SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
DIRECTIVE STATEMENTS

Please print your initials next to each directive statement after you have finished reading the directive. Date and Sign your name below.

_____ _____

Date Signature

1. I have received a copy of SCDMH Directive No. 837-03, entitled "Privacy Practices." I have read , understand and will adhere to the procedures provided and am aware of the penalties for unauthorized disclosure. South Carolina law provides that the penalty for unauthorized disclosure of confidential information is not more than one year imprisonment or a fine of not more than five hundred ($500.00) dollars, or both.

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Initial

2. I have received a copy of the SCDMH Directive No. 885-07, entitled "Prohibited Abusive, Neglectful and Exploitative Conduct Toward Patients and Clients." I have read, understand and will adhere to the written procedures and am aware that it is a criminal offense for a person to abuse, neglect or exploit any vulnerable adult. Any person convicted of such an offense may be fined up to $5,000.00 or imprisoned up to three (3) years.

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Initial

3. I have received a copy of SCDMH Directive No. 775-93, entitled "Searches for Contraband/Stolen Property." I have read, understand and will adhere to the written procedures. I am aware that employees of the South Carolina Department of Mental Health and other individuals afforded access to Department of Mental Health facilities are subject to a personal search, together with any packages, belongings or vehicles which such individuals bring onto Department property. I also understand that a refusal to permit a search of clothing, packages, or vehicle will subject me to disciplinary action.

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Initial

4. I have received a copy of SCDMH Directive No. 842-03, entitled "Harassment-Free Workplace." I have read, understand and will adhere to the written procedures. It is the policy of the SCDMH that an environment free from any type of harassment and intimidation shall be maintained.

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Initial

5. I have received a copy of SCDMH Directive No. 730-89, entitled "Drug-Free Workplace." I have read, understand and will adhere to the written procedures. Violation of this law by employees (regardless of permanent or temporary status), volunteers and students may lead to dismissal and criminal prosecution.

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Initial

6. I have received a copy of SCDMH Directive No. 859-06, entitled "Workplace Violence." I have read, understand and will adhere to the written procedures. I am aware that all forms of workplace violence are prohibited. It is the policy of the SCDMH to have zero tolerance regarding acts or threats of workplace violence.

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Initial

7. I have received a copy of SCDMH Directive No. 917-13, entitled "Social Media." I have read, understand and will adhere to the written procedures and am aware of the penalties for unauthorized disclosure of private information regarding residents, staff, volunteers and SCDMH through the use of social media. Violation of this and other applicable directives/policies/laws are subject to criminal, civil and/or professional liability.

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Initial

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE STATE DIRECTOR OF MENTAL HEALTH DIRECTIVE NO. 837-03 (5-100)

TO: All Employees

SUBJECT: Privacy Practices

Purpose

This Directive describes DMH policy for the use and disclosure of DMH Consumer medical and payment Protected Health Information or "PHI" (see Notice for terms that begin with a capital letter) and Consumer rights related to access, control, accounting and amending of their PHI. This Directive incorporates DMH Form M-010, "NOTICE OF PRIVACY PRACTICES" ("Notice"), as well as other forms and procedures listed in the Appendix. Appendix components are identified in this Directive by quotes and caps (e.g. "AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION"). This Directive includes future Notices, forms or procedures added to the Appendix, and adopted in accord with DMH policy and applicable law.

Each DMH employee, volunteer or other person (e.g., contract physician) incorporated in the DMH workforce ("workforce member" or "staff") and officials, must sign acknowledgement of receipt of, and agreement to comply with this Directive. The signed statement must be kept in the applicable personnel or other official folder. Each DMH component must ensure training of its staff consistent with this Directive and DMH Privacy Practices training. All DMH component policies or agreements must be consistent with this Directive.

Applicable Law

This Directive is to conform with, and is subject to, applicable federal and state law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 44-22-100 of the Code of Laws of South Carolina. Identifying information from alcohol and drug treatment programs is subject to additional restrictions and protections under federal law 42 CFR Part 2. If in doubt as to whether 42 CRF Part 2 applies to a DMH program, the applicable local director should consult with the DMH Office of General Counsel. In general, DMH is required by law to: follow the Notice requirements; keep Consumer information private; give Consumers the opportunity to review the Notice and request restrictions on PHI use or disclosure; not use or share PHI without Consumer Authorization except as described in the Notice; provide for Consumer rights involving control over his or her PHI; and a procedure for Consumer complaints about DMH privacy practices.

Additional requirements (e.g., for licensing, accreditation, etc.) may also apply to individual DMH components.

1) Notice

A copy of the current DMH Notice must be posted at each service site where persons seeking

DMH services will be able to read it. When DMH changes the Notice, a current copy must be posted in like manner. A copy of the Notice must also be posted on the DMH Internet Web site. Consumers must have the opportunity to review the Notice and receive a paper copy at any time. DMH service sites must attempt to obtain a Consumer□s signed acknowledgement of receipt of the Notice at the Consumer□s next visit beginning April 14, 2003. This acknowledgment is to be recorded on DMH Form C-107 (revised March, 2003) "CONSENT TO EXAMINATIONS AND TREATMENT" or an applicable intake or admission form, containing the statement (or an attached statement):"I have been provided a copy of the SCDMH Notice of Privacy Practices and an opportunity to review it and ask questions." If not signed, staff must note on the signature line of the statement, why signed acknowledgement was not obtained (e.g., "refused a copy of the Notice", "refused to sign", etc.) Questions concerning the Notice, this Directive, or DMH Privacy Practices should be directed to the local Privacy Officer or the DMH Privacy Officer.

2) DMH Uses and Disclosures of PHI

After providing the Consumer with the opportunity to review the Notice, and object and/or request certain restrictions, staff may share PHI as described in the Notice. In an emergency or if the Consumer is incapacitated, without giving the Consumer the opportunity to review the Notice, object or request limitations, DMH may use and/or share PHI as permitted under the Notice. As soon as reasonable after the emergency or incapacity, the Consumer must be given those opportunities. When practical and when it will not compromise Treatment, DMH should accommodate a Consumer□s request to limit PHI use or disclosure. As described in the Notice, PHI may be disclosed pursuant to a Business Associate Agreement, approved by the DMH Contracts Office and the DMH Privacy Officer. DMH workforce members should limit use or disclosure of PHI to the Minimum Necessary to accomplish the purpose for the use or disclosure as described in the Notice.

For use and disclosure of PHI for Operation purposes, applicable component directors must identify employees who need access to PHI to carry out their DMH duties (see Notice); and the PHI categories to which access is needed and any limitations to such access. For types of disclosure of, or request for, PHI made on a routine and recurring basis, the component must implement protocols limiting the PHI disclosed or requested to the Minimum Necessary to achieve the purpose of the disclosure or request. Protocols must be reviewed and approved by the local Privacy Officer. For other PHI disclosures or requests (i.e., non-routine, non-recurring), the component must develop protocols to limit the PHI disclosed or requested to the Minimum Necessary and review all such requests for disclosure on a case by case basis to determine that the PHI information sought is limited to the Minimum Necessary to achieve the purpose of the specific disclosure or request.

3) Other Exceptions, Legal Proceedings, Notice of Privacy Law

Unless disclosure is otherwise permitted by the Notice, upon receipt of a subpoena or other request for PHI, a statement substantially similar to the "MODEL NOTICE OF PRIVACY LAW" must be sent to the requester. If required to provide testimony or other information containing PHI in a legal proceeding, staff must follow the procedure described in "DISCLOSURES IN LEGAL PROCEEDINGS."

4) Authorizations

Unless permitted by the Notice, PHI may not be disclosed without a signed "AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION", to be kept in the Consumer□s medical record. Requests pursuant to an Authorization must be acknowledged within 15 days of receipt and completed within 60 days.

5) Re-Disclosure Notice

When PHI is authorized to be disclosed by the Notice (e.g. photocopies of a medical records sent to a non-DMH medical provider for Treatment), the disclosed copies of PHI must be accompanied by a notice cover sheet or other statement substantially similar to the "MODEL NOTICE PROHIBITING RE-DISCLOSURE."

6) Consumer Privacy Rights

The Notice describes the following Consumer PHI privacy rights: receipt of a copy of the Notice and opportunity to review and ask questions; object and request restrictions on some PHI uses or disclosures; request confidential communication/notification; inspect and obtain copy of PHI; request amendment to PHI; receive an accounting of PHI disclosures; and the right to file a complaint with DMH, HHS and Office of Civil rights about DMH privacy practices. As described following, exercise of Consumer privacy rights concerning his or her PHI, may require that a Consumer complete a written request and follow the noted procedure. Formal Privacy Practice complaints may involve the Privacy Officer and the Consumer Advocate.

7) Consumer Access to His or Her Own PHI, Psychotherapy Notes

A Consumer has the right to request ("REQUEST TO INSPECT AND/OR COPY SCDMH PROTECTED HEALTH INFORMATION") access and/or copies of his/her PHI as described in the Notice as long as DMH maintains the PHI. The applicable component must document and retain for 6 years, Designated Record Sets subject to Consumer access and titles of persons and/or offices responsible for processing access requests. The DMH component must act on a Consumer□s request as described in the Notice, but may deny access to some information including Psychotherapy Notes as described in the Notice. Note the narrow definition of Psychotherapy Notes in the Notice. All DMH Treatment and Payment information should be kept in the applicable DMH record. If a member of the DMH workforce keeps Psychotherapy Notes, he or she does so as an individual, and is therefore individually responsible for their content, control, protection, access and disclosure, including disclosure pursuant to a court order or as otherwise required by law.

As applicable, the DMH component must inform the Consumer that the request has been granted and provide access as requested (see "MODEL REPLY TO REQUEST TO INSPECT AND/OR COPY"). PHI should be provided in the format requested if readily reproducible or in readable hard copy or other format as agreed to by the Consumer, unless he or she agrees to a written summary as described in the Notice. If the same PHI is maintained in more than one Designated Record Set or at more than one location, the PHI may only be produced once. If the component does not maintain the requested PHI, but knows where it is maintained, the component must inform the individual where to direct the request.

If access is denied, the DMH component must provide a written denial within 15 days of the request (see "MODEL REPLY TO REQUEST TO INSPECT AND/OR COPY"). If the Consumer requests a review in writing, the component must designate a licensed health care professional who was not involved in the denial decision to review the denial. The designated person must give the Consumer written notice within 15 days of review request, the designated person□s decision, and take other action necessary to carry out the decision.

8) Consumer□s Right to Request Amendment to PHI

After a Consumer requests an amendment in writing ("REQUEST TO AMEND SCDMH PROTECTED HEALTH INFORMATION") staff must act on the request in accord with the Notice timelines and procedures. The request must be forwarded to the component director

with copy to the local Privacy Officer. The director must designate staff to review the request and take needed action documented on Page 2 of the "REQUEST" form. The request must be reviewed by the designated staff in conjunction with staff originally recording the PHI and by the staff□s supervisor(s), who must consult with other staff as needed to determine if an amendment is needed. Any conflict must be resolved by the director. The Consumer must be informed of the final decision by a letter substantially similar to the "MODEL REPLY TO REQUEST TO AMEND" with a copy of the original "REQUEST", including Page 2 documenting the DMH component□s review and basis for its decision.

If the request for amendment is approved, after notifying the Consumer as noted above and obtaining the Consumer□s agreement with the proposed amendment, the amendment should be made, the record flagged to indicate the amendment and the amendment form filed in the record. Staff should also attempt to secure the Consumer□s permission to notify necessary relevant persons of the amendment. If the Consumer refuses, document the attempt to obtain permission in the record prior to giving needed notification.

A request for amendment may be denied if the PHI: was not created by DMH; is not in the Designated Record Set; or the PHI is accurate and complete. If the request is denied, the Consumer must be notified in writing as described above indicating: the basis for the denial; that the Consumer may submit a one-page written disagreement, stating the basis for disagreement; that the Consumer may request that future disclosures of the disputed PHI include the request and the denial; and how the Consumer may file a Complaint.

Records must be maintained identifying the PHI in the Designated Record Set that is the subject of the disputed amendment and appended or otherwise linked to the Consumer□s request for amendment, DMH denial, Consumer□s statement of disagreement, and any DMH rebuttal. If a Consumer submits a statement of disagreement following a denial, subsequent disclosures of the disputed PHI must include the above items.

9) Consumer□s Right to Request Accounting of Some PHI Disclosures

DMH components must log each applicable PHI disclosure using the "ACCOUNTING LOG OF PHI DISCLOSURES". The accounting must include disclosures by DMH as well as disclosures to a DMH Business Associate. This accounting requirement does not include PHI used or shared before April 14, 2003 or other disclosures described in the Notice. The local Privacy Officer or designee must respond to a Consumer□s written request, and provide, a copy of the applicable accounting log as described in the Notice (see "MODEL REPLY TO REQUEST OF ACCOUNTING LOG"). However, a Consumer□s right to receive an accounting log must be suspended if a health oversight agency (HHS) or law enforcement official notifies DMH that providing an accounting would be reasonably likely to impede the health oversight or law enforcement agency□s activities and specifying the time for which the suspension is required. DMH must document that statement (including the identity of the agency or official) and temporarily suspend the Consumer□s right to an accounting for no longer than 30 days, unless a written statement is received from the applicable agency during that time.

10) Consumer Privacy Practice Complaints

Applicable DMH components must, in coordination with the local Privacy Officer and Consumer Advocate, have a process for Consumers to make a written complaint about DMH privacy practices or compliance with those practices ("SCDMH PRIVACY PRACTICES COMPLAINT") and must document all complaints received and their disposition as described in the Notice. At any time, a Consumer has the right to file a complaint with DMH and/or HHS as described in the Notice. DMH must provide records and compliance reports, as required by HHS and

otherwise permit access, as requested by HHS, to applicable facilities, records, and other sources of Information, including PHI as needed for a HHS inquiry or investigation pursuant to a Complaint.

DMH component or staff may not intimidate, threaten, coerce, discriminate against, or retaliate against any person for the exercise of rights or participation in any process relating to this Directive, or against any person for filing a complaint with DMH, HHS or other privacy related investigation, compliance review, proceeding or hearing, or engaging in reasonable opposition to any act or practice that the person in good faith believes to be unlawful under HIPAA or state law as long as the action does not involve disclosure of PHI in violation of the regulations, nor require individuals to waive any of their rights under HIPAA or state law as a condition of Treatment or eligibility for DMH services.

11) DMH Privacy Officer:

DMH must designate a DMH Privacy Officer responsible for the development and implementation of DMH privacy practices. Applicable DMH components must designate a local Privacy Officer and Privacy Practices workgroup that advise and support the local Privacy Officer and DMH Privacy Officer.

12) Training:

DMH components must document training on DMH Privacy Practices before April 14, 2003 for its workforce members. Each new workforce member must receive this training within 30 days after joining the workforce. Each workforce member, whose functions are impacted by a material change in this Directive, or by a change in position or job description, must receive the training as described above within a reasonable time after the change becomes effective. All training must be documented and records retained for 6 years.

13) Sanctions and Mitigation of Damages

DMH Human Resources office must document and each DMH component must apply, appropriate DMH employee disciplinary action, for employees who fail to comply with this Directive. Exceptions include disclosures made by employees as whistleblowers, for mandatory reporting or certain crime victims. Each DMH component must have a process to mitigate, to the extent practicable, any harmful effects of unauthorized uses or disclosures of PHI by the component or any of its Business Associates.

14) Security

Applicable DMH components must comply with "PRIVACY PRACTICES SECURITY" requirements.

15) Documentation Requirements:

Applicable DMH components must maintain Directive policies and procedures in written or electronic form as well as written or electronic copies of all communications, actions, activities or designations required to be documented by this Directive, for 6 years from the later of the date of creation or the last effective date.

16) Disclosure of Unidentifiable Information or Information in Limited Data Sets

PHI may be disclosed under the requirements and protocols described in "UNIDENTIFIABLE

OR DE-INDENTIFIED INFORMATION" or "LIMITED DATA SETS."

17) Charges for Copying and Other Expenses Related to Copying and Access to PHI.

As permitted by this Directive, PHI may be disclosed by photocopy or fax. A fee to cover costs of reproducing may be charged and collected in advance of providing copies in accord with DMH Regulation 87-4(D): "The first fifteen copies will be provided at no charge; beginning with the sixteenth copy, there will be a fee of twenty cents per page. If a request is made for records which are not readily available, the Department may determine a reasonable hourly rate for the expense of searching for and securing such records. The Department may also require a reasonable deposit for such anticipated expense from the person making the request prior to searching for or making copies of the records. "

18) Violations and Penalties

All violations of this directive must be reported to the applicable person's supervisor. DMH employees who make an unauthorized disclosure of PHI, or otherwise violate provisions of this Directive, are subject to disciplinary action in accordance with the DMH Employee Discipline Directive. Further, South Carolina law provides for penalties for the unauthorized disclosure of PHI up to one year imprisonment and/or a fine of up to $500. Federal law provides for penalties of $100 per incident up to $250,000 and ten years in prison. Unauthorized use or disclosure of PHI may also subject the employee to additional civil or criminal liability.

This Directive with referenced "Notice of Privacy Practices" and Appendix, replaces the DMH Directive No. 771-92 "Confidentiality of Medical Records and Patient Information." This Directive is effective April 14, 2003.

GEORGE P. GINTOLI
STATE DIRECTOR

APPENDIX TO SCDMH PRIVACY PRACTICES DIRECTIVE

NOTICE OF PRIVACY PRACTICES

ALCOHOL AND DRUG PROGRAM CONFIDENTIALITY (42 CFR PART 2)

CONSENT TO EXAMINATIONS AND TREATMENT

MODEL NOTICE OF PRIVACY LAW

DISCLOSURES IN LEGAL PROCEEDINGS

AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION

MODEL NOTICE PROHIBITING RE-DISCLOSURE

REQUEST TO INSPECT AND/OR COPY SCDMH PROTECTED HEALTH INFORMATION

MODEL REPLY TO REQUEST TO INSPECT AND/OR COPY

REQUEST TO AMEND SCDMH PROTECTED HEALTH INFORMATION

MODEL REPLY TO REQUEST TO AMEND

ACCOUNTING LOG OF PHI DISCLOSURES

MODEL REPLY TO REQUEST OF ACCOUNTING LOG

SCDMH PRIVACY PRACTICES COMPLAINT

PRIVACY PRACTICES SECURITY

UNINDENTIFIABLE OR DE-IDENTIFIED INFORMATION

LIMITED DATA SETS

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE DIRECTOR OF MENTAL HEALTH — DIRECTIVE NO. 885-07 (4-100)

TO: All Employees

SUBJECT: Abuse, Neglect or Exploitation of Patients and Clients Prohibited

I. Purpose:

The purpose of this directive is to describe the types of conduct involving patients and clients of the Department of Mental Health (DMH) which is prohibited, including that which is unlawful, and to establish procedures for the reporting and investigating of such conduct in any facility or program of DMH. This directive also sets forth guidelines governing staff relationships with patients and clients.

II. Policy:

It is the policy of the South Carolina Department of Mental Health that all of its programs and activities shall be conducted in accordance with current standards of good clinical practice. All employees shall carry out their duties in such a manner that the dignity and safety of every patient and client is protected to the fullest extent possible. Employees must report suspected abuse, neglect or exploitation of clients and patients as required by law and departmental policy. Following investigation, if improper conduct by an employee is found to have occurred, appropriate disciplinary action shall be taken.

III. Prohibited Conduct:

The following types of improper conduct are strictly prohibited, and any employee who is found to have engaged in such conduct or who has failed to report knowledge of such conduct by others shall be disciplined. Refer also to the current DMH Directive on Standards of Disciplinary Actions for other types of misconduct regarding patients and clients which will subject an employee to disciplinary action.

A. Physical Abuse:

"Physical abuse" means intentionally inflicting or allowing to be inflicted physical injury on a patient or client by an act or failure to act. Physical abuse includes, but is not limited to: slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery, use of medication outside the standards of reasonable medical practice for the purpose of controlling behavior, and unreasonable confinement. Physical abuse also includes the use of a

restrictive or physically intrusive procedure to control behavior for the purpose of punishment except that a therapeutic procedure prescribed by a licensed physician or other qualified professional is not considered physical abuse if it is part of a written plan of care.

Note: Excessive force. "Excessive force" means utilizing greater force than necessary to achieve physical patient control. Unless excessive force is done for the purpose of punishment, it is not physical abuse, but excessive force is nevertheless prohibited conduct, and use of excessive force will subject an offending employee to disciplinary action. Excessive force includes but is not limited to: utilizing unapproved techniques for patient control, using physical intervention when non-physical intervention is sufficient and unauthorized restraint or seclusion. Excessive force does not include physical control administered by a person in direct and primary contact with the patient for the sole purpose of restraining or correcting the patient for the protection of the person so acting out of fear of bodily harm for his own or the patient's safety or the safety of others. Such physical control must be reasonable in manner, moderate in degree and shall be administered in such a manner as to not produce permanent or lasting physical injury to the patient.

B. Psychological Abuse:

"Psychological abuse" means deliberately subjecting a patient or client to threats or harassment or other forms of intimidating behavior causing or likely to cause fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress. Psychological abuse includes but is not limited to, abusive language or gestures, use of profane language, calling names, spitting on or at a patient or client, threatening physical abuse, neglect or exploitation, derogatory gestures, teasing or ridiculing, making sexual or sexually suggestive comments or encouraging patients or clients to tease, ridicule, or make sexual or sexually suggestive comments.

Note: Profane or abusive language. All use of profane or abusive language to patients or clients, or use of profane or abusive language in the presence of clients, is improper and prohibited, and will subject an offending employee to disciplinary action, whether or not it is subsequently shown that such conduct caused or was likely to cause serious emotional distress.

C. Neglect:

"Neglect" means the failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a patient or client including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services. Neglect may be repeated conduct or a single incident which has produced or could produce serious physical or psychological harm or substantial risk of death. Noncompliance with regulatory standards alone does not constitute neglect. Neglect includes, but is not limited to: failing to intervene or assist a patient or client when they are in clear distress or in circumstances posing a risk of injury, or failing to carry out orders, policies or procedures related to patient or client care or safety.

Note: Negligence. Although non-compliance with regulatory standards or other standards of care alone may not constitute neglect, it will likely constitute negligence. Negligent conduct resulting in injury to a patient or client will subject an offending employee to disciplinary action. Negligent conduct includes violation of rules, requirements or standards of care in the

supervision and treatment of patients and clients by staff responsible for such supervision or treatment. Conduct may be negligent whether the violation of standards was intentional or unintentional.

D. Exploitation:

"Exploitation" means:

1. causing or requiring a patient or client to engage in activity or labor which is improper, illegal, or against the wishes of the patient or client (exploitation does not include requiring a patient or client to participate in an activity or labor which is a part of a written plan of care); or

2. an improper, illegal, or unauthorized use of the funds, assets, property, power of attorney, guardianship, or conservatorship of a patient or client for the profit or advantage of the employee or another person.

Exploitation includes, but is not limited to, borrowing money or property from a patient or client, selling goods or services to a patient or client or accepting gifts from a patient or client or their family in circumstances other than as permitted by state law and facility policy. Depending on the circumstances, purchasing property from a patient or client may also constitute exploitation. In any event, engaging in any financial or business transaction with a patient or client is prohibited, and subjects an offending employee to discipline. (See Paragraph VII, below "Staff-Patient/Client Relationships.")

IV. Reporting:

All DMH employees having reason to believe that a patient or client has been abused, neglected or exploited must report the circumstances giving rise to such belief in accordance with this paragraph.

A. Adult Patients or Clients

1. Incident occurring in a DMH operated/contracted-for-operation facility or residential program.

a. If the alleged abuse, neglect or exploitation occurred in a DMH facility or a residential program operated or contracted for operation by DMH, the employee must:

i. Personally report the incident to the State Law Enforcement Division (SLED) by calling the Special Victim's Unit Hotline (1-866-200-6066); and

ii. Personally report the incident to their supervisor.

b. Either the employee or their supervisor must additionally report the incident to the DMH Office of Public Safety.

2. Incidents occurring at a location other than a DMH operated/contracted-for-operation facility or residential program.

a. If the alleged abuse, neglect or exploitation occurred outside a facility or residential program operated or contracted for operation by DMH, (EG. a private community residential care facility, private home or apartment or in a non-residential DMH program, such as a mental health center clubhouse) the employee must personally report the incident to their supervisor.

b. In case of emergency, serious injury or sexual assault, an immediate report should be made directly to the local law enforcement agency with jurisdiction.

c. Either the employee or their supervisor must additionally report the incident to the DMH Office of Public Safety. All reports received by Public Safety will be forwarded to the appropriate agencies in accordance with the Adult Protection Act thereby relieving the individual employee of having to make a separate report under such statutes.

d. Public Safety shall report the incident to

i. the State Long Term Care Ombudsman Program for incidents occurring in private facilities; or
ii. the County Department of Social Services, Adult Protective Services program for incidents occurring in private settings other than a facility; when the alleged perpetrator is a family member or caretaker; or
iii. the local law enforcement agency with jurisdiction when it appears the alleged perpetrator is not in a caregiver role; or
iv. the State Law Enforcement Division (SLED) when it appears that although the incident did not occur in a DMH operated/contracted-for-operation facility or residential program, the alleged perpetrator is a DMH employee.

3. In addition to other required reports, the Medical Examiner or Coroner must also be notified in cases where it is suspected that a vulnerable adult died as a result of abuse or neglect.

B. Child and Adolescent Patients or Clients

1. Incidents occurring while the child or adolescent patient or client was in a DMH facility, mental health center or center.

a. All Department employees having reason to believe that a child has been or is likely to be abused, or neglected while in a Department facility or mental health, must immediately report the incident and facts to his or her supervisor.

b. In case of emergency, serious injury or sexual assault, an immediate report should be made directly to the local law enforcement agency with jurisdiction.

c. Either the employee or their supervisor must additionally report the incident to the DMH Office of Public Safety in Columbia. All reports of child abuse or neglect

received by Public Safety will be forwarded to the appropriate agencies in accordance with the Child Protection Act thereby relieving the individual employee of having to make a separate report under such statutes.

2. Incidents occurring while the child or adolescent patient or client was outside a Department facility or mental health center.

a. The South Carolina Child Protection Act requires that the following persons report to the applicable state or local entity:

> physician, nurse . . .or any other medical, emergency medical services, mental health, or allied health professional. . .school teacher, counselor, principal, assistant principal, social or public assistance worker, substance abuse treatment staff, or childcare worker in a childcare center or foster care facility, police or law enforcement officer. . .computer technician or a judge must report. . .when in the person's professional capacity the person has . . .reason to believe that a child has been or may be abused or neglected.

b. If the alleged person responsible for the abuse or neglect of a child or adolescent outside a Department facility or mental health center is a parent, guardian or other person responsible for the child's welfare, the report must be made within 24 hours or the next business day to the County Department of Social Services, Child Protective Services office. In an emergency, the report is first made to the local law enforcement agency with jurisdiction.

c. If the alleged person responsible for the abuse or neglect is other than a parent, guardian or other person responsible for the child's welfare, the report is made directly to law enforcement.

V. South Carolina Law

A. Adult Protection Act:

1. It is a criminal offense for any person to abuse, neglect, exploit or threaten to abuse, neglect or exploit any vulnerable adult. Any person convicted of such an offense may be fined up to $5,000.00 or imprisoned up to three (3) years.

a. "Vulnerable adult" means a person eighteen years of age or older who has a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection. This includes a person who is impaired in the ability to adequately provide for the person's own care or protection because of the infirmities of aging including, but not limited to, organic brain damage, advanced age, and physical, mental, or emotional dysfunction. A resident of a facility is a vulnerable adult.

b. "Facility" includes a nursing care facility, community residential care facility, a psychiatric hospital, or any residential program operated or contracted for operation by the Department of Mental Health.

2. It is a criminal offense for any person required to report actual abuse, neglect or exploitation of a vulnerable adult to knowingly and wilfully fail to make a report. Any person convicted of such an offense may be fined not more than twenty-five hundred dollars or imprisoned not more than one year. A person required to report under this chapter who has reason to believe that abuse, neglect, or exploitation has occurred or is likely to occur and who knowingly and wilfully fails to report the abuse, neglect, or exploitation is subject to disciplinary action as may be determined necessary by the appropriate licensing board. Employees of the South Carolina Department of Mental Health having reason to believe that a patient or client has been abused, neglected or exploited are further subject to disciplinary action if they fail to make the required report.

B. The Child Protection Act:

Employees of the Department of Mental Health are also required under the Child Protection Act to report or cause a report to be made of child abuse or neglect in those instances where the employee has reason to believe a child has been or is likely to be abused or neglected. Incidents which occur in Department residential facilities or programs must be reported orally or in writing to the Office of Public Safety or the Department of Social Services Out-of-Home Abuse and Neglect Investigations Unit. Incidents which occur in settings outside of a Department residential facility or program must be reported orally or in writing to the local law enforcement agency or the Child Protective Services Program of the County Department of Social Services.

VI. Care of the Patient or Client, Reporting and Investigation:

A. Inpatient Facilities (See Part B of this Section for Reporting and Investigations in Community Mental Health Centers):

1. Employee(s) who witness, discover or are notified of conduct which may be prohibited by this directive shall:

(a) Immediately take action to protect, comfort and assure treatment of the patient;

(b) Notify the State Law Enforcement Division (SLED) Special Victims Unit Hotline if the patient is an adult, and, in all cases, notify their supervisor and the Office of Public Safety, reporting all information surrounding the incident;

(c) Ensure the nursing supervisor and physician are notified immediately;

(d) Initiate the Unusual Occurrence Report form and document observations on the patient's record.

2. The Nursing Supervisor shall:

(a) Assess the patient, assist in providing immediate care and follow-up care;

(b) Obtain any additional information and confer with the Director of Nursing Service and Public Safety;

(c) Document observations on the patient's record.

3. The Physician shall:

(a) Examine the patient immediately;

(b) Complete the Unusual Occurrence Report form;

(c) Document findings on the patient's record.

4. The Office of Public Safety shall complete an initial Incident Report and, if the alleged victim is an adult, provide a copy to the SLED Special Victim's Unit.

5. All employees shall cooperate with investigating personnel and answer questions concerning the incident asked by their supervisor, SLED, Public Safety and/or other officials authorized to conduct a review or investigation. Failure to cooperate in an official investigation shall result in disciplinary action.

6. When circumstances strongly suggest that an employee has abused, neglected or exploited a patient, the employee shall be advised of the allegation and informed of their legal rights. Those include the employee's right to have an attorney present during questioning, at their own expense, and the right to not respond to questions. Interviews with employees shall be conducted in a professional manner, away from the employee's work area and other employees.

7. The investigation shall be concluded as promptly as possible.

B. Community Mental Health Centers

1. Employee(s) who witness, discover or are notified of conduct which may be prohibited by this directive shall:

(a) Immediately take action to protect, comfort and assure treatment of the client;

(b) If the client is an adult residing in a Center residential program, the employee shall notify the State Law Enforcement Division (SLED) Special Victims Unit Hotline. In all cases, the employee shall notify the Center Director, or other person in charge, and the DMH Office of Public Safety, promptly reporting all information surrounding the incident;

(c) Notify physician, if one is readily available;

(d) Initiate the Unusual Occurrence Report form and document observations on the client's record.

2. The manager, supervisor or other person in charge who is on duty at the time an incident occurs shall:

(a) Assess the client, assist in providing immediate care and follow-up care;

(b) Obtain any additional information and confer with the Center Director if or other person in charge and the Director of the Division of Community Care Systems or his/her designee;

(c) Document observations on the client's record.

3. If the incident occurred on the premises of the Center or on the premises of a non-residential program operated by the Center, the Center Director or other person in charge shall begin an investigation of the incident after conferring with the Office of Public Safety. If the incident occurred at a location not operated by the Center, the Center Director or person in charge shall promptly notify local law enforcement or the County Department of Social Services. If the incident occurred at a location not operated by the Center, but a Center employee is accused of the abuse, neglect or exploitation, the Center Director or other person in charge shall confer with the Office of Public Safety. The Office of Public Safety shall complete an initial Incident Report and promptly forward it to any outside investigatory entity which have jurisdiction to investigate the matter. Thereafter, Public Safety shall provide guidance to the Center on which cases must be investigated by SLED or another outside investigatory entity, and shall provide assistance to the Center as resources permit in those cases which may be investigated by the Center management.

4. Each employee shall cooperate with investigating personnel and answer questions asked by the official authorized to conduct a review or investigation.

5. When circumstances strongly suggest that an employee has abused, neglected or exploited a client, the employee shall be advised of the allegation and informed of their legal rights. Those include the employee's right to have an attorney present during questioning, at their own expense, and the right to not respond to questions. Interviews with employees shall be conducted in a professional manner away from the employee's work area and other employees.

7. The investigation shall be concluded as promptly as possible.

C. Action to be Taken:

1. When an investigation indicates prohibited conduct on the part of an employee, the Director of the facility, center or organizational component involved shall immediately ensure that appropriate disciplinary action is initiated in accordance with the current Department of Mental Health directive relating to Standards of Disciplinary Actions.

2. If disciplinary action is taken as a result of such an incident the Office of Public Safety shall be notified in order to indicate the disposition of the case in their records of the incident.

3. The decision to undertake criminal prosecution when the investigation indicates a violation of state law will be made by the appropriate Circuit Solicitor.

4. When the review of a report of alleged abuse, neglect or exploitation indicates that the incident is or includes an issue of patient's or client's rights, that issue or issues will be referred to the assigned Local Client Advocate or the SCDMH Client Advocate for review and resolution.

D. Knowledge and Training:

Each Facility Director and Center Director shall ensure that all employees review this directive and that all direct care employees receive sufficient training regarding actions which may constitute conduct prohibited by this directive and the procedures for reporting such conduct prior to the employee's assuming responsibility for the care and treatment of patients and clients.

E. Abuse, Neglect or Exploitation Occurring Outside the Department of Mental Health:

Reports of abuse, neglect or exploitation of patients and clients occurring within Department of Mental Health facilities or programs shall be made in accordance with the provisions of this directive. Reports of child abuse and abuse, neglect or exploitation of vulnerable adults occurring outside the Department of Mental Health facilities and programs must also be reported in accordance with the provisions of the Child Protection Act and the Omnibus Adult Protection Act. The SCDMH Office of General Counsel may be consulted when there are questions concerning the reporting of such incidents.

VII. Staff-Patient/Client Relationships:

All employee relationships with patients and clients of the Department of Mental Health should be therapeutic and professional in nature. However, the Department recognizes that friends, neighbors and relatives of Department employees have been, are, or may become patients or clients of the agency. In order to protect the welfare of patients and clients, encourage adherence to professional standards and preserve the public image and integrity of the Department, the following guidelines are issued to supplement the prohibited conduct listed in paragraph III. These guidelines shall be adhered to by all employees, and employees are subject to disciplinary action in the event of a violation.

A. An employee shall not be directly involved in providing care or treatment of a patient or client who is a friend or relative of the employee. If an employee becomes aware that a friend or relative has become a patient or client of the facility in which the employee works, the employee shall promptly notify their supervisor, who shall ensure the employee is not assigned to provide care or treatment for the individual. The employee is further expected to refrain from seeking or disclosing information concerning the treatment or condition of the patient or client except in accordance with the SCDMH Directive entitled "Privacy Practices."

B. For professional staff, it is uniformly contrary to standards governing the practice and conduct of the respective health care professions to form personal or business relationships with patients or clients under their care. Any professional employee who engages in conduct contrary to the standards published by the licensing body of the employee's respective profession is subject to discipline by the Department.

C. Treatment programs are structured to meet the patient's or client's treatment related needs for socialization without unnecessarily increasing the patient's or client's dependence on staff for social relationships. Moreover, such relationships may give rise to an appearance of impropriety, and compromise the public image and integrity of the Department. Therefore employees are prohibited from forming social or business relationships with patients or clients or former patients or clients except as outlined below:

1. Contacts as a result of the patient or client being a relative of the employee.

2. Any group social interactions that are a result of similar religious, political or civic affiliations.

3. Any approved group treatment, rehabilitation, socialization or business activities of the center or facility.

4. Contacts which are the result of the continuation of a social or business relationship which pre-dated the patient's or client's receipt of services from a Department of Mental Health facility or the employee's employment with the Department.

5. Social or business relationships with a former patient or client: (a) who was never under the direct care of the employee; and (b) which developed separate and distinct from the performance of official duties by the employee.

This Directive is effective January 1, 2007, and rescinds and supersedes SCDMH Directive No. 780-94, entitled "Prohibited Abusive, Neglectful and Exploitative Conduct Toward Patients and Clients."

John H. Magill
State Director

January 18, 2007

STATEMENT

I have been furnished a copy of the South Carolina Department of Mental Health directive entitled "Abuse, Neglect or Exploitation of Patients and Clients Prohibited" and will retain a copy for reference.

Date	Employee's Signature
	Employee's Name (Please Print or Type)
	Social Security Number

Please return this signed/dated Statement to your Center/Facility Personnel Department

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE DIRECTOR OF MENTAL HEALTH DIRECTIVE NO. 775-93
(5-100)

TO: All Organizational Components

SUBJECT: Searches for Contraband/Stolen Property

I. Policy

It is the responsibility of each inpatient facility to take reasonable measures to prevent the introduction of contraband into its facility or the possession of contraband by its patients. (See SCDMH Directive 718-88, "Contraband Law.") It is also the responsibility of every organizational component to take reasonable measures to prevent the theft of Departmental property. (See the State Government Accountability and Reform Act of 1993.) One measure available to supervisory, clinical and law enforcement personnel to fulfill these responsibilities is the conduct of lawful searches. It is the policy of the Department that all searches conducted pursuant to this policy be carried out in a professional manner with due regard for the rights and dignity of the individual being searched.

II. Purpose

The purpose of this directive is to describe the circumstances in which it is permissible to conduct searches of patients, visitors and employees of the South Carolina Department of Mental Health. This directive also requires each inpatient facility and the Office of Public Safety to develop procedures specific to their areas of jurisdiction to implement this directive. Community mental health centers may also develop policies and procedures to provide for searches of clients, visitors and employees in consultation with the Office of General Counsel.

III. Searches of Patients

1. Patients or their belongings may be routinely searched by either clinical staff or public safety officers pursuant to a uniformly applied facility policy designed to further the safety and security of the facility, e.g., upon admission, upon return from pass.

2. Patients or their belongings or their living area (to include storage areas) may be searched by eith6r clinical staff or public safety officers any time there is a reasonable suspicion that a particular patient is in possession of contraband or stolen property. Such suspicion Must be the result of facts or circumstances sufficient to give rise to an individualized suspicion, and the extent of the search should be reasonably related to the objective of the search.

3. In circumstances where the head of a treatment facility determines that there is a need, patients or their belongings may be searched by either clinical staff or public safety officers on a random basis using a systematic pattern which minimizes or eliminates staff discretion relative to which patients are searched. The extent and method of random searches should be reasonably related to the objective of such searches.

All patient searches must be carried out in accord with the requirements of the SCDMH Directive entitled, "Patient Rights Manual."

IV. Searches of Visitors

1. In general, visitors may not be searched absent their consent.

2. Other than visits by legal counsel, private physicians, the patient's clergy or advocates of Protection and Advocacy for the Handicapped, Inc., the director of a facility may make consent to search a prerequisite for visits to patients.

a. In cases of individualized concern, the reasons for imposing the requirement should be set forth in the medical record of the patient.

b. In cases where the nature of the facility or program creates a heightened concern for safety, and security (e.g., forensic unit or addictions programs), the facility director may promulgate a uniform requirement applicable to all visitors.

c. Visitors subject to a search requirement must be advised orally, in writing or both of the requirement and must sign a written Consent to Search form, a copy of which is attached to this Directive as Appendix A. Any visitor who declines to consent to a search will be escorted from the facility.

V. Searches of Employees.

1. Employees of the Department of Mental Health are deemed to have consented to searches of their person, belongings and vehicles as a condition of their employment. Should employees not wish to have their belongings or vehicle(s) searched, they are not to bring them onto Departmental property.

2. Employees or their belongings may be searched by either supervisory staff or public safety officers any time there is a reasonable suspicion that a particular employee is in possession of contraband or stolen property. Such suspicion must be the result of facts or circumstances sufficient to give rise to an individualized suspicion, and the extent of the search should be reasonably related to the objective of the search.

3. In circumstances where the head of a treatment facility or organizational component determines that there is a need, employees or their belongings or their vehicles may be searched by either supervisory staff or public safety officers on a random basis using a systematic pattern which minimizes or eliminates staff discretion relative to which employees or vehicles are searched. The extent or method of random searches should be reasonably related to the objective of such searches.

4. An employee's office or desk may be searched by supervisory staff for the purpose of retrieving work-related materials or to investigate possible violations of work-place rules.

5. Refusal to allow a routine search of clothing, belongings or vehicle, or refusal to stop for a routine search will subject the employee to disciplinary action.

VI. Implementation

1. Each inpatient facility shall develop procedures specific to their facility and the Office of Public Safety shall develop procedures and guidelines regarding searches of patients, visitors and employees, for its officers,

2. Every employee of the Department is to be provided a copy of this directive, The statement attached to this directive (Appendix B) is to be signed by each employee, and such other individuals, including students, trainees and volunteers, who are regularly provided access to inpatient facilities. The Division of Human Resource Services is charged with this responsibility and shall file the statement in the employee's personnel folder.

3. Each inpatient facility shall provide the patients of the facility information concerning their facility policy governing searches of patients and visitors as part of patient orientation.

4. In the event a community mental health center develops a policy and procedure pursuant to this directive, it shall provide information concerning such policy to its employees and others subject to such policy.

This directive supplements SCDMH Directive No. 718-88, "Contraband Law."

Joseph J. Bevilacqua, Ph.D.
Director

Date: 10-15-93

APPENDIX A
Visitor Consent to Search Form

APPENDIX B
Employee, Student, Trainee and Volunteer
Consent to Search Form

STATEMENT

I have read the South Carolina Department of Mental Health directive entitled "Searches for Contraband/Stolen Property" and will retain a copy for reference.

I understand that employees of the South Carolina Department of Mental Health and other individuals afforded access to Department of Mental Health inpatient facilities are subject to search, together with any packages, belongings or vehicles which such individuals bring onto Departmental property. I also understand that a refusal to permit a search of clothing, packages, or vehicle will subject me to disciplinary action.

Date

Signature

Name – Print or Type

Social Security Number

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE DIRECTOR OF MENTAL HEALTH DIRECTIVE NO. 842-03
(3-240)

TO: **ALL ORGANIZATIONAL COMPONENTS**

SUBJECT: **HARASSMENT □ FREE WORKPLACE**

THE LANGUAGE USED IN THIS DIRECTIVE DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENTS OF THIS DIRECTIVE, IN WHOLE OR IN PART, WITH OR WITHOUT NOTICE.

I. POLICY:

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

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

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

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

II. PROHIBITED CONDUCT GUIDELINES:

It is not the intent of this policy to prohibit conduct which is in furtherance of a purely personal/social relationship without a discriminating or harassing employment effect. However, the DMH also has an interest in maintaining a professional work environment, which fosters productivity and efficiency, and all employees are expected to refrain from horseplay, excessive socializing, or spending time on

personal matters while working. Accordingly, even employees engaging in invited or welcomed personal social interactions are subject to discipline if such conduct interferes with the performance of the duties of other employees.

It is also not the intent of this policy to remedy every rude, unpleasant or discourteous incident that an employee may experience. Most work settings will require that employees work with, interact with, and provide services to a diverse group of people, some of whom may be upset or in crisis. Employees are expected to be able to tolerate and respond professionally to a wide range of human behavior, including, on occasion, rude, angry or upset individuals, or critical statements or comments.

The DMH will review the totality of the circumstances, including the nature of the conduct, and the context in which the alleged incidents occurred prior to determining whether disciplinary action is warranted. If the challenged conduct would not substantially affect the work environment of a reasonable person, no violation should be found.

III. RESPONSIBILITIES:

A. Director, Human Resource Services:

The Director of Human Resource Services or his/her designee will serve in the capacity of the DMH□s Harassment-Free Workplace Officer. The Director of Human Resource Services has the authority to implement every facet of the DMH□s Harassment-Free Workplace plan and report directly to the State Director of Mental Health or his/her designee. The Employee Relations Manager, Human Resource Services, will assist the Director of Human Resource Services in all phases of the complaint and subsequent investigative procedures.
Specific responsibilities of the DMH□s Harassment-Free Workplace Officer include, but are not necessarily limited to:

1. Developing guidelines to prevent harassment and communicating such guidelines throughout the DMH.

2. Assisting in the identification of potential problem areas and propose resolutions or actions needed for correction.

3. Hosting periodic discussions with managerial personnel, supervisors, and employees to assure the DMH□s policies pertaining to Harassment-Free Workplace are promoted.

4. Assuring that managerial personnel and supervisors understand they will be evaluated at least annually on promotional enforcement of a harassment-free environment in addition to other job-related criteria.

5. Compiling reports based on data provided by facilities, centers, and organizational components as needed or required by internal or external personnel.

B. Facilities, Centers, Division Directors:

Facility, Center and Division Directors are responsible for ensuring that the work environment is free of prohibited harassment. It is also their responsibility to resolve complaints promptly at the lowest possible level. Once they are informed of a potential problem, they must take action.

C. Managers and Supervisors:

Managers and supervisors have as one of their responsibilities the promotion of a harassment-free environment. It is their responsibility to adhere to, implement and support the DMH policies designed to prevent harassment. In this regard, managers and supervisors are expected to intervene appropriately whenever they become aware of conduct by their employees which manifests any illegal or otherwise improper discriminatory behavior or which creates an intimidating and/or hostile work environment. Managers and supervisors are expected to take actions that are in the best interest of the DMH.

D. Employees:

All employees of the DMH are expected to treat their co-workers, as well as patients, clients, and members of the public with courtesy and respect. Employees are also expected to perform their duties without interfering with the duties of others. Harassment or even the appearance of harassment has no place in the workplace and employees are expected to conduct themselves at all times in a professional manner.

IV. PROCEDURE:

A. Informal Complaint Procedures:

It is the intent of the DMH to resolve complaints promptly and at the lowest level. If, after being advised of a complaint, the Facility, Center or Division Director deems informal resolution appropriate the following steps may be taken:

1. The alleged offender may be requested by his/her supervisor to cease the offending behavior.

2. A resolution may be negotiated by the alleged offender□s supervisor after consultation with the Facility, Center or Division Director.

3. All action must be properly documented. If an informal resolution is sought, an □Employee Harassment Form□ shall be completed, with an indication that the complaint is □Informal□.

4. All harassment complaint forms must be submitted to the Employee Relations Manager, Human Resource Services, to be maintained in a confidential harassment file.

5. If warranted, disciplinary action and/or another remedy may be issued.

B. Formal Complaint Procedures:

1. If the complaint cannot be resolved informally, redress may be sought through the Formal Complaint Procedure. An □Employee Harassment Form□ must be completed and submitted to the Facility, Center or Division Director and then forwarded to the Employee Relations Manager, Human Resource Services.

2. The Employee Relations Manager, Human Resource Services, shall contact the complainant to review all circumstances regarding the complaint. All parties to the complaint shall provide written statements to the Employee Relations Manager, Human Resource Services.

3. The investigation shall be completed within a reasonable period of time.

4. All DMH employees are required to cooperate in the official investigation pursuant to this policy.

5. The results of the investigation shall be forwarded to the Director, Human Resource Services, who shall review the information and distribute to the appropriate manager.

6. If the investigation determines that a complaint is without merit or is false, it shall be dismissed. Disciplinary action may be taken if it appears that willful false accusations have been made.

7. If disciplinary action is recommended, it shall then be conveyed by the Director, Human Resource Services, to the Facility, Center or Division Director.

8. Disciplinary actions imposed on persons found to be in violation of discrimination of any form should be addressed through the □Employee Disciplinary Standards□ policy.

V. OTHER REMEDIES:

Regardless of the outcome of the investigation, if the complaint alleges illegal discriminatory conduct, the complainant shall be advised by the Employee Relations Manager, Human Resource Services, that a complaint may be filed with other state and federal agencies that enforce compliance with laws prohibiting discrimination.

If the disciplinary action is grievable, the affected employee shall be advised of his/her right to grieve through appropriate channels.

VI. CONFIDENTIALITY:

All efforts shall be made to maintain the confidentiality of complaints and investigations of complaints. Harassment complaints and subsequent reports and investigations shall be maintained in files by the Employee Relations Manager, Human Resource Services, separate and apart from the official personnel file.

This Directive rescinds and supersedes South Carolina Department of Mental Health Directive No. 816-99, □Harassment-Free Workplace□.

GEORGE P. GINTOLI
STATE DIRECTOR

November 7, 2003

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE STATE COMMISSIONER OF MENTAL HEALTH DIRECTIVE NO. 730-89
(3-250)

TO: All Employees

SUBJECT: Drug-Free Workplace

I. Policy

A. This document sets forth the South Carolina Department of Mental Health's policy prohibiting the unlawful manufacture, distribution, dispensation, possession or use of illegal drugs in the workplace by employees regardless of permanent or temporary status, pursuant to state and federal law.

B. Violation of this policy by employees, regardless of status, may lead to dismissal in accordance with Directive No. 627-83 entitled "Standards of Disciplinary Action" and/or any related policy. Violation of the laws regarding manufacture, distribution, dispensation, possession or use of illegal drugs may lead to criminal prosecution.

C. Grant or contract employees are required to abide by the terms of this policy as a condition of employment on the grant or contract. Federal law requires the South Carolina Department of -Mental Health to notify the granting or contracting agency of a criminal drug statute conviction in the workplace within ten (10) days of the date the department receives notification.

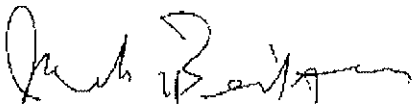
II. Procedure

A. Each employee of the South Carolina Department of Mental Health will be provided a copy of this policy at the time of its publication. Thereafter, each employee, including grant and contract employees, will receive a copy of this policy at the time of employment.

B. Although the unlawful manufacture, distribution, dispensation, possession or use of illegal drugs will subject the employee to the sanctions described in Section I. B. of this policy, employees are encouraged to seek assistance for problems which may affect their job performance, including drug problems, through the South Carolina Department of Mental Health, Employee Assistance Program. Referrals to the South Carolina Department of Mental Health, Employee Assistance Program, may be self-referrals or supervisory referrals pursuant to Directive No. 727-89 entitled 'Employee Assistance Program'.

C. Employees must, as a condition of employment, abide by the terms of the above policy and report any conviction under a criminal drug statute for violations occurring on or off agency premises while conducting agency business. A report of a conviction must be made within five (5) days after the conviction to the Personnel Records office.

D. The South Carolina Department of Mental Health will establish a drug-free awareness program to inform employees about the dangers of drug abuse in the workplace, the department's policy of monitoring a drug-free workplace, the Employee Assistance Program and the penalties that may be imposed upon employees for drug abuse violations.



Joseph J. Bevilacqua, Ph.D.
State Commissioner of Mental Health

May 30, 1989

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE STATE DIRECTOR OF MENTAL HEALTH **DIRECTIVE NO. 859-06 (3-250)**

TO: **All Employees, Volunteers, and Operating Components**

SUBJECT: **Workplace Violence**

THE FOLLOWING DOCUMENT IS TO BE INTERPRETED CONSISTENT WITH SECTION 41-1-110, CODE OF LAWS OF SOUTH CAROLINA. NOTHING IN THIS DOCUMENT OR ANY SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH (SCDMH) DIRECTIVE, EMPLOYEE HANDBOOK, MANUAL, POLICY, PROCEDURE, OR RELATED DOCUMENT, CREATES AN EMPLOYMENT CONTRACT OR CONTRACTUAL RIGHTS OR ENTITLEMENTS. SCDMH RESERVES THE RIGHT TO REVISE THIS DOCUMENT AND ANY SCDMH DIRECTIVE, HANDBOOK, MANUAL, POLICY, PROCEDURE, OR OTHER DOCUMENT. NO PROMISES OR ASSURANCES CONFLICTING WITH THIS STATEMENT CREATE AN EMPLOYMENT CONTRACT.

I. Policy

The SCDMH has a zero tolerance policy regarding acts or threats of workplace violence (as described in III).

II. Purpose

The purpose of this Directive is to help SCDMH centers, facilities, and other operating components assess and improve workplace security and to develop and implement policies and procedures to address workplace violence.

III. Workplace Violence

All forms of workplace violence are prohibited, including: attack or use of force with intent to harm; physical or verbal threats to cause harm; harassment or other behavior intended to worry the victim; stalking; intentional damage to property owned by SCDMH, the State, employees, officials, visitors or vendors; or unauthorized possession or use of firearms, weapons or other dangerous devises or materials on property owned, leased or under other SCDMH control.

IV. Implementation

Directors of SCDMH centers, facilities, and other operating components must, within thirty (30) days of the effective date of this Directive and annually thereafter, assess workplace security and assure compliance with applicable policies and procedures to address workplace violence. These functions are to be performed by the operating component Workplace Violence Prevention Committee or other committee with the responsibility and authority to assess workplace security and address workplace violence (e.g.; Health, Safety, Environmental Care, Risk Management, Quality Management, or similar committee.) The operating component must designate a liaison to, as needed, confer and work with the operating component and SCDMH offices related to specific Workplace Violence Prevention functions (e.g.; Human Resources Services, Quality

Management, Community Care, General Counsel, Public Safety, etc.)

Applicable policies and procedures include those contained in this Directive as well as other SCDMH Directives and operating component policies and procedures pertaining to employee injury, emergency care, and workplace safety; harassment; post-trauma counseling and other assistance services; leave and other benefits; background checks; employment counseling and discipline; pre-termination conferences and exit interviews; risk management and incident reporting; as well as BEST and other safety-related education or training programs. Further development of this Directive or related policies and procedures must incorporate applicable provisions of the S.C. Budget and Control Board, Office of Human Resources, Workplace Violence Model Policy.

Each SCDMH operating component must post a copy of this Directive (and any operating component written policy supplementing this Directive) in a prominent location within its building or office. Each operating component must clearly communicate the content of this Directive, (and any operating component□s written policy supplementing this Directive) to its employees and volunteers.

Employees, volunteers, and visitors must be advised that SCDMH will strictly enforce the applicable provisions of Section 16-23-420 and Section 16-23-460, Code of Laws of South Carolina, prohibiting firearms or concealed weapons in public buildings or adjacent areas. Operating components must post a sign to that effect at applicable entrances.

V. Workplace Environment

The workplace environment includes SCDMH buildings and grounds. Some points to consider in reviewing and making any needed changes to the workplace environment:

A. Designate and train employee contact/key persons in a emergency (e.g. fire/safety officer).

B. Provide a floor plan to key personnel and post a copy in conspicuous areas consistent with the fire/safety plans.

C. Post internal and external telephone numbers in conspicuous areas consistent with fire/safety plans.

D. Provide adequate lighting in parking areas and entrances and encourage employees to walk in groups to parking areas.

E. Review landscaping (hedges, trees, etc.) where intruders could hide.

F. Increase staff on duty during high-risk hours.

G. Arrange peer or other escorts for employees who work late.

H. If doors lock from the inside, post warning signs on the inside to remind employees to lock doors behind them.

The workplace environment also includes employee attitudes about SCDMH, employee perceptions of fair and equal treatment, and belief that they will be safe at work. Employees

must be encouraged to voice workplace concerns to their superiors or other designated staff (e.g., safety, risk management, human resource, or other staff.)

VI. Some Indicators of Potential Workplace Violence

In some cases, employees can be identified and provided assistance before they contribute to a violent incident. Some behaviors that should be considered are:

A. Known history of violent or threatening behavior;

B. Co-worker fear of an employee;

C. Extreme stress in an individual□s personal or job life;

D. Chemical dependency;

E. Obsession with weapons, recently publicized violent acts, or violent entertainment;

F. Observations of threatening behavior;

G. Routine violations of SCDMH Directives/operating component policy;

H. Harassment of co-workers;

I. Destructive behavior;

J. Obsession with retaliation after being disciplined, not receptive to criticism;

K. Little involvement with co-workers;

L. Significant adverse changes in behavior or beliefs;

M. Deteriorating physical appearance; or

N. Paranoid behavior.

VII. Reporting

A. Any employee who believes that there is a serious, imminent threat of violence in the workplace that requires immediate action must call 911 or law enforcement and notify his or her manager or supervisor. Employees should not attempt to take action themselves unless their life is threatened, but should follow safety and emergency procedures applicable to the operating component workplace.

B. Any employee who is the victim of or witnesses workplace violence must immediately report the incident to his or her supervisor or human resource representative. Any manager or supervisor receiving such a report must immediately contact his or her human resource representative to evaluate and take appropriate personnel action. An employee reporting an incident may request that his or her identity not be disclosed. Any employee who is the victim of or witnesses workplace violence must be offered post-trauma counseling.

C. Reports of workplace violence must be investigated by the operating component. If following the investigation the report is substantiated, appropriate action must be taken, including applicable disciplinary action, which may result in dismissal. Acts of workplace violence are also subject to civil and/or criminal prosecution.

D. The reporting employee will be notified of the investigation outcome and advised of any corrective or preventive action taken. However, the employee will not be told if any or what type disciplinary action was taken against another employee.

E. An employee reporting an incident in good faith will not be subject to retaliation by SCDMH. However, employees who knew of such incidents, but did not act consistent with this Directive or who knowingly made false reports are subject to appropriate discipline.

This is the first directive on this topic.

JOHN J. CONNERY, M.A.
INTERIM STATE DIRECTOR

February 10, 2006

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE STATE DIRECTOR OF MENTAL HEALTH DIRECTIVE NO. 917-13 (3-250)

TO: All Organizational Components

SUBJECT: Social Media

THE FOLLOWING DOCUMENT IS TO BE INTERPRETED CONSISTENT WITH SECTION 41-1-110, CODE OF LAWS OF SOUTH CAROLINA. NOTHING IN THIS DOCUMENT OR ANY SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH (SCDMH) DIRECTIVE, EMPLOYEE HANDBOOK, MANUAL, POLICY, PROCEDURE, OR RELATED DOCUMENT CREATES AN EMPLOYMENT CONTRACT OR CONTRACTUAL RIGHTS OR ENTITLEMENTS. SCDMH RESERVES THE RIGHT TO REVISE THIS DOCUMENT AND ANY SCDMH DIRECTIVE, HANDBOOK, MANUAL, POLICY, PROCEDURE OR OTHER DOCUMENT. NO PROMISES OR ASSURANCES CONFLICTING WITH THIS STATEMENT CREATE AN EMPLOYMENT CONTRACT.

I. PURPOSE:

This directive is to establish SCDMH policy for SCDMH employees, officials, volunteers, contractors and students regarding the use of internet or other electronic social media platforms, sites, forums, communities, and other social media activities as described herein including: blogs, podcasts, discussion forums, message boards and social networks (collectively: Social Media). With the rapid change in Social Media types and methods, the examples herein are for general reference only.

II. SOCIAL MEDIA DEFINITIONS:

Blogs: sites for posting written content, photos, videos and hyperlinks.

Podcasts: audio or video content/programs distributed via the internet.

Forums: sites for conversations through posted messages.

Social Networks: sites and other methods for users to post materials, comment, reply, rank, rate and/or link themselves to other users, including blogging and micro blogging (Twitter, Plurk, etc.), photo sharing (Flickr, Twitpic), video sharing (You Tube, Vimeo), life casting (Blog TV, Qik), status sharing or discussion (Facebook, MySpace), networking (LinkedIn, Plaxo) and others.

III. POLICY:

Employees, officials, volunteers, contractors and students must adhere to all applicable SCDMH Directives and other written policies regarding patient, client, employment and other private information. This includes SCDMH Directives and other written policies related to: Privacy Practices; Abuse, Neglect or Exploitation; Private Off-Duty Employment; Office of Network Information Technology (ONIT) Security; Corporate Compliance; and Public Information. Applicable Law includes: Health Insurance Portability and Accountability Act (HIPAA); 42 CRF Part 2; Section 44-22-100; Code of Laws of South Carolina, Section 30-2-

10 et seq; Code of Laws of South Carolina (Family Privacy Protection Act); Section 8-13-100 et seq, Code of Laws of South Carolina (Ethics Act), as well as laws related to computer or internet crime, professional licensing, discrimination, privacy, harassment, defamation, copyright, user license, etc.

IV. RELATED SCDMH DIRECTIVES AND OTHER COMPONENT POLICIES

Directive 875-06, Public Information Procedure
Office of Network Information Technology Policies and Procedures
Directive 846-04, SC DMH Internet Web Site and Intranet Web Site
Directive 910-12, South Carolina Department of Mental Health Letterhead and Logo, and Its Use
Directive 885-07, Abuse, Neglect or Exploitation of Patients and Clients, Prohibited
Directive 837-03, Privacy Practices
Directive 858-06, Privacy and the Use of Visual or Audio Recording and Transmitting Devices
Directive 786-94, Off-Duty Misconduct
Directive 808-98, Private Off-Duty Employment
DIS IM 5 Information Technology Services Policies and Procedures
DIS IM 2 Protected Health Information/Sequestering Medical Records

V. PROCEDURE:

Employees, officials, volunteers, contractors and students must follow all applicable Directives and other written policies noted above and Applicable Law, specifically SCDMH Directive 875-06 "Public Information Procedure" for release of information to the public. The SCDMH Director of Public Affairs is the official SCDMH spokesperson for release of information to the media and/or the public.

Unless specifically required by SCDMH job duties as documented and approved in writing by the applicable SCDMH director, SCDMH prohibits the use of Social Media while on duty or through the use of SCDMH or applicable SCDMH component network, devices, equipment or systems.

Employees, volunteers, contractors and students may, in an individual personal off duty capacity, in the exercise of lawful speech, use Social Media through their own or other non-SCDMH network, device, equipment or system (e.g. personal internet carrier, Wifi hotspot, PC, laptop, tablet, phone, etc.) However, even in that personal individual capacity, SCDMH employees, volunteers, contractors and students must not violate applicable SCDMH Directives or other written policies or Applicable Law related to privacy and/or security of any private information, including SCDMH Protected Health Information (PHI), employment or other personal, private or other non-public information.

If during individual personal use of Social Media, a SCDMH association is acknowledged, (e.g. Facebook biography names SCDMH as employer), use a disclaimer such as, "The views expressed are my own and do not reflect the views of my employer or anyone else."

Otherwise, in conducting individual personal social media activities:

1. Those activities must not interfere with your SCDMH job duties or position.

2. If likely to negatively impact SCDMH, do not refer to your SCDMH position or connection.
3. Do not use a SCDMH or applicable component e-mail or other address, site, link, etc.

4. Do not conduct a personal or business relationship with a current or former SCDMH client or patient unless specifically permitted by SCDMH Directive 885-07, "Abuse, Neglect or Exploitation of Patients and Clients, Prohibited", applicable licensing law and professional ethics.

5. Do not discuss SCDMH non-public information or issues related to your state employment.

6. Be truthful, respectful and courteous.

VI. **OTHER:**

Violations of this and other applicable directives and written policies, and/or applicable law, are subject to disciplinary or other adverse action, including termination of employment, or contractual or other agreement, and/or applicable criminal, civil and/or professional liability.

Nothing in this directive precludes an organizational component from issuing more specific guidelines or requirements concerning the subject of this directive, as necessary for the effective and efficient operation of the organizational component, consistent with his directive and the scope and mission of SCDMH.

This is the first directive titled "Social Media".

John H. Magill, State Director

September 12, 2013

South Carolina Department of Mental Health

Directive Statements

Please print your initials next to each directive statement after you have finished reviewing the directive. Date and sign your name below.

Initials

1. _____ **I have reviewed with the agency through which I am employed and understand form M-430 entitled, "Notice and Request for Return and Re-Confinement of SCDMH Involuntary Patient or Resident." I have also reviewed the following Policy and Procedure Directives: PC 9 "Elopement From Facility/Elopement From Pass," PC 9F "Elopement From Facility/Elopement From Pass," PC 9SV "Elopement From Facility," PC 20 "Off Campus Therapeutic Activities", RI 1 and RI 15 "Patient Paid Work Program." I have had an opportunity to ask questions and seek clarification related to content. I understand my role and responsibilities as related to procedures specified in these policies, including completion of the M-430 (Nursing Supervisors and Designees).**

2. _____ **I have reviewed SCDMH Directive #491-79 entitled, "Injuries and Occupational Diseases, Job Connected." I have read, understand and will adhere to the written procedures. I have received a copy of a completed "example" form HRS-16 (Report of Injury) and understand how to complete this form in case of an injury.**

3. _____ **I have reviewed SCDMH Directive #826-01 entitled, "Personal Appearance of Employees." I have read, understand and will adhere to the written procedures. It is the policy of the South Carolina Department of Mental Health that each employee's dress, grooming and personal hygiene should be appropriate to the employee's work situation and his/her profession. Violation of the directives may lead to appropriate disciplinary action.**

_____ _____

Print Name **Signature**

_____

Date

Division of Inpatient Services DMH South Carolina Department of Mental Health	POLICY AND PROCEDURE DIRECTIVE APPLICABLE TO: ☒ BPH ADULT PSYCHIATRIC ☒ BPH FORENSIC
SUBJECT: PATIENT PAID WORK PROGRAM	NUMBER: RI 1
	EFFECTIVE OR REVISED DATE: February 2014 Note: Individual pages may be revised and revised date shown on them.
PREPARED BY: AD HOC POLICY REVISION COMMITTEE	APPROVED:
DATES REVIEWED:	Versie J. Bellamy, Deputy Director

I. PURPOSE:

This directive describes guidelines for patient participation in "for pay" work opportunities.

II. POLICY:

A. Bryan Psychiatric Hospital (BPH) provides for a patient paid work program administered under the auspices of the Transitional Services treatment component.

B. Participation in the work program must have a therapeutic benefit as identified and documented by the treatment team. Patients voluntarily participate upon approval of the treatment team and the Privileges Review Team (see III.C).

C. Patients may work a maximum of two (2) hours per day for a total of not more than ten (10) hours per week. Work hours will not conflict with other treatment interventions.

D. Job sites for Bryan patients will be limited to the patient's assigned/"home" unit or lodge only.

E. Not more than 10 (2 per lodge) Bryan Adult Services patients may participate in the Paid Work Program at any one time. Not more than 12 (2 per unit) Bryan Forensic patients may participate in the Paid Work Program at any one time.

F. Job duration is limited to 90 days per occurrence; following a 90 day break in service, a patient may again be considered for participation.

G. The work program is conducted in accordance with all applicable local, state and federal laws and regulations relevant to hiring the handicapped.

III. PROCEDURES:

A. The Work Program Coordinator must have on file the number of available jobs, the specific job location, and a written position description to include necessary job knowledge, skills, abilities and/or physical requirements for each job.

B. Patients are preliminarily approved for participation in the Paid Work Program by the treatment team based on written, objective criteria. The treatment team must document the anticipated therapeutic benefit to the patient when approving participation in the work program. The treatment team must approve the specific job, position description, work hours, and work supervisor.

C. Following preliminary approval by the treatment team, the team coordinator will forward the request, along with relevant information/documentation to the

Program Director. Relevant information will include, at a minimum, progress over the past 30-60 days, any negative behaviors documented, diagnosis, legal status, treatment compliance and any other information to aid the Privileges Review Team (PRT) in making an informed decision. The Privilege Review Team, consisting of the Program Director, Program Director of Nursing, and Program Medical Director must concur with the treatment team before the patient is allowed to participate in the work program. The decision of the PRT is final.

D. Upon approval, participation in the work program will be documented on the plan of care as a treatment intervention. Progress, to include the therapeutic benefit, must be documented as required for other treatment interventions.

E. Patients will not be assigned to jobs that carry an inherent risk of danger such as climbing, operating machinery or using toxic chemicals.

F. Each patient worker is assigned a work site supervisor who oversees job performance, provides on the job training, and maintains and submits time records. The treatment team must provide the supervisor with written relevant information such as physical restrictions, precautions, required observation/monitoring.

G. Prior to supervising patient workers, job site supervisors must successfully complete a required orientation conducted by the Work Program Coordinator or designee. The content of the orientation will be written and must be approved by the DIS Executive Staff. The record of orientation will become a part of the employee's personnel field folder.

H. Job site supervisors must abide by all DMH and DIS P&Ps, rules and regulations regarding professional conduct with patients. Job site supervisors or other staff in the work area must not:

1. Discuss other patients or staff with or in the presence of patient workers;
2. Discuss personal or confidential matters with or in the presence of patient workers;
3. Develop a personal relationship with patient workers;
4. Perform personal services for patient workers such as shopping, relaying information from the patient to family or others, or allowing patient workers to use work or personal phones;
5. Borrowing from or lending money to patient workers.

Note: This list is not meant to be all inclusive.

I. Prior to beginning the work assignment, the job site supervisor will provide or arrange for patient workers to receive necessary training specific to the job duties they are asked to perform including safety and infection control practices, as indicated by the job type. (for example, the Infection Control Practitioner may be asked to address infection control practices).

J. To participate in the Patient Paid Work Program, a patient must have a verifiable Social Security number. To continue participation in the work program, the patient must comply with his/her treatment program and cooperate with treatment staff and the work site supervisor.

K. If the patient is not performing satisfactorily on the assignment, the work site supervisor may request the treatment team remove the patient from the assignment or transfer the patient to another assignment. The patient may also request re-assignment. The work site supervisor will consult with the Work Program Coordinator before any action is taken.

L. The patient receives wages commensurate with the economic value of the work as related to the individual's productivity/performance. Individual pay rates are determined by time study/performance evaluation performed by the Work Program Coordinator or designee, and prevailing wage rates for specific jobs. This process and the pay rate must be reviewed and approved by the facility director.

IV. DISTRIBUTION:
Each Psychiatric Service Chief, Administrative Department Head, and Discipline Chief will read this policy and brief subordinates.

V. RESCISSIONS:
This directive rescinds DIS Policy and Procedure Directive RI 1, "Patients' Paid Work Program" dated December 2011.

awb
January 2014

Division of Inpatient Services DMH South Carolina Department of Mental Health	POLICY AND PROCEDURE DIRECTIVE APPLICABLE TO: ☒ SVPTP
SUBJECT: Resident Paid Work Program	NUMBER: RI 15
	EFFECTIVE OR REVISED DATE: JANUARY 2014 Note: Individual pages may be revised and revised date shown on them.
PREPARED BY: AD HOC POLICY REVISION COMMITTEE	APPROVED:
DATES REVIEWED:	Versie J. Bellamy, Deputy Director

I. PURPOSE:

This directive describes guidelines for SVPTP resident participation in "for pay" work opportunities. The SVPTP supports the therapeutic benefits of employment which includes improvement of self-esteem, development of appropriate coping skills, problem solving skills, communication skills and pro-social skills.

II. POLICY:

A. Division of Inpatient Services (DIS) provides for a SVPTP resident work program administered under the auspices of the SVPTP Work Program Coordinators.

B. Participation in the work program has a therapeutic benefit as identified and documented by the Work Program Coordinators and treatment team. Residents voluntarily participate upon approval of the treatment team and Work Program Coordinators. Should a resident choose not to participate in the work program it will not be viewed negatively by the treatment team.

C. Residents may work a maximum of no more than 10 hours per week. Work hours will not conflict with other treatment interventions.

D. Job sites for resident workers will be within assigned program space. When resident workers must move from one unit to another, the resident must be escorted by Public Safety.

E. Residents may participate in the Work Program if they have a privilege band of green or blue. The Work Program Coordinator will match the required job duties with the required knowledge, skills and abilities of the resident.

F. Residents who progress from a red to green band can be placed on a list to request a job. The treatment team and Work Program Coordinator will work together on assignment of an appropriate job.

G. The work program is conducted in accordance with all applicable local, state and federal laws and regulations relevant to hiring the handicapped.

III. PROCEDURES:

A. The Work Program Coordinator must have on file the number of available jobs, the specific job location, and a written position description to include necessary job knowledge, skills, abilities and/or physical requirements for each job.

B. Residents are preliminarily approved for participation in the Work Program by the treatment team based on written, objective criteria. The treatment team must

document the anticipated therapeutic benefit to the resident when approving participation in the work program.

C. Following preliminary approval by the treatment team, the case manager will forward the request, along with relevant information/documentation to the Work Program Coordinator. Medical Provider, Nurse Manager, Case Manager and Work Program Coordinator must concur with the treatment team before the resident is allowed to participate in the work program.

D. Upon approval, participation in the work program will be documented on the plan of care as a treatment intervention. Progress, to include the therapeutic benefit, must be documented as required for other treatment interventions.

E. Residents will not be assigned to jobs that carry an inherent risk of danger such as operating heavy machinery or using toxic chemicals.

F. Each resident worker is assigned a work site supervisor who oversees job performance, provides on the job training, and maintains and submits time records. Only DIS staff with clinical experience/experience working with and supervising the activities of residents may serve as job site supervisors. The treatment team must provide the supervisor with written relevant information such as physical restrictions, precautions, required observation/monitoring.

G. Prior to supervising resident workers, job site supervisors must successfully complete a required orientation conducted by the Work Program Coordinator or designee. The content of the orientation will be written and must be approved by the DIS Executive Staff. The record of orientation will become a part of the employee's personnel field folder.

H. Job site supervisors must abide by all DMH and DIS P&Ps, rules and regulations regarding professional conduct with residents. Job site supervisors or other staff in the work area must not:

1. Discuss other residents or staff with or in the presence of resident workers;
2. Discuss personal or confidential matters with or in the presence of resident workers;
3. Develop a personal relationship with resident workers;
4. Perform personal services for resident workers such as shopping, relaying information from the resident to family or others, or allowing resident workers to use work or personal phones;
5. Borrowing from or lending money to resident workers.

Note: This list is not meant to be all inclusive.

I. Prior to beginning the work assignment, the Work Program Coordinator will provide or arrange for resident workers to receive necessary training specific to the job duties they are asked to perform including safety and infection control practices, as indicated by the job type (for example, the Infection Control Practitioner may be asked to address infection control practices).

J. To participate in the Resident Work Program, a resident must have a verifiable Social Security number. To continue participation in the work program, the resident must comply with his/her treatment program and cooperate with treatment staff and the work site supervisor.

K. If the resident is not performing satisfactorily on the assignment, the work site supervisor may request the treatment team remove the resident from the assignment or transfer the resident to another assignment. The resident may also request re-assignment. The work site supervisor will consult with the Work Program Coordinator before any action is taken.

L. The resident worker receives minimum wage based on all State and Federal minimum wage guidelines. This process and the pay rate must be reviewed and annually approved by the Program Director.

IV. DISTRIBUTION:

Each Psychiatric Service Chief, Administrative Department Head, and Discipline Chief will read this policy and brief subordinates.

V. RESCISSIONS:

This directive rescinds DIS Policy and Procedure Directive RI 1, "Patients' Paid Work Program" dated December 2011.

awb
January 2014

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE DIRECTOR OF MENTAL HEALTH DIRECTIVE NO. 824-01 (7-100)

TO: All Organizational Components

RE: Bloodborne Pathogens: Prevention, Treatment and Control

I. PURPOSE

A. To define the obligations of the Department of Mental Health (DMH) as related to the OSHA Bloodborne Pathogen Standard. These bloodborne pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV);

B. To establish guidelines for HIV testing and counseling of high-risk patients;

C. To establish guidelines and mechanisms for the appropriate care of DMH patients diagnosed with HBV, HCV or HIV;

D. To establish guidelines for management of DMH employees with HBV, HCV or HIV;

E. To outline procedures to limit the spread of HBV, HCV, HIV, and other bloodborne pathogens.

II. POLICY

A. The Department of Mental Health (DMH) accepts for inpatient treatment mentally ill patients or chemically dependent patients who may also have HBV, HCV or HIV. Upon completion of inpatient treatment of the patient's mental illness or chemical dependency, the patient is discharged and referred to a more appropriate health care provider for continued care of HBV, HCV or HIV and associated medical problems.

B. The attending physician orders HIV serologic testing as clinically indicated, following informed consent and counseling, on any patient(s) deemed at high risk. Examples: Patient with a history or indications of:

1. High risk sexual activity (whether heterosexual, bisexual, or homosexual), especially with multiple partners, and especially if a partner is known or suspected of having HIV;

2. Injectable drug abuse;

3. Accidental or incidental exposure to blood or other potentially infectious body substances;

4. Blood transfusion/blood products prior to June 1992.

C. The DMH provides safe, appropriate, and dignified care with an individualized treatment plan to all patients, including those who also have HBV, HCV or HIV. This care includes the consistent usage of current Standard Precautions and standard infection control processes, which eliminate the need for any unique precautions.

D . The DMH promptly and effectively assists employees with HBV, HCV or HIV humanely and confidentially, to include continued employment if consistent with the findings of their attending physician. To prevent potential exposure situations which could result in possible infection of patients or staff, health care workers with HBV, HCV or HIV who perform invasive procedures which qualify as "Exposure-Prone Invasive Procedures" are required to receive confidential appropriate Expert Panel review and recommendation as set forth in the Health Care Professionals Compliance Act.

III. PROCEDURES FOR PATIENTS

A. Testing for HBV, HCV or HIV

1. DMH physicians in all Inpatient Facilities are authorized to order appropriate serological testing for HBV, HCV or HIV when the attending physician considers the testing, clinically indicated. Informed consent, preferably written and with the signature of the patient, legal guardian or decision maker is obtained when possible and documented for patients undergoing diagnostic HIV testing. HIV specific counseling, both pre-test and post-test, is given to the patients when feasible. If a patient, once counseled, refuses the test, two physicians determine if the patient is to be tested. If the patient forcefully refuses the test, consultation with the Legal Department is sought.

2. DMH physicians in all Mental Health Centers are authorized to order appropriate serological testing for HIBV, HCV or HIV when the attending physician considers the testing clinically indicated and informed consent has been obtained. Center clients may also be referred for testing to the local health department.

3. Patient HBV,.HCV or HIV testing for healthcare worker post-exposure evaluation shall be conducted on source patients in accordance with established medical protocols, Center for Disease Control (CDC) recommendations and state law. **State law authorizes HIV testing of a patient without consent when related to a health care worker exposure.**

4. HBV, HCV and HIV baseline testing shall be conducted on both patients in the event of an exposure (i.e., percutaneous, ocular, oral, cutaneous, or sexual intercourse) involving two patients.

5. HCV and HIV positive results will be confirmed by further testing.

6. As with all medical information, strict confidentiality shall be maintained for test results.

B. Patient Exposures

1. In the event of a patient exposure to blood or other potentially infectious body substances the patient shall receive immediate medical evaluation.

2. HBV, HCV and HIV baseline testing shall be conducted if status unknown or previously negative.

3. HIV testing is available through the SCDMH laboratory.

4. If a patient exposes another patient to HIV, the exposed patient shall be informed of an exposure to the HIV but the source patient's identity shall not be disclosed.

5. If the exposed patient's HIV baseline is seronegative and the source patient is positive for HIV antibody or has HIV risk factors, the exposed patient shall be retested at six (6) weeks, three (3) months, six (6) months and twelve (12) months.

6. In the event of a patient exposure (i.e., percutaneous, ocular, oral or cutaneous) involving an HIV positive patient, HIV preventive treatment shall be offered and administered, if indicated, according to CDC recommendations.

7. If HIV preventive treatment is indicated, medical evaluation and treatment shall be obtained promptly. Preventive HIV treatment is most effective if administered within two (2) hours of the exposure incident.

8. If a patient exposes another patient to HBV, the patient shall receive immediate medical evaluation and preventive treatment is offered.

9. If a patient exposes another patient to HCV, the exposed patient shall be retested at six (6) months and twelve (12) months.

10. If an exposed patient is discharged, discharge planning efforts will include referral to an appropriate community health care provider for follow-up care.

C. Treatment for HBV, HCV or HIV

1. The Facility and Center directors are responsible for the provision of safe, appropriate, and dignified treatment to patients with HBV, HCV or HIV, with emphasis on the individualized treatment needs and rights of the patient, as well as ensuring adequate procedural and environmental control to protect staff and other patients from possible exposure in accordance with appropriate infection control procedures, including Standard Precautions.

2. An integral part of the treatment is continued counseling of the patients regarding the nature of their disease, with emphasis on the prevention of transmission of HBV, HCV or HIV to others.

IV. PROCEDURES FOR EMPLOYEES

A. Exposure Control Plan

DMH facilities and mental health centers shall maintain an Exposure Control Plan that is reviewed and updated at least annually and whenever necessary that reflects changes in technology that eliminate or reduce exposure to bloodborne pathogens.

B. Employee Responsibility

The employee is responsible for complying With Bloodborne Pathogen training and policies to prevent the exposure of themselves and others to HBV, HCV or HIV.

C. Standard Precautions

Since the medical history and examination cannot reliably identify all patients infected with HBV, HCV or HIV, or other bloodborne pathogens, all patients are considered potentially infectious, and Standard Precautions shall be applied consistently in the care of all patients.

D. Safer Medical Devices

DMH facilities and mental health centers shall provide a process to consider, evaluate, approve, train and implement safer medical devices as they become commercially available, with direct care givers participation.

E. Occupational Exposure Categories

An exposure category is determined for each employe6:

Category 1: Your job routinely involves potential exposure to blood, body fluids, or tissues.

Category 11: Your job may expose you occasionally or in emergency situations to blood, body fluids, or tissue.

Category III: Your job does not involve exposure to blood, body fluids, or tissue. You do not perform or help in emergency medical care or first aid as part of your job.

F. Training

DMH facilities and mental health centers shall provide a bloodborne pathogen training program to employees in Categories I and II. This training is provided prior to initial assignment and at least annually thereafter. The content of the training shall include at least the minimum elements listed in the OSHA Bloodborne Pathogen regulations.

G. Pre-Exposure Protection

1. Hepatitis B vaccination shall be made available after the employee has received training on bloodborne pathogens and within ten (10) working days of initial job assignment.

2. Employees who provide direct patient care or who have potential for exposure to blood and other potentially infectious materials, (Categories I and 11 above) are strongly encouraged to receive the Hepatitis B vaccine.

3. For employees with potential for occupational exposure, who elect to have the protection of Hepatitis B vaccine, the vaccine shall be available through the Employee Health Program.

a. Hepatitis B vaccine, a three step vaccination series, and any associated testing performed shall be provided at no cost to the employee.

b. Participation in a pre-screening program is not mandatory for receiving hepatitis B vaccination nor is it routinely recommended. However, when pre-vaccination lab work is indicated, testing shall be provided by the SCDMH laboratory for facilities located in the Columbia area. Blood samples will be obtained at the employee's home facility and forwarded to the laboratory during normal working hours. Blood sample requisitions will be labeled "pre-vaccine".

c. Post-vaccination testing shall be performed from 30 to 60 days after completion of the vaccine series for employees with potential for occupational exposure. Blood sample requisitions will be labeled "post-vaccine". Re-vaccination with the three dose series will be offered for employees who do not respond to the initial vaccine' series.

4. Employees with potential for occupational exposure who decline to accept Hepatitis B vaccination shall be required to read and sign the mandatory Hepatitis Vaccine Declination Statement as required by OSHA.

5. Employees with potential for occupational exposure who initially decline the hepatitis B vaccination, but at a later date decide to accept, may request and receive HBV vaccination at any time at no cost.

H. Post Exposure

Accidental percutaneous (needle stick, laceration, or bite), ocular, oral, or cutaneous (chapped, abraded or otherwise non-intact skin) exposure to blood or other potentially infectious materials shall be handled as follows:

1. The exposed employee **immediately** thoroughly washes or flushes the exposure site as appropriate.

2. The exposed employee **promptly** reports to their supervisor.

3. The supervisor initiates a P-16 "Report of Injury" form describing the injury and prompt refers the exposed employee to their affiliated health care services for examination, treatment and follow-up. Prompt treatment is essential since preventive treatment is time limited (i.e., HIV preventive treatment is most effective if administered within two (2) hours of the exposure incident).

a. DMH Facilities and Mental Health Centers

Employees are promptly provided transportation if needed to the designated health care services as indicated by their facility/center policy.

b. Agency Personnel

Agency personnel who receive injuries that may expose them to blood or other potentially infectious materials are required to report the injury promptly to their agency since they are covered under the agencies' Workers' Compensation Program.

4. The post-exposure evaluation, treatment, and follow-up are provided at no cost to the employee. All bills incurred are forwarded to the Worker's Compensation Coordinator in the Benefits Office of DMH Human Resource Services.

5. If the employee terminates employment prior to completion of the Hepatitis B vaccine series, HCV testing series or HIV testing series **after a job-related exposure,** the employee may make arrangements through their previous facility or mental health center to complete the series.

I. Record Keeping

A. DMH facilities and centers shall establish and maintain a medical record for all employees with potential for occupational exposure. Employee Health records of training, vaccinations, immunizations, etc. shall be maintained for the duration of employment, plus thirty (30) years. Employee Health records shall be kept confidential and will not be disclosed or reported without the employees expressed written consent to any person within or outside the facility/center except as required by OSHA Standard or other federal, state or local regulations.

B. DMH facilities and mental health centers shall establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps. The information in the sharps injury log is recorded and maintained in such a manner as to protect the confidentiality of the injured employee. The sharps injury log contains at a minimum the type and brand of device involved in the incident, the department or work area where the exposure incident occurred and an explanation of how the incident occurred. If medical treatment beyond minor first aid is rendered, the occupational exposure is recorded on the OSHA log and summary of occupational injuries and illnesses and on the Adverse Incident Report form #C-174.

J. HBV, HCV or HIV Positive Employees

1. Only those health care workers who perform invasive procedures which qualify as "Exposure-Prone Invasive Procedures" (EPIPs) are required in accordance with the Health Care Professionals Compliance Act (HCPCA) to determine their HBV, HCV or HIV serostatus. Employees with HBV, HCV and/or HIV comply with current CDC recommendations and the HCPCA. Those who perform EPIPs must seek Expert Panel review and recommendations. If those specific recommendations include notification of a supervisor or employer, this must be complied with or grounds for dismissal exist.

2. For any other employee it is requested, but not required, that the employee report their HIV positive status to the Employee Health Nurse to allow for accurate interpretation of the annual PPD and to assist in determining need for further evaluation.

3. If the HBV, HCV or HIV positive employee does not comply with measures recommended to prevent transmission or there is evidence that the employee may be transmitting infection, the need for removal from direct patient care shall be assessed by the Facility Director or designee to assure staff and patient safety.

V. CONFIDENTIALITY

The fact that a patient or employee is seropositive for HBV, HCV or HIV is confidential medical information.

VI. RESCISSION

This directive rescinds and supercedes Directive No. 774-93 September 30, 1993 and entitled "Bloodborne Pathogens: Prevention, Treatment and Control."

GEORGE P. GINTOLI
STATE DIRECTOR

July 13, 2001

BLOODBORNE PATHOGNES RISK CLASSIFICATION FORM – AGENCY STAFF	
JOB CATEGORIES AND RISK OF EXPOSURE	
☐Category I:	Your job routinely involves potential for mucous membrane or skin contact with blood, body fluids or tissues. Employees whose duties include anticipated tasks for potential exposure include: physicians, nurses, phlebotomists, environmental services, transportation, mental health specialists, public safety offices, grounds maintenance
☐Category II:	Your job may expose you occasionally or in emergency or unplanned situations to blood, body fluids or tissues. This potential exposure may be required as a condition of employment. Employees whose duties include such potential include: activity therapists, psychologists, social workers, vocational rehabilitation, pharmacy, supply, dietary, librarian, volunteers, chaplains
☐Category III:	Your job does not involve exposure to blood, body fluids or tissue. You do not perform or help in emergency medical care or first aid as part of your job. Tasks that involve handling or implements or utensils, use of public or shared bathroom facilities or telephones and personal contacts such as handshaking are Category III tasks. Employees included in Category III include: secretarial staff, administration, business office, medical records

Date: _____

I have reviewed the categories described and understand that my category of risk as an Agency Nursing staff as indicated above.

_____

Print Name

_____

Signature

_____

Social Security Number

_____

Name of Agency

Division of Inpatient Services DMH South Carolina Department of Mental Health	POLICY AND PROCEDURE DIRECTIVE
	Applies to: ☒ WSHPI ☒ Bryan Adult Psych ☒ Morris Village ☒ C.M. Tucker ☒ HPH
SUBJECT: ELOPEMENT FROM FACILITY (EFF) ELOPEMENT FROM PASS (EFP)	NUMBER: PC 9
	EFFECTIVE OR REVISED DATE: February 2014 Note: Individual pages may be revised and revised date shown on them.
PREPARED BY: AD HOC POLICY REVISION COMMITTEE	APPROVED:
DATES REVIEWED:	Versie J. Bellamy, Deputy Director

I. PURPOSE:

This directive standardizes policies and procedures to be followed when it is suspected or confirmed that a patient has left or is absent from, the premises of a SCDMH Division of Inpatient Services (DIS) facility, or from a DIS authorized activity without authorization, or failure to return from a pass as scheduled.

II. APPLICABLE TO:

- William S Hall
- Morris Village
- Harris Psychiatric Hospital
- Bryan Psychiatric Hospital Adult Services
- CM Tucker

For Bryan Psychiatric Hospital Forensic Services: See P&P Directive PC 9F
For Sexually Violent Predator Treatment Program (SVPTP): See P&P Directive PC 9SV

III. DEFINITIONS:

A. Absence: When a patient is suspected of being, or known to have left the DIS facility premises, or authorized activity (e.g., community outing medical appointment, court appearance, etc.), or otherwise cannot be accounted for within thirty (30) minutes of a search for the patient, or within thirty (30) minutes of a failure to return from pass as scheduled.

B. Unauthorized Absence: Absence of a patient who is involuntarily admitted (emergency admission or judicial admission/commitment), or who is voluntarily admitted and who has also been certified for an emergency admission by a physician as likely to cause serious harm to self or others due to mental illness or chemical dependency if not immediately hospitalized. Voluntary patients who are not likely to cause serious harm as noted above, will be administratively discharged in accord with DIS procedures and policies including notification.

C. Elopement from Facility (EFF): Unauthorized Absence from DIS facility premises or from a DIS authorized off-premises activity.

D. Elopement from Pass (EFP): Unauthorized Absence by failure to timely return from pass.

IV. POLICY:

The Leadership and staff of the Division of Inpatient Services are committed to protecting the well-being of patients and the public. To this end, specific procedures in this directive are designed to decrease the risk of elopement and to increase the likelihood of locating the individual as soon as possible in case of elopement.

V. PROCEDURES:

A. It is the responsibility of the Program Director to ensure that medical records are "flagged" in accordance with DIS P&P IM 6, entitled Flagging Records and Files, in order to alert staff to readily accessible information relevant to required notifications and to provide contact information in case of elopement.

B. Within 24 hours of admission, the appropriate A&D office supervisor or designee will forward to the Office of Public Safety a copy of the medical record face sheet for each admission. If the record is flagged, Public Safety will be provided an updated copy in the event the information is revised. Facilities in the Columbia area will send face sheet copies to:
Office of Public Safety Dispatch,
Building 17 - Crafts-Farrow Campus
The A&D office at Harris Hospital will forward copies of face sheets to the Public Safety office at that facility.

C. The first person who becomes aware that a patient cannot be accounted for is to immediately notify Public Safety providing the following information:
1. Patient name
2. Clothing worn at last sighting
3. Where the patient was last seen
- The notification to Public Safety is to be made immediately, without delay; do not attempt to confirm elopement before notification to Public Safety.

D. That person will then immediately notify the nurse in charge on the patient's unit and begin a search of the immediate area when the patient was last known to be.
- The notification to the charge nurse is to be made after notification to Public Safety but within 15 minutes of the time the patient cannot be located.

E. Public Safety has responsibility to notify local law enforcement and other appropriate law enforcement agencies, including home county and State law enforcement Division (SLED).

F. The nurse in charge on the unit will then immediately notify the nursing supervisor; the supervisor has responsibility to notify:
1. The Program Director, who has responsibility to notify:
   a. DIS Deputy Director
   b. DIS Medical Director
   c. Program Medical Director`
2. Program Director of Nursing who has responsibility to notify the DIS Nurse Executive
3. The attending LPP or OD/ON
4. The patient's correspondent

G. The charge nurse or designee will notify the A&D Office of the elopement, and of the patient's return, if applicable.

H. If the patient is located and taken into protective custody by Public Safety, that office will determine appropriate action necessary to return the patient to the facility, and notify applicable law enforcement.

I. If an order of re-confinement has been issued by the responsible LPP (Form M-430) and the patient is later located and in custody, the Program Director, in consultation with other DIS administrative staff, will determine appropriate actions to be taken.

J. If a patient has not returned from an authorized pass at thirty (30) minutes beyond the scheduled return time, the nurse in charge on the unit will immediately notify Public Safety and consult with the Program Director regarding an appropriate course of action.

VI. REQUIRED DOCUMENTATION:

Form M-430 is completed as verification of the LPP's re-confinement order. Public Safety will further document required notifications using applicable OPS forms and procedures.

A. The Nursing Supervisor or designee will complete Form M-430, and obtain the signature of the LPP issuing the order and provide it to Public Safety.
B. Public Safety will make and document other required notifications.
C. A copy of Form M-430 will be placed in the patient's medical record.

VII. RECONFINEMENT ORDERS:

A. An LPP's re-confinement order is effective indefinitely for a patient who elopes with pending criminal charges or has been found Not Guilty by Reason of Insanity (NGRI). In all other cases, the re-confinement order is effective for one year. After one year from the date of the re-confinement order, the facility may administratively discharge the patient after notification to the applicable Probate Court, absent any applicable outstanding judicial proceeding.
B. In cases where the patient is administratively discharged after one year, a memorandum will be sent from the Program Director to the Office of Public Safety requesting cancellation of the Notice and Request for Re-confinement.

VIII. DISTRIBUTION:

Each Psychiatric Service Chief, Administrative Department Head and Discipline Chief will read this policy and brief subordinates.

IX. RESCISSIONS:

This directive rescinds DIS Policy and Procedure PC 9, Elopement From Facility (EFF) or Pass (EFP) dated October 2012.

X. REFERENCES:

SCDMH Directive ___-14, Unauthorized Patient Absences
DIS P&P IM 6, Flagging Records and Files

awb
3/2014

Division of Inpatient Services DMH South Carolina Department of Mental Health	POLICY AND PROCEDURE DIRECTIVE Applies to: ☒ Bryan Forensic
SUBJECT: ELOPEMENT FROM FACILITY (EFF) and ELOPEMENT FROM PASS (EFP)	NUMBER: PC 9F EFFECTIVE OR REVISED DATE: March 2014 Note: Individual pages may be revised and revised date shown on them.
PREPARED BY: AD HOC POLICY REVISION COMMITTEE DATES REVIEWED:	APPROVED: Versie J. Bellamy, Deputy Director

I. PURPOSE:
This directive standardizes policies and procedures to be followed when it is suspected or confirmed that a patient has left or is absent from, the BPH Forensic Inpatient Hospital premises (Forensics) or from a DIS authorized activity or authorized absence

II. APPLICABLE TO:
This directive is applicable to Bryan Psychiatric Hospital Forensic Services only.

III. DEFINITIONS:
A. Absence: When a patient is suspected of being, or known to have left the Forensics' premises, or authorized activity (e.g., community outing, medical appointment, court appearance, etc.), or otherwise cannot be accounted for within thirty (30) minutes of a search for the patient, or within thirty (30) minutes of a failure to return from pass as scheduled.
B. Unauthorized Absence: Absence of a patient who is involuntarily admitted (emergency admission or judicial admission/commitment), or other court order (e.g. for evaluation).
C. Elopement from Facility (EFF): Unauthorized Absence from DIS facility premise or from a DIS authorized off-premises activity.
D. Elopement from Pass (EFP): Unauthorized Absence by failure to timely return from an authorized leave of absence/pass.

IV. POLICY:
The Leadership and staff of the Division of Inpatient Services are committed to protecting the well-being of our patients and the public. To this end, specific procedures in this directive are designed to decrease the risk of elopement or to increase the likelihood of locating an individual as soon as possible in case of elopement.

V. PROCEDURES:
A. Within 24 hours of admission, the A&D office supervisor or designee will forward to the DIS Office of Public Safety a copy of the medical record face sheet for each admission. Public Safety will be provided an updated copy in the event the information is revised or updated. Copies of face sheets should be forwarded to:
- Office of Public Safety Dispatch

- Building 17 - Crafts-Farrow Campus

B. The first person who becomes aware that a patient cannot be accounted for is to immediately notify Public Safety providing the following information:
   1. Patient name
   2. Clothing worn at last sighting
   3. Where the patient was last seen
   - The notification to Public Safety is to be made immediately, without delay; do not attempt to confirm elopement before notification to Public Safety.

C. Should an absence occur on DMH/DIS property, (e.g., Building 16 at Crafts-Farrow, sub-specialty clinics at Midlands) the immediate area will be promptly secured until a thorough search has been completed. Should the incident occur away from DMH/DIS property, (e.g., community medical office, community hospital), DIS staff will request that the immediate area be secured and request assistance with conducting a search. PSO/staff will immediately notify or request notification of local security, police, etc. providing a description of the patient.

D. That person will then immediately notify the nurse in charge on the patient's unit. .
   - The notification to the charge nurse is to be made within 15 minutes of the time the patient cannot be located.

E. The nurse in charge on the unit will immediately notify the Chief of Security located at BPH Forensic who will coordinate with Public Safety to facilitate their response.
   - The notification to the BPH Forensic Chief of Security is to be made within 15 minutes of the time the patient cannot be located.

F. Public Safety has responsibility to notify local law enforcement and other appropriate law enforcement agencies, including home county and State Law Enforcement Division (SLED).

G. The nurse in charge on the unit will then immediately notify the nursing supervisor; the supervisor has responsibility to notify:
   1. The Program Director, who has responsibility to notify:
      a. DIS Deputy Director
      b. DIS Medical Director
      c. Program Medical Director
      d. Forensic Staff Attorney, who will ensure notification is made to the appropriate court personnel
      e. BPH A&D Office of the elopement, and of the patient's return, if applicable.
   2. Program Director of Nursing who has responsibility to notify the DIS Nurse Executive
   3. The attending LPP or OD/ON
   4. The patient's correspondent

H. The charge nurse or designee will notify the Bryan Hospital A&D Office of the elopement and when the patient is returned, if applicable.

VI. REQUIRED DOCUMENTATION:

Form M-430 is completed as verification of the LPP's re-confinement order. Public Safety will further document required notifications using applicable OPS forms and procedures.

1. The Nursing Supervisor or designee will complete form M-430, obtain the signature of the LPP issuing the order and provide it to Public Safety.
2. Public Safety will make and document other required notifications.
3. A copy of form M-430 is to be placed in the patient's medical record.

VII. RECONFINEMENT ORDERS:

1. An LPP order for re-confinement is effective indefinitely for an individual who elopes with pending criminal charges or has been found Not Guilty by Reason of Insanity (NGRI). In all other cases the re-confinement order is effective for one year from the date of the order, and thereafter the facility may administratively discharge the patient after notification to the applicable Probate Court absent any applicable outstanding judicial proceeding.
2. In cases where the patient is administratively discharged after one year, a memorandum will be sent from the Program Director to the Office of Public Safety requesting cancellation of the Request for Return for Re-confinement.

VIII. DISTRIBUTION:

Each Psychiatric Service Chief, Administrative Department Head and Discipline Chief will read this policy and brief subordinates.

IX. RESCISSIONS:

This directive rescinds DIS Policy and Procedure PC 9 "Elopement From Facility (EFF) or Pass (EFP)" dated October 2012.

X. REFERENCES:

SCDMH Directive _____-14, Unauthorized Patient Absences

Division of Inpatient Services DMH South Carolina Department of Mental Health	POLICY AND PROCEDURE DIRECTIVE Applies to: ☒ SEXUALLY VIOLENT PREDATOR TREATMENT PROGRAM (SVPTP)
SUBJECT: ELOPEMENT FROM FACILITY (EFF)	NUMBER: PC 9SV EFFECTIVE OR REVISED DATE: March 2014 Note: Individual pages may be revised and revised date shown on them.
PREPARED BY: AD HOC POLICY REVISION COMMITTEE DATES REVIEWED:	APPROVED: Versie J. Bellamy, Deputy Director

I. PURPOSE:
This directive standardizes policies and procedures to be followed when it is suspected or confirmed that a resident has left or is absent from the assigned SVPTP unit or from a staff supervised out of facility activity.

II. APPLICABLE TO:
This directive is applicable to the Sexually Violent Predator Treatment Program (SVPTP) only.

III. DEFINITIONS:
A. Absence: When an SVPTP resident is suspected of being, or known to be absent from the assigned SVPTP unit, or a staff supervised out of facility activity (e.g., medical appointment), or otherwise cannot be accounted for within thirty (30) minutes of a search for the resident.
B. Elopement from Facility (EFF): Absence from SVPTP facility premises or from a staff supervised out of facility activity.

IV. POLICY:
The leadership and staff of the Division of Inpatient Services are committed to protecting the well-being of our residents and the public. To this end, specific procedures in this directive are designed to decrease the risk of elopement or to increase the likelihood of locating an individual as soon as possible in case of elopement.

V. PROCEDURES:
A. Within 24 hours of admission, the A&D office supervisor or designee will forward to the DIS Office of Public Safety a copy of the treatment record face sheet for each admission. Public Safety will be provided an updated copy in the event the information is revised or updated. Copies of face sheets should be forwarded to:
- Office of Public Safety Dispatch
  Building 17 - Crafts-Farrow Campus

B. Should an absence occur on DMH/DIS property, (e.g., SVPTP or sub-specialty clinics at Midlands) the immediate area will be promptly secured until a thorough

search has been completed. Should the incident occur away from DMH/DIS property, (e.g., community medical office, community hospital), PSO/staff should request that the immediate area be secured and request assistance with conducting a search. PSO will immediately notify or request notification of local security, police, etc. providing a description of the resident.

C. The first person who becomes aware that a resident cannot be located is to immediately notify Public Safety providing the following information:
   1. Resident name
   2. Clothing worn at last sighting
   3. Where the resident was last seen
   - The notification to Public Safety is to be made immediately, without delay; do not attempt to confirm elopement before notification to Public Safety.

D. That person will then immediately notify the nurse in charge on the resident's unit who will immediately notify the Program Director.
   - The notification to the charge nurse is to be made within 15 minutes of the time the resident cannot be located.

E. All available staff will participate in an immediate search.

F. The Public Safety Supervisor has responsibility to notify the Duty Warden at Broad River Correctional Institute (BRCI) at 896-2234.

G. Public Safety has responsibility to notify local and other applicable law enforcement including the SC Law Enforcement Division (SLED).

H. The Program Director has responsibility to notify SCDMH Office of General Counsel (during business hours) and the Deputy Director within 15 minutes of the time of a resident's EFF. The Deputy Director will notify other DIS and DMH officials.

I. Unless there are instructions to the contrary, the charge nurse will notify the correspondent.

J. The charge nurse will notify the Bryan Hospital Admissions/Discharge Office at 935-7140, ext. 9 of the elopement and in the event the resident is returned.

VI. REQUIRED DOCUMENTATION:

Form M-430 is completed as verification of the LPP's re-confinement order. Public Safety will further document required notifications using applicable OPS forms and procedures.

1. The charge nurse will complete Form M-430 and obtain the signature of the LPP issuing the order, and provide it to Public Safety.
2. Public Safety will make and document other required notifications.
3. A copy of Form M-430 is to be placed in the resident's treatment record.

VII. DISTRIBUTION:

The Program Director and each Department/Discipline Chief will ensure that all employees have read and are aware of the content of this policy.

VIII. RESCISSIONS:

This is the first SVPTP policy on this subject.

IX. REFERENCES:

SCDMH Directive ___-14, Unauthorized Patient Absences

Division of Inpatient Services DMH South Carolina Department of Mental Health	POLICY AND PROCEDURE DIRECTIVE Applies to: ☒ WSHPI ☒ Bryan Adult Psychiatric ☒ C.M. Tucker ☒ MV ☒ Bryan Forensic ☒ HPH
SUBJECT: OFF-CAMPUS THERAPEUTIC ACTIVITIES	NUMBER: PC 20 EFFECTIVE OR REVISED DATE: February 2014 Note: Individual pages may be revised and revised date shown on them.
PREPARED BY: AD HOC POLICY REVISION COMMITTEE DATES REVIEWED:	APPROVED: Versie J. Bellamy, Deputy Director

I. PURPOSE:

This directive establishes policy and procedures for off-campus therapeutic activities.

II. POLICY:

The Division of Inpatient Services (DIS) supports the occasional use of off-campus activities as an opportunity for patients to apply what they have learned in treatment to "real life" settings. Through these supervised activities, patients have opportunity to practice strategies that reduce their anxiety and ease their transition back into the community. An exception to "occasional" applies to Long Term Care (LTC) facilities, which are home for most residents. Therefore, LTC staff and residents have more flexibility in planning and participating in off-campus activities.

Note: This directive is not relevant to the following:

- Therapeutic home/community trial visitations which are usually arranged to assess the patient's ability to function in a less structured home/community environment.
- Therapeutic Pass which can generally be defined as a short duration leave of absence granted for therapeutic reasons and incorporated into the plan of care. (P&P LD 20, entitled Therapeutic Passes provides guidelines)
- Off grounds medical appointments.

Note: The Sexually Violent Predator Treatment Program (SVPTP) does not provide off-campus activities.

Note: As a general rule, the Bryan Forensic Services does not routinely provide off-campus activities; however, requests will be considered on a case by case basis. (See IV. B. 2.)

III. DEFINITION:

An off-campus therapeutic activity includes any patient activity not excluded in section II. above that occurs off the facility grounds. Activities may or may not require transportation; e.g., a staff supervised walk off-grounds is considered an off-campus therapeutic activity.

IV. PROCEDURES:

A. Transportation

The trip organizer is responsible for arranging transportation. For the Columbia facilities the Request For Transportation, form E-21AA), is completed to include the specific destination (ex. Ryan's Steakhouse, Two Notch Rd) by the organizer. The request is forwarded to SCDMH Vehicle Management at least 24 hours prior to the scheduled activity. Transportation is scheduled by Vehicle Management on a first-come, first-served basis. Harris Hospital utilizes hospital assigned state vehicles for transportation. Under no circumstances will private vehicles be used to transport patients.

B. Approval for Patient Participation

1. General Requirements for All Facilities:

a. At least (2) two business days in advance, the trip organizer (usually a member of the Activity Therapy Department), must obtain treatment team recommendation for the activity. The organizer will present details regarding the purpose, destination, activity, travel plans, staff to patient ratio, and plan for patient supervision. Additionally, the treatment team will review each patient participant for the purpose of identifying any special needs (such as increased supervision, avoiding sunlight, etc.), and legal/security issues, as indicated.

b. Each patient's participation in an off-campus therapeutic activity requires authorization by order of the patient's licensed prescribing practitioner (LPP) or designee. No patient will be taken on an off-campus activity without an order of the LPP; it is the responsibility of the organizer to ensure there is an order in the medical record before taking a patient on an off-campus activity. The LPP order must be specific to the particular activity; it is inappropriate to write an order which reads "may participate in off-campus activities X 28 days". Additionally, the Off-campus Therapeutic Activity List is to be signed by the Facility Director and the attending LPP.

c. Within two hours prior to the departure time, an RN must have rounded on each patient participant for the purpose of noting any obvious signs or symptoms that may call into question the advisability of the patient leaving the facility, i.e., lethargy, agitation, unsteady gait, etc. If for any reason the nurse has doubts or questions the advisability of a patient's participation, the LPP will be contacted with a request for further assessment and approval or denial of the patient's participation. An RN will enter a progress note in the medical record relevant to each participant.

d. An Off-campus Therapeutic Activity List (Form PS-132) is completed for each activity to ensure timely approval of patient participation and verification of staff/patient escort assignment. The form clearly denotes the patient and escort's names, date, departure and return times, destination (specific Location as listed on the "Request for Transportation" Form E- 21AA) and any special considerations.

e. The Off-campus Therapeutic Activity List is to be distributed as follows:

- Original - Files of the service/department chief
- Copy to:
  - Charge Nurse on the patient care unit
  - Public Safety Office

- Unit Director, as applicable
- Program Director
- Each escort.

f. It is the responsibility of the person organizing the activity to ensure that any other staff or department (nutritional services, for example) whose services may be impacted be given appropriate advance notification.

g. A DMH/DIS issued cell phone, to be used for emergencies/official business, will be in the possession of the organizer during the duration of the activity. The phone is to be obtained from the office of the facility director immediately prior to departure and returned immediately upon return to the facility.

2. Additional Requirements for Forensics Services:

a. Patients with pending charges and those who have been found not guilty by reason of insanity (NGRI) of a violent crime will not be permitted to participate in off-campus therapeutic activities. (A violent crime includes those offenses described in the SC Code Section 16-1-60, and the common law offense of assault and battery of a high and aggravated nature).

b. The treatment team coordinator will review any request for an off-campus activity, along with relevant information/documentation with the Program Director who will review the request with the Forensics legal consultant. Relevant information will include at a minimum, the legal status of each patient (see a. above). The legal consultant and Program Director must support the request in order for it to proceed through approval channels.

c. If the legal consultant and Program Director support the request, the Program Director will request final approval from the DIS Medical Director and Deputy Director. The request must be approved by the Medical Director and the Deputy Director.

C. <u>Escort Responsibilities</u>

1. Each staff escort will be assigned specific patients to monitor and keep in line of sight at all times. Each escort will take a count of the patients assigned to him/her at the commencement of the outbound and inbound trips, and at 30 minute intervals during the activity. Patient counts are documented with time and signature by the responsible escort.
Changes in escort assignment may be approved by the organizer in case of emergency and/or if therapeutically indicated. When reassigned, each escort will document it on his/her copy of the PS-132 by listing the patient's name, the time and the escort's initials.

2. The maximum staff/patient ratio for off-campus therapeutic activities is 1:5. The driver may <u>not</u> be counted as an escort. The staff/patient ratio established and approved by the treatment team and LPP is not reduced at any time except in case of emergency conditions beyond staff control. (See emergency procedures for off-campus activities in this directive).

3. At least one escort will be currently trained in basic first aid and cardiopulmonary resuscitation (CPR). If escorting patients around water, at least one escort must be trained in general water safety. If the activity involves patients going into or onto water, a lifeguard must be on duty, or at least one escorting staff member must be certified as a lifeguard and CPR for the Professional Rescuer. It is the responsibility of the organizer to ensure that a first aid kit is taken on all activities. It is the responsibility of the department/service chief of the organizer to verify that requirements

for training/certification are met and that evidence of training/certification as required is filed in the employee's personnel folder.

4. All staff and patients must comply with DIS safety standards regarding the mandatory use of seat belts in vehicles so equipped.
5. It is the responsibility of escorting staff to ensure that patients do not have access to or bring back to the facility any items considered inappropriate or contraband.

D. Emergency Procedures

1. Once the activity is underway, the organizer will call the nurse in charge on the patient's unit to report any obvious or patient subjective complaints of illness. The nurse will consult with the patient's LPP regarding an appropriate response which may be to return the patient to the facility or some other action.
2. Medical/Psychiatric Emergencies
   In case of life-threatening emergency call 911 immediately; assess the individual for need for CPR. In case of non-life-threatening emergencies or accident, in Columbia notify DIS Emergency Dispatch at 935-5499; for Harris Hospital notify Public Safety at 231-2668. Proceed with basic first aid, Behavioral Emergency Stabilization (B.E.S.T.), or other measures as appropriate. In case of loss of consciousness, the individual should immediately be assessed for the need for CPR or airway maintenance.
3. Missing Patient
   a. Secure other patients and begin immediate search of area. In Columbia notify DIS Emergency Dispatch at 935-5499; for Harris Hospital notify Public Safety at 231-2668. Public Safety will immediately notify local law enforcement. Provide Public Safety with the following information: patient name; age, if known, or best guess; race and gender; clothing worn at last sighting; where the patient was last seen.
   b. Notify the nurse in charge on the patient's unit. .
   c. Abort the activity and return to the facility.
   d. If the patient is not located, procedures as outlined in P&P PC 9, PC 9F, or PC 9SV, as appropriate will be followed.
4. Vehicle Failure
   Ensure the safety and security of patients and in Columbia contact Transportation at 935-7729; for Harris Hospital notify Public Safety at 231-2668. Notify the patient care unit and the organizer's supervisor.
5. Reduction in Staff-Patient Ratio
   Should reduction in the staff/patient ratio occur due to staff injury, illness or any other reason, and an immediate replacement cannot be arranged, the group will return to the facility.

E. Post-Activity

1. Upon return to the facility, the organizer will verbally report any significant/relevant information regarding patients to the nurse in charge.
2. Responsible nursing staff will enter a progress note addressing the status of each patient upon return.
3 Each escort will enter a progress note for his/her assigned patients relevant to participation, behaviors, response to the experience, and any other relevant information.
4. Relevant information regarding the activity will be reported to the treatment team at the next scheduled meeting.

V. DISTRIBUTION:

Each Psychiatric Service Chief, Administrative Department Head, and Discipline Chief will read this policy and brief subordinates.

VI. RESCISSIONS:
This directive rescinds DIS Policy PC 20 "Community Outings" dated June 2013; Forensics P&P # 012, Community Reintegration Program dated June 30, 2010.

VII. REFERENCES:
SCDMH Directive No. 870-06 "Utilization of State-Owned Vehicles"

VIII. APPLICABLE FORMS:
Refer to forms: PS-132, "Off-Campus Therapeutic Activity List" and E-21AA, "Transportation Request"

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE STATE COMMISSIONER OF MENTAL HEALTH DIRECTIVE NO. 491-79 (5-100)

TO: All Employees

SUBJECT: Job-Connected Injuries and Occupational Diseases

I. General Provisions

The South Carolina Department of Mental Health is operating under and subject to the Occupational Safety and Health Act of 1970 and the South Carolina Workmen's Compensation Fund.

Under the provisions of the Occupational Safety and Health Act, each employer has the general duty to furnish each of his employees employment and places of employment free from recognized hazards causing, or likely to cause, death or serious physical harm; and the employer has the specific duty of complying with safety and health standards promulgated under the Act. Each employee has the duty to comply with these safety and health standards, and all rules, regulations, and orders issued in compliance with the Act which are applicable to his own actions and conduct.

Under the provisions of the South Carolina Workmen's Compensation Law, each employee is protected against total loss of income and expenses incurred if he sustains a disabling injury or occupational disease arising out of and in the course of his employment. No compensation is payable if the injury, occupational disease, or death is caused by the employee's willful misconduct, his intention to bring about the injury or death of himself or another employee or his intoxication.

II. Definitions

Terminology used in this directive has been defined as follows in order to assist employees in more clearly understanding usage as set forth by the South Carolina workmen's Compensation Law, and the Occupational Safety and Health Act:

A. Safety and Health Standards - In general, job safety and health standards consist of rules for avoidance of hazards which have been proven by research and experience to be harmful to personal safety and health.

B. Recordable Injury Under the Occupational Safety and Health Act Recordable occupational injuries and illnesses or any injury or illness which results in a fatality, regardless of the time between injury and death or length of illness; lost workday cases; or injuries or illnesses which result in transfer to another job or termination; or require medical treatment (other than first aid), loss of consciousness or restriction of work or motion. Medical treatment as used here does not include first aid, one-time treatment and subsequent observations of minor scratches, cuts, burns, splinters, and so forth which do not ordinarily require medical treatment even though provided by a physician or registered professional personnel.

C. Arising Out of and In the Course of Employment - The words "arising out of" refers to the origin or the cause of the accident while the words "in the course of employment" refers to the time, place and circumstances under which the accident occurs.

D. Compensation - The money allowance payable to an employee or, in the event of an employee's death due to a compensable on the job injury, to his dependent.

E . Death - The term "death" as a basis for right to compensation means only death resulting from an on the job injury.

F . Disability - The term "disability" means incapacity because of an on the job injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment.

G. Disfigurement - The word "disfigurement" means that which impairs or injures the beauty, symmetry or appearance of a person; that which renders unsightly, misshapen or imperfect, or deforms in some manner. In order to constitute disfigurement so as to be compensable, it must be more than slight and must partake of permanency.

H. Injury and Personal Injury - "Injury" and "Personal Injury" shall mean only injury by accident arising out of and in the course of employment and shall not include a disease in any form, except when it results naturally and inavoidably from the accident and except such diseases as are compensable under the provisions of Chapter 2 of the South Carolina Workmen's Compensation Law.

I. Occupational Disease - The words "occupational disease" means a disease arising out of and in the course of employment which is due to hazards in excess of those ordinarily incident to employment and is peculiar to the occupation in which the employee is engaged. A disease shall be deemed an occupational disease only if caused by a hazard recognized as peculiar to a particular trade, process occupation, or employment as a direct result of continuous exposure to the normal working conditions thereof.

J. State Workmen's Compensation Fund - The State Workmen's Compensation Fund is the insurance carrier for all state employees.

K. Industrial Commission - The Industrial Commission is the group of Commissioners that were appointed for judicial review of injury cases.

III. Employee's Notice of Accident to Employer

Every injured employee or his representative must give immediate notice to his supervisor or person in position of authority in the absence of the supervisor. The person receiving the report must initiate SCDMH Form P-16, "Report of Injury". Failure to give such immediate notice may cause serious delay in the payment of compensation to the injured employee or, in the event of the employee's death due to a compensable injury, to his dependents, and may result in failure to receive any compensation benefits whatever under the law.

No compensation shall be payable unless such notice is given within ninety days after the occurrence of the accident or death, unless reasonable excuse is made to the satisfaction of the Industrial Commission for not giving such notice and the Commission is satisfied that the employer has not been prejudiced thereby.

Once a Form P-16 has been filed, it shall be the responsibility of the SCDMH Office of Public Safety to file with the Industrial Commission all forms required by state law, concerning the accident.

The right to compensation shall be forever barred unless a claim is filed with the Industrial Commission within two years after the accident and if death results from the accident, unless a claim is filed with the Commission within one year thereafter.

In those instances where an injured employee wishes to apply for Workmen's Compensation benefits, the employee or his representative must notify the supervisor and the SCDMH Office of Public Safety in order that the Industrial Commission Form No. 17, "Employee Supplemental Report for Injury" can be filed, as soon as notification has been received. No compensation is payable unless the employee complies with the requirements under the Workmen's Compensation Law.

IV. Commencement of Compensation

Any employee of the South Carolina Department of Mental Health who is injured in the line of duty may choose to use his accumulated sick and/or annual leave, or be placed on leave without pay and receive Workmen's Compensation benefits if the Workmen's Compensation Fund considers the case compensable and accepts liability. The injured employee must notify the supervisor as to his or her desire to use either sick and/or annual leave or to be placed on leave without pay and receive Workmen's Compensation.

If the employee chooses to use his accumulated sick and/or annual leave, then time lost should be deducted from sick leave. If all accrued sick leave becomes depleted then annual leave may be used. In no instance can an employee be paid from accumulated leave and receive Workmen's Compensation for time lost from work simultaneously. No compensation shall be allowed for the first seven (7) calendar days of disability resulting from an injury; but if the injury results in disability of more than fourteen (14) days, compensation shall be allowed from the date of the disability. The Workmen's Compensation Fund payments are made on a monthly basis.

V. Instructions for Timekeepers

When an employee loses time from work as a result, of and injury incurred in the line of duty, the timekeeper must be sure to mark the time correctly. The day of the pay period lost from work as a result of an injury should be marked under the leave classification of "Injury Duty." If the absence is to be charged against sick leave or annual leave, this should be indicated in that column classification. If the employee requests to receive payments from the Industrial Commission for time lost from work if all accrued annual and/or sick leave has been exhausted, then this should be indicated under the column marked leave without pay. No time will be charged against the employee on the date of the accident while the employee is seeking medical attention at the Byrnes or McLendon Clinics or by a physician on the staff of any facility in Mental Health.

The injured employee may be placed in a leave without pay status which, along with any paid leave that has been taken shall not exceed 180 days, if supported by a physician's certificate describing the disability and giving the projected inclusive dates of the disability. The dates set forth in the physician's certificate can be amended by the attending physician. In extenuating circumstances, the State Commissioner of Mental Health, at his discretion, may extend the period of leave without pay up to a total of 365 days. The employee shall have the option of using or retaining accrued annual leave prior to leave without pay. This is in compliance with the sick leave guidelines set forth in 1974 By the S, C. State Personnel Division.

The timekeeper or the employee's immediate supervisor shall immediately inform the SCDMH Office of Public Safety and the facility Fire and Safety Officer of any lost time by the employee. If the employee is out for an extended period of time or when there is a change in the employee returning to work, there must be a follow-up report to both the SCDMH Office of Public Safety and the Fire and Safety Officer of the facility.

I. Instructions for Supervisors Upon Notification of Injury

The procedures outlined below must be followed by the supervisor upon notified by an employee that an injury has occurred.

A. General Instructions - Immediately upon being notified that an employee has received an injury in the line of duty, the supervisor shall complete an original and four (4) copies of the South Carolina Department of Mental Health Form P-16, "Report of Injury". The original and all copies will be sent to the Employee Physician with the employee except in cases of emergency. In case of emergency, the employee shall report to the Emergency Treatment Room or the Surgical Ward of the Byrnes Clinical Center or the Sol B. McLendon Clinical Center and the Form P-16 shall be sent as soon thereafter as possible. To insure legibility, it is required that these forms be typewritten, unless it is not feasible. Employees of Crafts Farrow State Hospital, Morris Village, and Bryan Psychiatric Hospital shall be treated at the McLendon Clinical Center. Employees of South Carolina State Hospital, William S. Hall Psychiatric Institute, C. M. Tucker, Jr., Human Resources Center, Division of Administrative Services, Community of Independent Living, Columbia Area Mental Health Center, and the Central Office, Division of Community Mental Health Services shall be treated at the Byrnes Clinical Center.

B. Community Mental Health Clinics and Centers - Immediately upon being notified that an employee has- received an injury in the line of duty, the supervisor shall complete South Carolina Department of Mental Health Form P-16, "Report of Injury". The forms should be given to the attending physician, and upon completion the original forwarded to the SCDMH Office of Public Safety. In the event the employee consults his own physician, Industrial Commission Form No. 13, "Standard Form for Surgeon's Report", in triplicate, along with a statement of charges should be submitted to the SCDMH Office of Public Safety for submission to the State Workmen's Compensation Fund. The procedure for the handling of injuries in the Central Office, Division of Community Mental Health Services, shall be the same as outlined for the other facilities.

C. Work Injury Resulting in Hospitalization of Five or More Employees or Death of

One or More Employees- The supervisor must notify SCDMH Office of Public Safety within twenty-four (24) hours of any accident resulting in the hospitalization of five or more employees or the death of one or more employees in order that the SCDMH Office of Public Safety may comply with the Federal Occupational Safety and Health Act reporting requirements. In the interest of time, this information may be reported by telephone; however, a Form P-16 for each employee involved must be forwarded to the SCDMH Office of Public Safety as soon thereafter as possible. The Fire and Safety Officer of the facility concerned must be notified as soon as possible after the accident.

V I I. How to Obtain Medical Care

Each employee who receives an injury, no matter how minor, shall report it immediately or as soon thereafter as practicable to his supervisor. All employees must then be referred immediately to the Employee Physician for screening in order to insure that all rights and benefits relating to workmen's Compensation are protected. In the event of a serious injury, the supervisor will send the employee directly to the Emergency Treatment Room or the Surgical Ward of the James F. Byrnes Clinical Center or the Sol B. McLendon Clinical Center, as provided for in the SCDMH directive pertaining to employee medical benefits.

An employee who requires hospitalization or who requests private treatment will then be referred to another hospital. Responsibility will rest with the South Carolina Industrial Commission once liability is determined. If after investigation, the S. C. Workmen's Compensation Fund determines that they are not liable, the expenses incurred will be the responsibility of the employee and not the South Carolina Department of Mental Health.

VIII. Forms to be Completed by Attending Physician

The attending physician should complete the Physician's Report on the reverse side of the South Carolina Department of Mental Health Form P-16 as soon as he has completed his examination. The Employee Physician should retain a copy of the Form P-16 for his files and forward the original to the SCDMH Office of Public Safety, a copy to the employee's supervisor, a copy to the respective facility Fire and Safety Officer and a copy to the SCDMH Personnel Office. When the physician feels that the employee's injury may have residual complications or may result in time lost from work, he should indicate that a "First Report of Injury", Industrial Commission Form 12-A, should be filed by the SCDMH Office of Public Safety with the State Workmen's Compensation Fund.

In the event only first-aid treatment is necessary and no time should be lost from work, the physician should check the appropriate block. In cases where the physician is required by the Industrial Commission to complete Industrial Commission Form No. 13, "Surgeon's Report", and Industrial Commission Form No.14, "Physician's Certificate of Termination of Disability and Itemized Statement of Charge for Treatment," these completed forms should be sent to the SCDMH Office of Public Safety in quadruplicate for transmittal.

In the event the attending physician feels that the original diagnosis indicating only first-aid treatment and that the Report of Injury should not be filed with the State Workmen's Compensation Fund should change, then he should immediately notify the SCDMH Office of Public Safety that in view of the employee's present condition, a report of the injury should be filed with the State Workmen's Compensation Fund.

IX. Compensation Benefits

A. Total Disability - When an employee receives in the line of duty an injury which is totally disabling, the Workmen's Compensation law provides during disability a weekly compensation equal to sixty-six and two-thirds percent (66 2/3 %) of his average weekly wages, up to one hundred percent (100%) of the average wage of the average worker for the state for the previous year as determined by the Employment Security Commission, but not less than twenty-five dollars ($25.00) a week, not to exceed the maximum set by the 1976 S. C. Code of Laws, as amended, and in no case shall the period covered by such compensation exceed five hundred (500) weeks.

B. Partial Disability - In cases where injuries occurring in the line of duty are partially disabling, compensation is based at the rate of sixty-six and two-thirds percent (66 2/3%) of the difference between his average weekly wage earned at the time of the injury and the average weekly wage the employee is capable of earning thereafter, but not more than two-thirds (2/3) of the average weekly wage in this state for the previous calendar year. In no case shall the period covered by such compensation be greater than three hundred and forty (340) weeks from the date of the injury.

C. Occupational Disease - Compensation payable for disability from an occupational disease is the same as that provided for an injury, except that benefits for partial disability shall be limited to fifty-two (52) weeks.

D. Disfigurement - In case of serious facial, head or bodily disfigurement, the Industrial Commission may award equitable compensation not to exceed fifty (50) weeks but an employee cannot draw such compensation if an award is made for permanent and total disability or for fatal injuries.

E. Loss of Members - Compensation for the loss of a member of the body (arm, leg, toe, hand, etc.) shall be for a specified period in accordance with the schedule published under the Workmen's Compensation Law, section 42-9-30 of the 1976 S. C. Code of Laws, as amended.

F. Death Benefits - In case of death of an employee as a result of an on the job injury, Workmen's Compensation will pay the employee's beneficiary benefits in accordance with the state's laws pertaining to Death Benefits.

G. Medical, Hospital, Surgical, etc., Treatment and Supplies: Artificial Members - Medical, surgical, hospital, and other treatment, including medical and surgical supplies as may reasonably be required for life shall be provided by the South Carolina Workmen's Compensation Fund. The refusal of an employee to accept any medical, hospital, surgical, or other treatment when provided by the employer, their insurance carrier, or then so ordered by the Commission shall bar such employee from further compensation until such refusal ceases and no compensation shall at any time be paid for the period of suspension unless in the opinion of the Commission may order a change in the medical or hospital service. An employee can accept Workmen's Compensation payment for medical expenses only and be placed on a sick and/or annual leave status with the Department provided such leave has been accrued by the employee. In this

instance, Workmen's Compensation would compensate for medical expenses only and not for salaries or wages.

H. Payment for Broken Eye Glasses - Eye glasses broken as a result of injury in the line of duty will be replaced by the State Workmen's Compensation Fund provided the employee sustains an actual injury to the face in the proximity of the eye or to the eye itself.

Employees who have eye glasses broken in the line of duty due to an accident must report this to the supervisor. The supervisor must complete a SCDMH Form P-16, "Report of Injury." In the event of an actual injury to the face in the proximity of the eye or the eye itself, the employee is to be sent to the Employee Physician, if during his office hours, or to the emergency room at either the James F. Byrnes Clinical Center or the Sol B. McLendon Clinical Center. The employee then may be referred to the EENT Clinic. In the event that glasses are to be repaired or replaced, the employee must go to the facility Administrator's office so that a memorandum can be prepared authorizing the repair or replacement of the glasses by an optical company. In cases where the Workmen's Compensation Fund assumes responsibility, the administrator shall forward the bill from the optical company to the SCDMH Office of Public Safety, for filing with the Industrial Commission.

Glasses will be repaired only to the extent of the damage and payment will not be authorized unless one or both lenses are broken or scratched to the extent that they cannot be used or unless frames are broken. When frames are replaced, the new frames will be comparable to those that were broken (in quality and price). When glasses are broken in the line of duty but there is no injury which comes within the purview of the Industrial Commission rules, the broken eye glasses may be replaced at the expense of the facility. The facility administrator shall be responsible for determining if the facility should replace broken eye glasses in these cases. In cases where the administrator determines that the broken eye glasses are to be repaired or replaced, this will be accomplished according to the SCDMH directive pertaining to this subject.

I. Dental Service - Dentures broken as a result of an injury in the line of duty will be compensable by the South Carolina Industrial Commission if it is ruled that the injury comes within the purview of the Industrial Commission. When dentures are broken as a result of an injury in the line of duty but the injury does not come within the purview of the Industrial Commission, the broken dentures may be replaced at the expense of the facility. The facility administrator shall be responsible for determining if the facility should replace broken dentures in these cases. In cases where the administrator determines that the facility will repair or replace dentures, this will be accomplished according to the SCDMH directive pertaining to this subject.

X. Responsibility of the SCDMH Office of Public Safety

When an employee receives an injury which is disabling, the SCDMH Office of Public Safety will complete South Carolina Industrial Commission Form 12-A, "Employee's First Report of Injury", and send it to the S. C. Workmen's Compensation Fund.

S. C. Industrial Commission Form No. 17, "Supplemental Report of Injury", must be filled out by the SCDMH Office of Public Safety when an employee request to receive benefits for time lost from work. The supervisor is required to notify the SCDMH Office of Public Safety and the facility Fire and Safety Officer immediately when there is a change in the employee's leave status and when the employee returns to work in order that Industrial Commission Form No. 17 may be completed indicating that the employee has returned and compensation benefits should cease. The supervisor must also notify the SCDMH Office of Public Safety and the facility Fire and Safety Officer in the event the employee later becomes disabled or loses time from work.

When requested by the Industrial Commission, Industrial Commission Form No. 2C, "A Statement of Days Worked and Earnings of Injured Employee", is completed by the SCDMH Office of Public Safety and sent to the Industrial Commission to assist them in determining the average weekly wage.

XI. Responsibility of the Facility Fire and Safety Officer

The facility Fire and Safety Officer is responsible for facility compliance with all phases of the Occupational Safety and Health Act. He is to insure that his respective facility is in compliance with all federal and state regulations pertaining to Occupational Safety. Further, he must maintain facility compliance with the federal and state record keeping requirements under the Occupational Safety and Health Act. A log of injuries recordable under the Occupational Safety and Health Act is to be maintained on Occupational Safety and Health Act Form No. 200 or equivalent. The log must be completed no later than six (6) days after receiving information that a recordable case has occurred. He must inspect his respective facility at least each quarter and report corrective action taken on all discrepancies found to the SCDMH Office of Public Safety.

In addition, an annual summary must be prepared of all recordable injuries under the Occupational Safety and Health Act. This summary must be completed no later than one month after the close of each calendar year and must be posted for a period of thirty (30) days in a place accessible to employees.

The facility Fire and Safety Officer will be responsible to the SCDMH Office of Public Safety for compliance with all federal and state safety standards and will conduct an investigation of all reportable accidents and submit a written report to the SCDMH Office of Public Safety.

XII. Occupational Safety and Health Act Records for the Division of Community Mental Health Services

The Occupational Safety and Health Act Form No. 200, referred to above must also be maintained by each Community Mental Health Clinic and Center. A copy of these records must be submitted to the SCDMH Office of Public Safety at the end of each year for use in compiling departmental summaries and records.

XIII. Notice of Action Taken by Industrial Commission

After the SCDMH Office of Public Safety has filed the "Employer's First Report of Injury" with the S. C. Workmen's Compensation Fund, the employee shall be given notification of any action by the S. C. Workmen's Compensation Fund and/or the S. C. Industrial

Commission.

XIV. Hearing Procedures

In the event an agreement cannot be reached between the employee and State Workmen's Compensation Fund, then either party may make application to the Industrial Commission for a hearing in regard to matters at issue and for a ruling. Forms for requesting a hearing may be obtained from the Industrial Commission at either party's request. Immediately after such application has been received, the Commission shall set a date for a hearing which shall be as soon as practicable. The Commission shall notify the parties concerned of the time and place of the hearing, which shall be held in the city or county in which the injury occurred unless other-wise agreed to by the parties and authorized by the Commission.

The Commission may appoint a disinterested and duly qualified physician or surgeon to examine the injured employee and to testify thereto.

It is not necessary for the employee to retain the services of an attorney for the hearing, but this shall be the prerogative of the employee and at the employee's own expense.

XV. Additional Information

All questions or inquiries concerning injuries or Occupational Safety and Health Act compliance should be referred to the SCDMH Office of Public Safety, Telephone 758-3657 or 758-3669.

Any previous instructions which are in conflict with this directive are hereby rescinded.

This directive rescinds and supercedes SCDMH Directive No. 357-75, entitled "Job Connected Injuries and Occupational Disease".

William S. Hall

WILLIAM S. HALL, M.D.
STATE COMMISSIONER OF MENTAL HEALTH

March 30, 1979

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

OFFICE OF THE DIRECTOR OF MENTAL HEALTH

DIRECTIVE NO. 826-01
3-250

TO: ALL ORGANIZATIONAL COMPONENTS

SUBJECT: PERSONAL APPEARANCE OF EMPLOYEES

I. PURPOSE:

The purpose of this directive is to update the South Carolina Department of Mental Health's general requirements regarding employee personal appearance.

II. POLICY:

It is the policy of the South Carolina Department of Mental Health that each employee's dress, grooming, and personal hygiene should be appropriate to the employee's work situation and his/her profession.

II.. GENERAL STANDARDS:

Employees in management positions and other employees who have contact with the public representing the South Carolina Department of Mental Health are expected to dress in, a manner that is generally acceptable in professional healthcare business establishments.

Employees who do not meet the public should follow basic requirements of safety and comfort, but should still be as neat and businesslike as working conditions permit.

In all instances it is expected that grooming will be appropriate to the performance of professional work.

On days designated as casual dress day, employees may dress in a more casual fashion than is normally required. On these occasions employees are still expected to present a neat appearance and are not permitted to wear ripped, cut off, or disheveled clothing, shorts, or tank tops or similarly inappropriate clothing.

Employees who violate the dress standards stated within this directive will be subject to appropriate disciplinary action.

Nothing in this Directive precludes an organizational component from issuing more specific guidelines or requirements concerning employee attire.

This directive rescinds and supersedes South Carolina Department of Mental Health Directive No. 320-74, entitled "Employee Uniform and Dress Standards."

GEORGE P. GINTOLI
STATE DIRECTOR

September 5, 2001