.) will be available through Crisis/Emergency Services. The person desiring emergency/crisis services will only have to make one (1) telephone call to reach an individual trained to triage the situation.

People can contact the emergency/crisis hotline at 1-888-943-3022. This number is posted on the CCS website (www.ccsms.org), recorded on office answering machines, as well as, local phone books and promotional materials. An after-hours rotation will be maintained with a staff member scheduled for either primary or secondary duty. Should the primary emergency on-call staff member not be able for some reason to answer the

emergency on-call cellular telephone, the call is automatically sent to the emergency on-call cellular telephone of the staff member on secondary emergency on-call duty, who will handle/assess the situation. All individuals scheduled to be on the on-call rotation, will attend an emergency on-call training, with accompanying training/resources materials on telephone crisis intervention, as well as, identifying community resources. It will be the responsibility of the staff member on-call to assess the given situation. If determined to be a crisis situation as defined above, the staff member responding to the call will utilize an assessment tool required by the DMH in order to determine the person's risk. Areas assessed will include, but not be limited to suicide/homicidal ideation, substance abuse history/current use, mental status, current/past mental health diagnoses and treatment, coping skills, medical conditions, and available resources/support systems. If after assessing the situation over the phone, it is determined that a face-to-face contact is deemed appropriate, The M-CeRT Coordinator will be contacted so members of the respective M-CeRTs (Eastern/Western) can be dispatched. Persons must be seen within one (1) hour of initial time of contact in urban settings and within two (2) hours of initial time of contact if in a rural setting. Based on data from the USDA, all counties served by CCS are categorized as rural. Every emergency contact, whether telephone or face-to-face, shall be documented by the clinical service provider handling the emergency. Documentation is provided by completing the Crisis Contact Summary. Submission of the report will follow the procedure outlined in ES 01: Emergency/Crisis Contact Summaries.

Emergency On-Call:

Procedures utilized for Emergency On-Call primary or secondary duty: Eligibility for On-Call Duty: The responsibility for providing after-hours on-call duty shall be a part of the job description of full-time employees of CCS that have a Bachelors or Master's degree, are clinically competent/qualified to perform Emergency On-Call responsibilities, individuals whose work hours are generally during the day, and individuals who have no after-hour supervisory responsibilities. In addition to the items identified above, the individual must successfully complete the emergency on-call training class. For those employees holding less than a Master's Degree, they must be employed by the agency for a minimum of six months prior to be placed on the Emergency On-Call roster.

Emergency On-Call Training: Training for those individuals eligible for emergency on-call duty, as well as, M-CeRT team members, shall be conducted in compliance with DMH minimum standards for training. Training shall be conducted according to the established curriculum, which shall include, but is not limited to, a) an overview of CCS' Policy and Procedure for Crisis Response, b) description of how the after-hours emergency system works, c) dealing with emergencies by telephone, d) dealing with callers who are experiencing psychotic episodes, f) dealing with callers who are suicidal, g) referral sources and techniques, and h) procedures for pre-evaluation screening and civil commitment. Should any individual not successfully complete the training class, the matter shall be brought to the attention of the employee's supervisor. An individualized corrective action plan will be developed by the supervisor and the Emergency-On-Call instructor. After implementation of this plan, the individual will be required to complete whatever areas he/she did not pass. The HR Department shall maintain a list of all eligible staff members who have successfully completed the training class for incorporation into the Emergency On-Call roster. In addition, all staff will be

trained in Crisis Prevention Intervention (CPI). M-CeRT Team members will receive additional training as identified below under training of M-CeRT team members.

Assignment: After-hours Emergency On-Call Duty shall be from 5:00 p.m. Wednesday - 5:00 p.m. the next Wednesday. The emergency-on-call roster shall be prepared and maintained by the HR Department, and shall cover a period of no less than six (6) months. The roster shall be prepared no less than thirty (30) days before its implementation from the list of those individuals who have successfully completed the emergency-on-call training class. Assignment to the roster is considered to be binding. Once assigned to the roster, individuals may be excused only for serious personal emergencies. Individuals may trade assignments, with the agreement of both individuals involved and notification of the HR Department.

Publication of the Roster: The HR Department shall provide copies of the roster, including the home telephone numbers of all individuals on the roster, no less than fifteen (15) days prior to its implementation. When changes are made to the roster, the HR Department will notify appropriate individuals. When vacancies occur in the roster due to emergency, illness, extended leave or termination, the HR Department shall fill the vacancy with an individual on the list of those who have successfully completed the training but who have not yet been incorporated into the roster. Should there be no such individual, the person whose name is on the end of the roster shall be moved to fill the vacancy.

Expectations: Individuals assigned to both primary and secondary duty are expected to notify the HR Department immediately if the On-Call Notebook and cellular telephone are not received as scheduled, test the cellular telephone when received to verify that it is operating correctly (if not, contact the HR Department immediately), and be available to provide direct telephone contact to callers. The emergency on-call cellular telephone and notebook shall be with the staff member during all non-business hours, seven days a week, during the assigned rotation. Specifically, responsibilities include provide/arrange any necessary services, answer the emergency on- call cellular telephone at all times**,** and triage all calls to identify appropriate level of intervention/response. For individuals whose crisis is resolved over the telephone, the staff member on-call shall offer to arrange an appointment for the following day. If the caller is a CCS client, efforts will be made to schedule the appointment with his/her therapist. When the issue is unable to be resolved over the telephone, the appropriate M-CeRTs (Eastern/Western) will be contacted. Appropriate documentation should be completed and submitted to the HR Department at the conclusion of an individual's rotation.

Mobile Crisis Response Teams (M-CeRT):

M-CeRT team members: The following outlines staffing requirements for each M-CeRT team:

- Certified Peer Support Specialist
- Licensed and/or Credentialed Master's Level Therapist with experience and training in crisis response
- Community Support Specialist with experience and training in crisis response

- M-CeRT Coordinator with a minimum of two years' experience and training in crisis response, as well as, a Licensed and/or Credentialed Master's Level Therapist
- Access to Medical and psychiatric support at all times (this can be done through the use of telemedicine)

A team approach will be utilized, including other appropriate members when necessary for the benefit of the person in crisis or when additional support is warranted. If safety is of concern, a request should be made for law enforcement to accompany the M-CeRT team. The M-CeRT Coordinator, as well as, Administrators On-Call, are available resources at all times.

Training: Staff members assigned to an M-CeRT team will have received training as outlined under the Emergency On-Call training section identified above. In addition, members will receive training on best practices for responding to emergencies/crisis situations, including solution-focused and recovery-orientated interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more segregated setting, Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid (MHFA), and completion of relevant crisis intervention course through the Relias Learning Management such as Cultural Competence, Crisis Planning with Families, Groundwork for Multicultural Care, Crisis Management, and Incorporating Recovery Principles and Practices into Mental Health Treatment.

Assignment: Members of the M-CeRTs will be scheduled for a one week rotation. The schedule will be maintained by the M-CeRTs Coordinator.

Expectations: Individuals assigned to an M-CeRT Team will be available to provide direct face-to-face contact to people experiencing a mental health crisis. Members will be issued a CCS cell phone so they can be accessible during all times of their scheduled duty. The nature of the crisis will determine the number of staff needed to respond, as well as, the location of where services will be provided. If the person's location presents an imminent safety concern for members of the M-CeRT Team, team members will arrange for a safe location where face-to-face services can be provided. This may occur at a local hospital/emergency room, sheriff offices, police stations, or other secure public facility (i.e., a CCS office). Services can be provided at a person's home if this does not present an imminent risk for M-CeRT Team members. As indicated previously, when safety is of concern a request should be made for law enforcement to accompany the M-CeRT team to the location of the individual.

When face-to-face contact is warranted, the M-CeRT Coordinator shall be notified of the initial time of the request for face-to-face contact. Face-to-face contact shall be within two (2) hours of the initial contact in rural settings. The M-CeRT Coordinator shall be notified of the meeting location and available for support as requested. If the physical presence of the M-CeRT Coordinator is not deemed necessary to appropriately respond to the presenting situation, the M-CeRT Coordinator shall be notified at the conclusion of the contact to ensure all staff members have safely returned to his/her location. If the secured location is a CCS office in which other staff members are not present, the person attempting to arrange face-to-face contact should ensure at least two members of the M-CeRT Team is present to ensure additional support and safety needs are taken into consideration. It will be the responsibility of the responding M-CeRT team members

to assess the given situation. If determined to be a crisis situation, the staff member(s) responding to the call will utilize the tool required by DMH in order to determine the individual's risk. Areas assessed will include, but not be limited to suicide/homicidal ideation, substance abuse history/current use mental status, current/past mental health diagnoses and treatment, coping skills, medical conditions, and available resources/support systems.

Service Provision: M-CeRT team members shall utilize acceptable practices for responding to emergencies/crisis situations, including solution-focused and recovery-orientated interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more segregated setting. Members of M-CeRT will follow-up daily and provide any necessary services to the person between the initial stabilization of the crisis and the initiation of typical therapy and psychiatric care. The M-CeRT Peer Support Specialist will play a critical role in supporting people post crisis. When the crisis situation has subsided and in collaboration with members of the M-CeRT Team, people will be transitioned to traditional therapy services with a mental health provider of the person's choice (if the individual is able to remain in the community). This will include a member of the M-CeRT Team directly linking the individual with the provider using face-to-face or phone transfer.

Documentation Requirements: Every emergency contact, whether telephone or face-to-face, shall be documented by the clinical service provider handling the emergency. Documentation is provided by completing the Crisis Contact Summary. Submission of the report will follow the procedures outlined in ES 01: Emergency/Crisis Contact Summaries.

Outreach Plan for Informing the Public: In an effort to make the community aware of the availability of Emergency/Crisis Services, the Crisis Hotline number is maintained on the CCS website, is listed on agency answering machines, and referenced in local phone books. The Emergency/Crisis Hotline number will be included in all CCS publications/brochures. Information regarding Crisis/Emergency Services will be included in any CCS public release about the broad range of mental health services offered. Consultation and Education will be offered to the community and local agencies. Included topics will consist of mental health crisis response/intervention, suicide prevention/intervention, as well as, information about Crisis/Emergency Services. Mental Health First Aid (MHFA) training is available, with emphasis placed on trainings for first responders, health care professionals, emergency room personnel, and law enforcement personnel.

Collaboration with Community Agencies: The M-CeRT Coordinator will be a member of the Making A Plan (MAP) teams (both child and adults) and regularly attend meetings. Participation will be encouraged by law enforcement, first responders, emergency room personnel, and chancery court personnel in order to develop strong working relationships. The M-CeRT Coordinator will also conduct outreach efforts with local law enforcement agencies, as well as, other community agencies to provide education them about Crisis Response Services. Documentation will be maintained of contacts with these agencies. Crisis assessment and support will be provided when requested by a certified mental health holding facility, local jails that have a person with a mental health emergency, and local emergency rooms. Mental Health First Aid will be offered regularly to law enforcement agencies, local detention centers/jails, and emergency

room personnel. Documentation will be maintained of the request, response, and if training was provided.

Collaboration with Office of Consumer Support (OCS): When contacted by the OCS, the M-CeRT Coordinator will work with the person calling to respond to any crisis call referrals, that are in reference to an individual who resides in Region VII catchment area, that were generated from the DMH Help Line or any agency DMH contracts with to provide after-hours Help Line coverage.

Program Evaluation: Monthly data will be submitted to DMH as requested/required. Information provided will include number of emergency calls received that required face to face response by the M-CeRT teams, number of crisis situations which resulted in diversion from hospitalization, incarceration, or a segregated setting, number of people referred for hospitalization, and number of people in which the commitment process was pursued. The M-CeRT Coordinator will be responsible for submitting data each month in compliance with defined timelines. Data will be collected from services submitted on the service log as crisis services, as well as, data collected from the completion of the Crisis Contact Summaries.

Transportation: If through the assessment conducted, it is determined a person needs a higher level care because he/she is an imminent danger to self or others, the M-CeRT Team is responsible for arranging transportation to the most appropriate treatment setting. This includes arranging an assessment/transportation to the Crisis Stabilization Unit designated for the provider catchment area for people in need of crisis residential services.

Section: Crisis/Emergency Services
Policy: Crisis Residential Services - CSU
Policy No: CES 03
Effective: 11/1/2018
Review/Approved: 06/22/2021

Policy: It is the policy of Community Counseling Services (CCS) that Crisis Residential Services will be provided twenty-four (24) hours per day, seven (7) day a week basis.

Purpose: To ensure that all people needing Crisis Residential Services and meeting criteria, are able to access these services in an effective and timely manner.

Procedure:
General: Crisis Residential Services are time-limited residential treatment services provided in a Crisis Stabilization Unit, which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to people who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Residential Services are designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress, and further decompensation. Crisis Residential Services content may vary based on each person's needs, but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

Crisis Residential Services consist of evaluation, observation, supportive counseling, substance abuse counseling, individual, group, and family therapy, targeted case management and/or community support services, family education, and therapeutic activities (i.e. recreational, psycho-educational, social/interpersonal). These direct services are provided, at a minimum, 5 hours per day, 5 days per week. A daily schedule, for 24 hours, is maintained and posted in a prominent location.

Admission: Admissions (voluntary and involuntary) are accepted twenty-four (24) hours per day, seven (7) days per week. People must be eighteen (18) years of age or older to be considered for admission. People with a history of significant, recent violence or sexually predatory behaviors will not be considered for admission. People with a primary diagnosis of substance use and/or in need of detox will not be considered for admission. People with certain medical conditions that cannot be appropriately treated and managed in a Crisis Stabilization Unit will not be eligible for admission.

Assessment: Crisis Residential Services provides initial assessment, medical screening, drug toxicology screening, and psychiatric consultation within twenty-four (24) hours of admission to determine the need for services and to rule out the presence of mental symptoms that are judged to be the direct physiological consequence of a general medical condition and/or illicit substance/medication use.

Discharge/Transition Planning: Discharge planning occurs from the time of admission. Prior to discharge from Crisis Residential Services, an appointment is made for the person to begin or continue services with CCS or other mental health provider. Upon the treatment team determining the person has reached maximum benefit and

stabilization, whereby the person can have his/her needs met at a lower level of care or different level of care, the person will be discharged upon the approval of the staff psychiatrist or psychiatric mental health nurse practitioner. Examples of stabilization include, but not limited to, a person no longer being suicidal or no longer experiencing psychosis.

Personnel/Training: Crisis Residential Services provides adequate nursing and psychiatric services to all individuals served, at a minimum of every seven (7) days (or more often if clinically indicated). An individual therapy session is provided to each individual admitted within the first seventy-two (72) hours of admission. There is a full-time (40 hours per week) director and full-time (40 hours per week) therapist on-site. A ratio of one (1) direct service staff to four (4) residents is maintained twenty-four (24) hours per day, seven (7) days per week. A Registered Nurse (RN) is on site during all shifts and may be counted in the required staffing ratio. Direct care staff will assist in meeting the daily needs of people based on their independent level of functioning. Assistance in activities of daily living will be provided when needed, including personal hygiene care, grooming, and any other support identified. All staff will successfully complete training and hold certification in a nationally recognized or DMH approved program for managing aggressive and/or risk to self-behavior. See policy HR 34: Training of Staff Members/Staff Development for additional information regarding Staff Training Plans.

Unit Orientation: Crisis Residential Services has an orientation package, which is readily understood and person-first and person-friendly that includes the expectations of the Crisis Stabilization Unit and how the person can be successful. The orientation package is provided to the person/parent/legal representative during orientation or when the person is stable enough to comprehend the information in the package, and this provision is documented. The orientation package information is provided in an person's language of choice when necessary.

The orientation packet includes the philosophy, purpose, and overall goals of the services. Included in the orientation packet are visitation guidelines, a person's rights to define family and support system for visitation purposes unless clinically/socially contraindicated. Actions regarding visitation are documented in the person's case record. Visitation rights are not withheld as punishment nor limited in ways that unreasonably infringe on the person's stated rights.

Daily private communication (phone, mail) occurs without hindrance unless clinically contraindicated. Restrictions regarding outside communication is documented in the case record and restrictions on telephone use are reviewed daily. The orientation package addresses dating, off-site activities, housekeeping tasks, use of alcohol, tobacco, and other drugs, and respecting the rights of other residents' privacy, safety, health, and choices.

The orientation packet addresses circumstances, designated staff, documentation, and consequences of discovery of prohibited items upon searches of a person's room, person, and/or possessions. Screening for prohibited and illegal substances includes a) circumstances for screening to occur, b) designation of staff, c) documentation, d) consequences of positive screen for prohibited/illegal substances, e) consequences for

refusing a drug screen, and f) process for people to confidentially report use of prohibited/illegal substances before drug screening.

The orientation packet addresses assisting people in arranging and accessing emergency medical and dental care, with agreements with local physicians, dentists, and hospitals, as well as process for obtaining permission from parent/guardian, if necessary. The packet also addresses staff's responsibility for protection of the person and personal property and rights, and determination of the need, implementation, and supervision of behavior change/management programs. There is a description of how risks to health and safety of people in the program are assessed and mitigation strategies are put in place as a result of the assessment.

Environment and Safety: Observation of people upon admission and regular intervals is possible through first hand observation of staff, as well as, monitoring of cameras located throughout the facility. Observations should be conducted at a minimum of every 30 minutes by direct care staff and/or nurses to ensure all people are safe and accounted for. Annually, the CSU Director will evaluate the level of observation that is required and implement any necessary changes to ensure the safety of all people. See policy ES 06: Environment and Safety Standards for Community Living/Crisis Stabilization Unit for additional information.

Emergency Care and Health and Safety: When medical or dental needs are identified, the CSU Director or his/her designee will contact the medical provider contracted to provide medical screenings for admissions to the CSU for consultation. If it is determined that the person needs emergency medical/dental care, staff will assist people in receiving needed services. If the person is not able to consent for care, staff will contact the person's legal guardian to gain permission for treatment. People are responsible for the cost of medical and/or dental services received outside the Crisis Stabilization Unit.

Infection Control: Hand washing is the single most important means of preventing the spread of infection. All people at the CSU play a key role in stopping the spread of infection. As such, both staff and residents shall wash his/her hands when (a) when his/her hands are obviously soiled, (b) after removing gloves, (c) after use of the toilet, (d) after blowing or wiping the nose, and (e) before eating. Any time an person communicates concerning symptoms (i.e., sore throat, fever/chills, diarrhea, fatigue, muscle aches, coughing) the nurse on duty will be consulted. Recommendations of the RN on duty will be followed. The CSU Director will be contacted if outside care is required for emergency medical/dental care.