

**INTRODUCTION TO PRISON HEALTH SERVICES
AND CORRECTIONAL HEALTH CARE**

PRISON HEALTH SERVICES

Prison Health Services, Inc. (PHS) is the founder of the managed healthcare industry. Since 1978, PHS has delivered value driven healthcare to numerous jails, prisons and juvenile facilities across the United States.

In 1991, PHS became a publicly traded wholly owned subsidiary of America Service Group, Inc., (ASGR). “ASGR” is listed on the NASDAQ National Market System. As a public company, PHS is the only dedicated correctional healthcare company held accountable to the strict standards of both public and regulatory scrutiny.

Employing over 4,200 healthcare professionals and support staff across the country, we lead the correctional healthcare field in the application of proven managed care principles to ensure appropriate, cost-effective healthcare at each of our client facilities.

In January 1999, American Service Group (ASG), the parent company for PHS, acquired EMSA Government Services, another leading company in managed correctional healthcare. This further increased the scope of resources, management and clinical talent available to service our clients. Today, we serve over 275 correctional sites around the country through 120 contracts that cover over 174,000 lives in 27 states.

The comprehensive healthcare programs we provide all correctional facilities to control costs by managing inmate healthcare and ensuring each individual receives the most appropriate level of service in the most appropriate setting. At the same time, we also insure our clients meet community standards for medical care and assist them in obtaining accreditation by the National Commission on Correctional Healthcare (NCCHC), the American Correctional Association (ACA) and numerous state and local accrediting agencies. PHS also reduces the facility’s liability burden associated with medical care through an aggressive risk management and legal support function.

MISSION STATEMENT

Prison Health Services, Inc. specializes in setting the benchmark for quality managed healthcare services to correctional facilities throughout the United States.

VISION STATEMENT

Prison Health Services, Inc. will lead the correctional healthcare field in reputation and results, differentiated from competitors by the highest standards of operational excellence, clinical quality and client services.

OUR VALUES

The correctional healthcare industry is evolving every day. We, at PHS believe that all our employees must share and embrace a singular set of values that do not change. These values are taught to all new employees and reinforced in the workplace everyday. They are part of our culture and differentiate us in the marketplace.

◆ **QUALITY**

PHS is committed to providing quality healthcare services at a reasonable cost in accordance with each client's needs. We never settle for mediocrity, but work diligently to improve the effectiveness and efficiency in all that we do. We strive to provide services by which all others are compared.

◆ **INTEGRITY**

PHS employees conduct business in a professional and ethical manner. We establish credibility with our clients by consistently performing in accordance with all contractual agreements and by proactively addressing any potential deficiencies. We ensure that all employees and independent contractors understand PHS' policy on "Ethics and Integrity" to assist them in decision making.

◆ **SERVICES**

We are a client service industry. Therefore, our effectiveness in servicing our clients must be reviewed regularly. We seek continuous feedback from each of our clients at all levels of their organization. Responding proactively and appropriately to client needs is a key to our growth. Remember that our clients may not always be right, but they are never wrong.

◆ **CREATIVITY**

The correctional healthcare landscape has many emerging issues. Prison Health Services seeks to acknowledge and reward our employees for creativity. We establish forums that allow our employees to creatively problem solve and recognize that their ideas lead to a more empowered, responsive organization.

◆ **COMPASSION**

We at PHS work with, perhaps, the most unique and challenging population in all of society. Our role is to serve and not to judge. We treat this population with compassion and courtesy. This is demonstrated by providing the appropriate evaluation, care and treatment services in accordance with all professional guidelines.

◆ **TEAMWORK**

PHS possesses a team of leaders in the correctional healthcare industry. We recognize that the most potent marketing/public relations program is supporting our employees who, in turn, become spokespersons for our company every day.

◆ **DIVERSITY**

PHS supports the philosophy that diversity in experience, education and culture can only serve as a platform to strengthen our organization. We do not seek to standardize the individual, but rather to establish an appropriate vehicle where each individual's uniqueness can benefit the whole team.

◆ **RESPECT**

We attribute our success to, and recognize that our future success is dependent upon, developing our greatest asset: people. Through supervision, evaluation, development and a compensation system that matches performances and rewards, we will ensure that employees clearly understand their duties, responsibilities and authority.

Within the restrictions of a correctional setting, we strive to provide an environment in which employees can grow, excel and take pride in their workplace contributions.

PRIVATE CONTRACTING FOR INMATE HEALTH SERVICES

“Privatization,” or the process of government contracting with a private company for the provision of specified services, has found growing favor at all levels of government and has taken on many forms. One of the more unusual forms of privatization involves the provision of healthcare services to inmate in prisons and jails.

Obviously, there are some advantages or benefits in contracting with a private company for inmate healthcare services. The benefits to healthcare contracting can generally be grouped into three categories; Financial; Operational; and Management advantages.

Financial:

- ◆ Cost savings, both direct cost savings resulting from the contract arrangement itself and indirect cost savings produced by efficiencies in areas not directly related to but impacted by the healthcare contract, such as transportation and security.
- ◆ Budgetary Control (present and future) and knowing the real cost of the services provided as a result of a fixed-price contract.
- ◆ Funding of needed capital equipment or improvements, such as the addition of a dental unit within the correctional facility.
- ◆ Streamlined purchasing/procurement procedures: Since the private contractor does not have to follow often cumbersome and time consuming governmental procedures for purchasing needed medical equipment and supplies, such necessities can be made available faster. Consequently, the contractor can quickly take advantage of volume discounts and short-term price reduction opportunities offered by suppliers.

Operations:

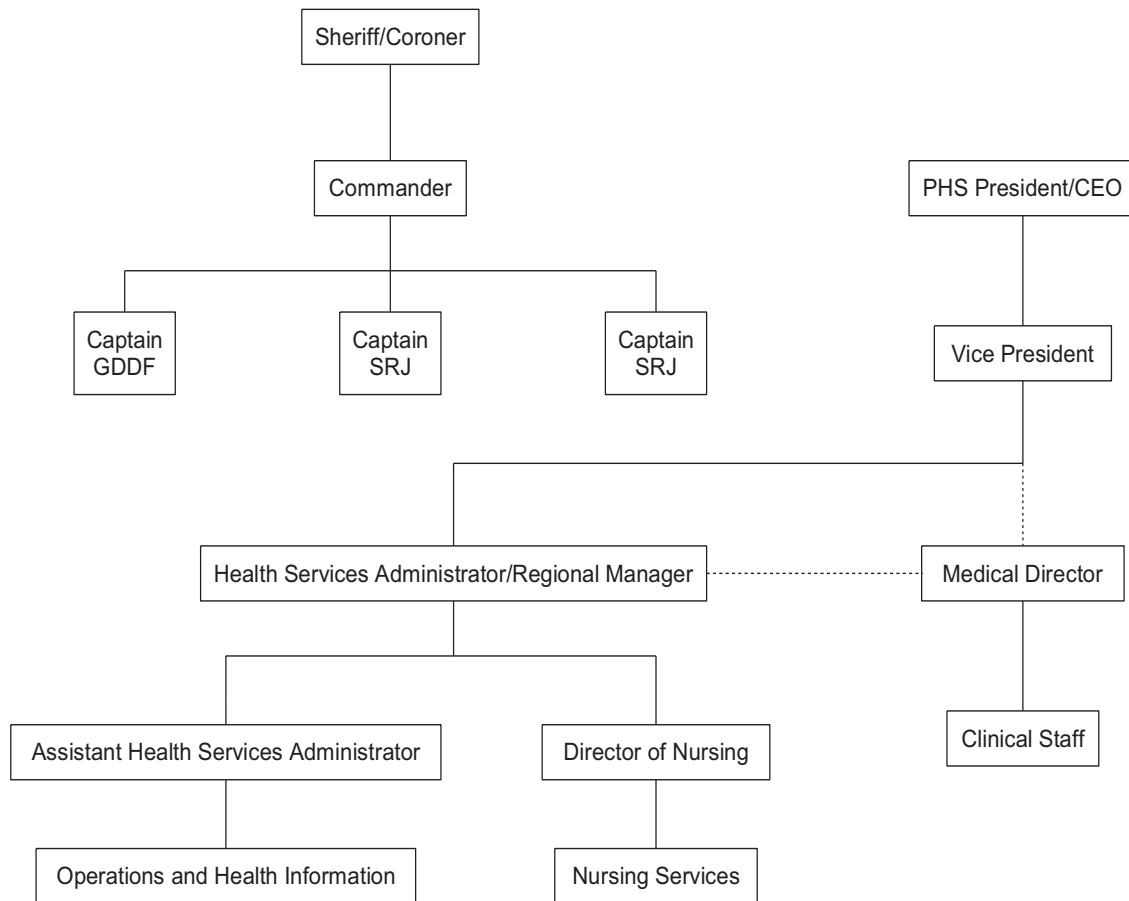
- ◆ As a specialist, the contractor brings expertise and resources to the table, which the government may not possess. Correctional healthcare is a unique practice, which requires specialized healthcare skills and experience.
- ◆ Expanded or improved healthcare services often result from a contract, since the contractor has a broader resource base and talent pool to draw upon than may be available to the government.
- ◆ As a healthcare specialist, the contractor has ready access to the latest technology and medical information. It is the contractor’s business to know, for example, the latest and most effective treatment or medication to be used in fighting AIDS.

Management:

- ◆ The recruitment and day-to-day management of healthcare personnel become the contractor's responsibility rather than the correctional facility administrators.
- ◆ Reduction in liability exposure for the county and/or state and its officials, since the contractor provides medical malpractice insurance.
- ◆ Government becomes a "buyer" of services rather than a "provider" of services gaining the added clout and control that nay buyer can exercise over a seller whom "aims to please.

These are but a few of the advantages which county government may realize through a contract for healthcare services for its correctional facility. It is an alternative worth exploring, as many county governments have already discovered.

**Prison Health Services
Organizational Chart
Santa Rita Jail/Glenn Dyer Detention Facility**



CORRECTIONAL HEALTHCARE

INTRODUCTION TO THE CORRECTIONAL ENVIRONMENT

The Primary Function of a Correctional Facility Is Security

Today, most people acknowledge the fact that inmates are totally dependent upon the healthcare personnel of the correctional facility for their medical, dental and mental health needs. Therefore, it is the responsibility of the healthcare professional to ensure that inmates receive unimpeded access to healthcare services as well as timely evaluation and treatment.

The dimensions of healthcare practice in correctional facilities encompass the same characteristics that guide healthcare professionals in other health care settings: philosophy and ethics, responsibilities, functions, roles, skills and legal authority. Healthcare professionals who work in correctional facilities must strive to achieve the goal of preserving and promoting the health of the incarcerated individual while working with the following realities:

- ◆ The primary goal of the facility is security.
- ◆ Inmates are usually poor, uneducated, disproportionately minorities, and commonly, of a low socioeconomic status.
- ◆ Inmates are often alcoholics, drug abusers and/or have mental health disorders.
- ◆ Inmates frequently have not had health insurance and have had limited access to healthcare services while in the community.

This results in a population base that has a higher risk for diseases such as heart disease, hypertension, diabetes and other chronic illnesses. In addition, inmates have a high incidence of communicable diseases such as Tuberculosis, Hepatitis B, HIV, and other sexually transmitted diseases.

The major thrust of correctional health nursing is the provision of primary care services for the facility's population from the time of entry, through transfer and release. Primary health services in the field include the use of all aspects of the nursing process while carrying out screening activities, providing direct healthcare services, analyzing individual health behaviors, and providing health education. Correctional healthcare professionals must assist inmates to assume responsibility for their own health to the best

of their ability, knowledge and circumstance. The primary roles of a nurse in the correctional environment include:

- ◆ INTAKE SCREENING
- ◆ TRIAGE
- ◆ SICK CALL
- ◆ CHRONIC CARE CLINICS
- ◆ SUICIDE PREVENTION
- ◆ HEALTH ASSESSMENTS
- ◆ INFECTION CONTROL
- ◆ PATIENT EDUCATION
- ◆ EMERGENCY SERVICES
- ◆ SEGREGATION CHECKS
- ◆ DIAGNOSTIC TESTING
- ◆ MEDICATION ADMINISTRATION

JAILS – A jail is a place of confinement for persons held in lawful custody under the jurisdiction of a local government – city and/or county.

- ◆ Jails tend to have a transient, short-term population staying less than one year.
- ◆ Individuals entering the jail may be poor, often disproportionately minorities, and frequently without health insurance.
- ◆ Many are in obvious need of healthcare services.
- ◆ Health conditions common in the jail environment include chronic illnesses, sexually transmitted diseases, alcoholism and drug abuse, mental illness, and developmental disabilities.

PRISONS – A prison is a place of confinement, usually under State or Federal jurisdiction, for individuals convicted of serious crimes.

- ◆ Prisons are long term facilities, usually with a stable base population staying more than one year.
- ◆ An inmate will only be admitted to a prison after being in a jail; therefore, healthcare needs have usually been identified and treatment initiated.
- ◆ The healthcare delivery system should emphasize health maintenance and the management of chronic illnesses.

HEALTHCARE IN THE CORRECTIONAL ENVIRONMENT – The correctional facilities present a challenging environment for the delivery of healthcare. Some correctional facilities are faced with deficiencies which may affect an inmate's health status:

- ◆ Overcrowding
- ◆ Inadequate Ventilation
- ◆ Insufficient Diets
- ◆ Poor Sanitation
- ◆ The lack of recreation and exercise facilities

DELIBERATE INDIFFERENCE – Supreme Court decisions in the 1970’s determined that the right to adequate healthcare for inmates is protected by the 8th Amendment of the U.S. Constitution. In Estelle v. Gamble, the courts held that “deliberate indifference to serious medical problems of inmates constitutes cruel and unusual punishment”. The court’s decision was influenced by the fact that inmates are not given a choice to evaluate various healthcare settings and providers. The constitution does not specifically state that inmates are entitled to the best care available. Inmates are entitled to adequate healthcare. That is, inmates have the right to quick and efficient healthcare that treats and prevents serious healthcare problems. Court judgments have determined “adequate healthcare for inmates” includes:

- ◆ Access to healthcare services
- ◆ Healthcare professionals to evaluate and treat inmates
- ◆ Provision of healthcare consistent with that of the community.
- ◆ Availability of appropriate service.
- ◆ Continuity of care, follow-up, referral services, and discharge planning.
- ◆ Management of the facility’s healthcare system by healthcare professionals, not correctional staff.

CORRECTIONAL HEALTHCARE STANDARDS – Prison Health Services has recognized accreditation as a way to show that established standards are being met. Many PHS facilities comply with voluntary accreditation standards set forth by the National Commission on Correctional Healthcare (NCCHC) and the American Correctional Association (ACA). The standards cover:

- ◆ Facility Governance and Administration
- ◆ Managing a Safe and Healthy Environment
- ◆ Healthcare Services Support
- ◆ Inmate Care and Treatment
- ◆ Health Promotion and Disease Prevention
- ◆ Special Needs and Services
- ◆ Health Records
- ◆ Medical-Legal Issues

Standards have been established for jails, prisons, and juvenile detention facilities. The standards are developed through a consensus process by a task force comprised of healthcare, legal, and correctional professionals. The task force determines the requirements necessary for providing adequate healthcare services in the correctional environment.

The accreditation standards are stated in broad terms to afford each institution some flexibility in program design and operation. The goal of accreditation is not to standardize healthcare programs, but to assure that the appropriate resources and services are available to meet the minimum requirements. There are a variety of ways in which a program may meet the standard.

The main difference between of NCCHC and the ACA accreditation programs is the scope of the process. ACA evaluates and accredits the entire facility while the NCCHC program targets health services.

POLICIES AND PROCEDURES

Prison Health Services' healthcare programs each have a complete set of site specific polices and procedures that are designed to be in compliance with local, state, and federal guidelines. Additionally, the policies and procedures are designed to be in compliance with the standards set forth by NCCHC and ACA. The policies and procedures are designed to provide direction to the healthcare staff. Each staff member is required to familiarize him/herself with the policy and procedure manual.

A manual that specifies the healthcare policies and procedures at a given facility is essential. Such a document serves as an important reference for the existing healthcare staff and as an excellent training tool for orienting new healthcare staff to the facility. A policy is the facility's official position on a particular issue related to an organization's purpose. The procedure describes how the policy is carried out.

When revisions are made in the manual, they must be dated and signed by the health authority. For ease of access, each policy should be cross-referenced with the appropriate ACA and NCCHC standard or standards.

Annual review of policies, procedures, and programs is good management practice. This process allows the various changes made during the year to be formally incorporated into the agency's manual. More important, the process of annual review facilitates decision making regarding previously discussed, but unresolved, matters.

STATE RULES AND REGULATONS

In addition to complying with correctional standards of care, some state governments may have specific legislative laws and/or regulations related tot he delivery of healthcare in correctional facilities. In California, Title 15 is the regulation governing standards in adult and juvenile detention facilities. Often, specific state laws or regulations correlate directly to national standards.

RESPONSIBLE HEATLH AUTHORITY

The responsibilities of the health authority include arranging for all levels of healthcare and providing quality, accessible health services to inmates. The health authority may be a physician, a *health administrator*, or an agency (e.g., health department). When this

authority is other than a physician; final medical judgments rest with a single designated, licensed *responsible physician*.

The responsible health authority at this facility is the Health Services Administrator. The responsible physician at this facility is the Medical Director.

MEDICAL AUTONOMY – National standards require that in all matters of healthcare delivery, the healthcare staff, not security personnel, have complete responsibility and authority. However, the healthcare staff must work closely with security personnel and must work within the security requirements of the facility. The healthcare staff is subject to the same security regulations as other employees.

Prison Health Services has designated the Health Services Administrator as the on-site health authority. The health authority is responsible for arranging for all levels of healthcare and providing quality, accessible healthcare services to inmates.

- ◆ The physician is the designated responsible physician. The responsible physician has final authority regarding all medical decisions.
- ◆ Corrections, custody, and administrative staff should not become involved in providing direct medical treatment or in analyzing and evaluating the validity of health requests.

ACCESS TO INMATES – The Health Services Administrator has the responsibility, on a day-to-day basis, to ensure that proper coordination is maintained between the health services and the correctional staff assigned to moving inmates to and from the health unit.

- ◆ Situations such as lockdowns will arise in which the healthcare staff may be delayed in performance of certain duties due to security reasons. Lockdowns may occur sporadically or at regularly scheduled times.
- ◆ Head-counts performed by security staff provides an accounting for each and every inmate occur at scheduled times throughout a 24-hour period.
- ◆ In the jail setting the healthcare staff should have access to the inmate immediately upon arrival to ensure that his/her health status is appropriate for the jail setting.
- ◆ Administrative and disciplinary segregation status should not prevent healthcare personnel from accessing an inmate.

HEALTHCARE STAFF MEETINGS

Healthcare staff meetings occur on a monthly basis. All healthcare unit staff is expected to attend the meetings. The meetings include discussion of relevant correctional healthcare issues as well as continuing education in-services and updates.

COMMUNICATION OF SPECIAL-NEEDS PATIENTS

Prison Health Services' policy requires healthcare staff to notify correctional personnel whenever an inmate has a significant medical illness, mental health illness, or developmental disability that will affect the inmate's housing or program assignment, imposition of disciplinary sanction, or transfer to another institution.

In cases of identified special-needs patients, where correctional personnel initiate action, consultation will be made with medical personnel before any changes are implemented. In an emergency, correctional personnel may take action immediately to protect the inmate, staff or others.

Inmates who have special needs include, but are not limited to, the following conditions:

1. Chronically ill
2. Communicable diseases
3. Physically disabled
4. Pregnant
5. Frail or elderly
6. Terminally ill
7. Mentally ill
8. Developmentally disabled

Typical cases where such medical/correctional consultation is required include, but are not limited to:

1. Housing assignment
2. Program assignments
3. Disciplinary segregation
4. Medical segregation
5. Intra-system transfer
6. Hospitalized inmates
7. Work assignment limitations

- ◆ Upon arrival at the facility, the intake/receiving nurse will assess and determine whether an inmate meets the criteria of special needs. If an inmate meets the criteria, the individual will be recommended for the housing unit best equipped to meet his special needs.
- ◆ If an inmate is determined to have special needs, the nurse communicates with custody staff to ensure that the inmate is appropriately housed.
- ◆ Once assigned to a housing unit, the nurse will arrange for follow-up evaluation during sick call by a nurse, mid-level or higher clinician. The findings will be communicated to correctional personnel to provide housing, work assignment, and program participation appropriate for the patient.

- ◆ Prior to transfer to another facility, a Transfer Summary will be completed to identify special requirements that will need to be considered while in transit and upon arrival at the inmate's destination.

PRIVACY OF CARE

Healthcare will be provided with consideration for the inmate-patient's dignity and privacy. A staff member of the same gender will be present when undressing is necessary or required for a physical examination or for exposure of an inmate's private area.

A correctional staff member will be present only in circumstances where security warrants it. A primary purpose of custody staff is to ensure the safety of health care staff while performing their duties. Custody staff are instructed and trained in confidentiality of health information and health records.

- ◆ Reasonable efforts should be made to provide the inmate with visual and auditory privacy from other staff members and other patients.
- ◆ The inmate is informed in advance of medical examinations and treatments and will be asked for their consent. An inmate may refuse treatment.
- ◆ Verbal and physical interaction with the inmate should be done in such a way as to encourage the inmate's subsequent use of health services.

NOTIFICATION IN EMERGENCIES

Custody staff will notify the inmate's family, next of kin, legal guardian, or personal representative in the case of an emergency, serious illness, serious mental illness, injury or death.

- ◆ Information regarding whom to notify should be obtained from each inmate by the correctional staff, during the admitting/booking procedure and should be kept current and accessible.
- ◆ The medical staff will make the assessment of a serious illness or death and communicate to the facility administrator or his/her designee.
- ◆ The facility administrator, or designee, will then notify the next of kin, legal guardian, or personal representative.
- ◆ In case of serious illness or injury, notification will be done via telephone or by written communication when telephone contact is not possible.
- ◆ The facility administrator will notify the next of kin in all cases of inmate death.
- ◆ The PHS medical director should be notified of all deaths via a mortality incident report.

- ◆ In the event of an inmate death the following will be followed: The charge nurse will notify:
 1. Medical Director, who will decide which MD, will report to the facility.
 2. Physician on call. Please note: In the event of an inmate death, the PHS MD on call must report to the facility in which the death occurred to prepare a death summary.
 3. Health Services Administrator (HSA)
 4. Director of Nursing (DON) or designee
 5. The Mortality Incident Form is given to HSA or DON.
 6. Copies of the health record are made for distribution.

The physician or Charge Nurse will complete a Mortality Incident Form and review the chart for completeness.

Four copies of the medical record must be copied at notification of death by the Health Information Services Department (HISD) or, if HISD not available, by a nursing supervisor or charge nurse. Three copies of the document are forwarded to the Sheriff's Office and one copy to Director of Health Information Management (HIM) for distribution to PHS Patient Safety Committee.

FORENSIC INFORMATION – The role of the healthcare staff is to serve the health needs of the inmate population. The position of the healthcare staff as neutral, caring, healthcare professionals is compromised when they are asked to collect information from inmates to be used against them. Forensic information may be collected with the written consent of the inmate. Forensic information includes:

- ◆ Psychological evaluations for use in adversarial proceedings
- ◆ Body cavity searches
- ◆ Blood draws for DNA or other analysis

Healthcare staff should not become involved in disciplinary actions or writing up disciplinary reports.

INFORMED CONSENT

All examinations and procedures governed by traditional informed consent practices within the jurisdiction are observed in inmate-patient care. The informed consent of next of kin, guardian or legal custodian applies when required by law.

Informed consent is the written agreement of the inmate to treatment, examination, or procedures after the inmate receives information about the nature, consequences, and risks of the proposed treatment or procedure.

Exceptions to the requirement for informed consent include life-threatening conditions, emergency care of inmates who are unable to comprehend information given, and public health matters mandated by the public health authority. When care is provided without written informed consent, the clinician must exercise his/her best medical judgment.

Thorough documentation should be completed in the health record regarding all aspects of the inmate's condition and the reason for medical intervention.

- ◆ The physician/dentist will fully inform the inmate of the risks and benefits in cases of invasive procedures and/or dental extractions, and ensure the inmate is provided with answers to any questions he/she may have.
- ◆ Following informing the inmate, the physician will complete the Informed Consent Form and have the inmate sign it. The form becomes part of the health record. A witness should be present in addition to the physician, dentist, or nurse.
- ◆ The complete, signed consent form is placed in the inmate's health record.
- ◆ The physician/dentist may obtain informed consent for any case in which he/she feels is appropriate to do so. However, the following are examples of when a physician/dentist should obtain informed consent prior to performing:
 - a. Dental Extractions
 - b. Incision and drainage
 - c. Removal of moles, warts, etc.
 - d. All procedures requiring use of local anesthesia
 - e. Sutures

RIGHT TO REFUSE TREATMENT

An inmate may refuse at any time of being offered health evaluation, treatment, or care. The refusal should be in writing and describe the nature of the condition for which evaluation, treatment, or care is offered and the nature of the service to be provided. The requirement for written refusal generally is satisfied by the signature of the inmate on the refusal document. In the event the inmate refuses to sign the refusal document, a witness signature is needed. The witness acknowledges the inmate read the refusal form or had it read to him/her in a language understood by the inmate.

Facilities should not maintain a policy that allows inmates to give an overall refusal that encompasses all future treatments. By refusing treatment at a particular time, the inmate does not necessarily waive his/her right to subsequent healthcare. Healthcare professionals should counsel inmates against refusals of treatment, including inmates who repeatedly do not keep clinic appointments, and should continue to counsel inmates

who have refused a particular treatment, when it is believed to be in the inmate's best interest.

A refusal of treatment is to be in writing on a Release of Responsibility form and must be countersigned by the medical staff if the inmate refuses to sign. Medical request forms (a.k.a., sick call slips) have a Release of Responsibility section included.

- ◆ It is the responsibility of the healthcare staff to assure that the inmate who refuses medical treatment understands the purpose of the proposed care, how the care will be provided, and the consequences and risks of their refusal.
- ◆ In situations where the inmate refuses care and refuses to sign a Release of Responsibility form, the nurse documents on the form and in the progress notes. A second staff member countersigns the form as witness to the inmate's refusal.
- ◆ An inmate who refuses essential medical care should be evaluated by a clinician. In extreme cases, the administrator of the facility may be notified by the Health Services Administrator or responsible physician of such refusal of care.
- ◆ When an inmate refuses to come to the medical unit for scheduled appointments or treatments, every effort should be made to have the inmate brought to the medical unit for a healthcare professional to verify their refusal of care.
- ◆ The nurse will counsel the inmate who refuses to take critical medications on the importance of taking their medications. The nurse will explain the possible risks involved in refusing to take critical medications. The nurse will document the counseling session fully in the progress notes.
- ◆ Medication refusals are documented on the MAR indicating how and why the patient refused the medication and the follow actions will be taken:
 - a. First refusal – document refusal, and encourage inmate to take medication
 - b. Second refusal – document refusal, and counsel inmate if possible
 - c. Third refusal – document refusal, counsel inmate, and notify the clinician
- ◆ By refusing treatment at a particular time, the inmate does not necessarily waive his/her right to subsequent healthcare. It does not absolve the healthcare staff from offering and rendering other aspects of healthcare that are deemed appropriate for the inmate and for which the inmate-patient does not refuse.

A refusal of care which could endanger the inmate should be reported to the responsible physician and/or the health authority and the facility administrator.

GRIEVANCE MECHANISM

Each facility has a mechanism in place to allow inmates to express their complaints regarding healthcare services. Healthcare complaints are included in the formal grievance process. Inmates are told soon after they are admitted what the grievance procedures are. If someone other than a member of the medical staff responds to inmates' grievances, medical staff input is solicited prior to responding to an inmate's complaint.

Grievance mechanisms are an important component of a facility's quality improvement program. While not all complaints from inmates are well founded, those that are can help administrators to identify problems with specific providers or procedures.

Prison Health Services requires compliance with the written grievance procedure regarding complaints about healthcare services.

- ◆ The Health Services Administrator will work with the facility administrator to ensure that there is a well-defined procedure for handling inmate complaints.
- ◆ When a complaint about healthcare services is received, the medical record is reviewed, and if necessary, the inmate is interviewed. A written response is given to the inmate within the time constraints require by the facility's plan.
- ◆ Immediate resolution is expected if the complaint involves the inmate's access to healthcare.
- ◆ Reasonable effort will be made to resolve the inmate's complaint to his/her satisfaction.
- ◆ If the complaint cannot be resolved to the inmate's satisfaction, the inmate may request an appeal in which case the written grievance will be reviewed through the facility review process.

Review of inmate healthcare complaints is included in the Quality Improvement meetings and identified problems are viewed as opportunities to improve care.

MEDICAL RESEARCH

Prison Health Services supports the involvement of inmates in non-invasive medical research that has been reviewed and approved by external research and ethics boards and that offers potential benefit to the participants. The FDA must approve the participation of inmates in research programs.

Inmates are only allowed to participate on a voluntary basis and must sign an Informed Consent prior to involvement.

Research of an experimental nature is prohibited.

- ◆ Prior to any inmate becoming involved in medical research, the responsible physician and Health Services Administrator must have evidence that all federal regulations regarding inmate participation in medical research have been met.
- ◆ All proposed medical research involving inmates should be thoroughly reviewed by external research and ethics committees prior to initiating inmate participation.
- ◆ Included in appropriate research topics for inmate populations are those that study:
 - a. Possible causes, effects, and processes of incarceration
 - b. Conditions particularly affecting inmates as a group
 - c. Practices, both innovative and established, which are intended and reasonably can be, expected to improve the health and well being of the subjects.

SERVICES PROVIDED TO HEALTHCARE STAFF BY SECURITY

The healthcare services unit in a correctional facility cannot operate efficiently without the support of security personnel. The cooperation and collaborative efforts of healthcare and security personnel allows for efficient healthcare services. The roles of security personnel include:

- ◆ Escorting inmates to and from the healthcare services area.
- ◆ Transporting inmates to healthcare appointments in the local community.
- ◆ Escorting healthcare staff through the facility. Healthcare activities such as medication administration and sick call should be performed at the same time each day to facilitate the scheduling of security personnel.
- ◆ Security personnel should be present or available in the healthcare services unit whenever inmates are in the area. This includes the supervision of inmates who may be in the healthcare services unit performing janitorial duties.
- ◆ When indicated, security personnel should be available to healthcare personnel during inmate healthcare encounters. It is possible to maintain privacy of care with a security chaperone in the room.
- ◆ Security personnel should not be involved in collecting medical requests, scheduling appointments, taking vital signs or inmate histories, filing healthcare forms or records, or performing direct patient care activities.

SERVICES PROVIDED TO SECURITY AND VISITORS BY THE HEALTHCARE STAFF

In the event of a medical emergency, the on-site Prison Health Services' healthcare staff may provide healthcare services to correctional staff and visitors within the correctional facility to stabilize their medical condition until ambulance services arrive. Prison Health Services healthcare personnel should not be involved in providing routine services to anyone other than the inmate population.

**SHERIFFS OFFICE STANDARDS OF PERFORMANCE:
“THE CARDINAL SINS”**

The Alameda County Sheriff has discussed expectations of conduct and standards of performance. All civilian employees and contractors are expected to abide by these rules. It is understood that the Sheriff and/or his designee will meet out severe discipline up to and including termination for those employees culpable of the following misconduct:

1. Accepting gratuities of any sort or description.
2. Making disparaging utterings or writing disparaging ethnic remarks, whether or not intended as humor.
3. Misrepresenting or lying in instances involving official County business, either orally or in writing.
4. Consumption of controlled substances or being present where controlled substances are being used or knowingly becoming intoxicated through the use prescribed drugs.
5. Engaging in any form of sexual harassment; this includes any unwanted comments or contact as defined in the sexual harassment policy.
 - a. Becoming involved in an inappropriate or romantic relationship with an inmate.

Although not specifically listed as one of the Sheriff’s five priority conduct concerns, he nonetheless stated that discipline would be forthcoming to any employee engaging in retribution against fellow employees based on political sympathy or affiliation, political persuasion or political choice.

The afore-mentioned expectations of conduct for employees of the Sheriff’s Office do not alter or lessen any current written policy governing the conduct of such employees.

INTERACTING WITH INMATES

Your attitude and behavior toward the inmates determine the quality of healthcare and security in the facility. Be caring and considerate, yet firm. Treat the inmates with dignity, but always maintain an attitude of professionalism. Sometimes body language speaks louder than words. Maintain body language that communicates a concern balanced with professionalism.

Inmates may tend to be manipulative and demanding. Accommodate inmate needs and requests when appropriate; when in doubt, seek help. Always set firm limits with inmates and be consistent in applying these limits to all inmates while ensuring compliance with policies, procedures, regulations, and routines of both the correctional and health services departments. If you feel an inmate's special needs require intervention of another department, never promise specifics.

Because of the nature of the correctional environment, aggressive approaches may be used to maintain an inmate. The aggressive behaviors may be verbal or physical and, at times may require the use of force and/or restraints. **THESE APPROACHES INVOLVE SECURITY PERSONNEL ONLY AND ARE NEVER TO BE USED BY HEALTHCARE PERSONNEL.** If this need arises remove yourself to a safe area, as previously specified by security personnel.

Your attitude and behavior reflects on Prison Health Services. You should always be cooperative, courteous, pleasant and professional.

Maintain an open and honest relationship with security staff. Do not hesitate to ask questions or voice concerns. The only stupid question is the one not asked. If you have a concern regarding a situation, discuss it with security staff when there are no inmates present.

Never go against what security staff asks you do in a situation. Never position yourself between inmate and security personnel. If a situation arises, you become another obstacle for security to deal with before they can deal with the crisis.

Do not share personal information with information with inmates. Any conversation you have with another person or on the telephone you can be sure an inmate is trying to listen.

24 hours per day, 7 days per week, safety and security is everyone's job.

CCHP Program

Health practitioners working in correctional settings face challenges unique to the correctional environment. Managing difficult patients, working within strict security regulations, dealing with overcrowded facilities, and understanding the complex legal and public health considerations of providing healthcare to incarcerated populations are just some of the challenges that distinguish correctional healthcare from health services in other settings.

The National Commission on Correctional Health Care (NCCHC) offers a national certification, Certified Correctional Health Professional (CCHP), which recognizes your knowledge of national standards for providing health services in correctional settings. Certification under the CCHP program identifies you, as someone who mastered the unique knowledge needed to provide care in these unique settings.

CCHP is a symbol of accomplishment and recognition of self-improvement. It is highly regarded by peers, staff and others. A Certified Correctional Health Professional is one who has shown mastery of national standards and the knowledge expected of leaders working in the field of correctional healthcare. In some employment settings, CCHP certification is rewarded with special bonuses.

The CCHP designation can be used with your name or letterhead, business cards, and all forms of address. In addition, CCHP's receive many benefits.

- ◆ A certificate suitable for framing
- ◆ A lapel or tie pin with CCHP insignia
- ◆ Special discounts on NCCHC publications
- ◆ Special discounts on NCCHC educational conferences
- ◆ A press release to send to employee newsletters and local media
- ◆ Listing in a national directory
- ◆ Special networking and publishing opportunities
- ◆ A subscription to the *Journal of Correctional Healthcare*

Persons meeting the basic application requirements participate in an examination. Upon receiving a passing score, certification is awarded for one year. Each year, CCHP's are required to register participation in at least 18 hours of relevant continuing education activities.

All correctional healthcare professions, such as physicians, nurses, mental health workers, nurse's aids, etc. are eligible to participate in the CCHP certification program. Other professionals working in the area of correctional healthcare, such as attorneys, administrators, medical record technicians, etc. are also eligible to participate.

For further information about the Certified Correctional Health Professional program, contact the National Commission on Correctional Healthcare on the website www.ncchc.org.

MANAGING SAFE AND HEALTHY ENVIRONMENT

SAFETY AND SECURITY GUIDELINES

SAFETY ISSUES – All staff should be concerned with minimizing exposure of self and others to potentially dangerous situations and preventing accidents and injuries to staff and inmates.

- ◆ Healthcare personnel must work within the security requirements of the facility to assist in maintaining a safe environment.
- ◆ Identification tags must be worn above the waist at all times.
- ◆ Healthcare personnel must maintain control of all keys and equipment.
- ◆ The healthcare service area must be locked when unoccupied.
- ◆ Healthcare personnel must not access restricted areas and must limit movement in the facility when directed by security personnel.
- ◆ Do not allow an inmate in the clinic area unless an officer is present. Never leave an inmate in a clinic room. Do not allow inmate to handle keys.
- ◆ Healthcare personnel are required to dress professionally. Revealing and tight clothing should not be worn.

CONTRABAND

Contraband is defined as goods or merchandise of which possession is forbidden. Because of the need for security, many common items are considered to be contraband. In the correctional setting, any items not specifically approved by security for an inmate to have in his/her possession are considered contraband. In addition, facility regulations may prohibit healthcare and correctional personnel from bringing some items classified as contraband into the facility. The healthcare staff must consider virtually everything to be contraband.

Many items directly related to the delivery of healthcare services are classified as **contraband**.

- ◆ Healthcare items, including but not limited to: **needles, syringes, Q-tips, tongue blades, alcohol wipes, and items that contain metal or glass.**
- ◆ Items for basic hygiene are provided by the correctional facility. Therefore, all basic hygiene items not provided directly by the facility are considered contraband. Do not give inmate soap, contact solution, lotion or any other hygiene items unless provided through Prison Health Services or the correctional facility.

DO'S AND DON'TS OF CORRECTIONAL HEALTHCARE

DO'S	DON'TS
1. Pocket your keys securely.	Don't leave keys available for others, especially for inmates.
2. Lock and close doors behind you when leaving the room. Keep all clinic area doors locked when unoccupied.	Don't leave a door open and accessible for entry.
3. Lock all cabinets and drawers in the Healthcare Services Unit.	Don't leave cabinets open, leaving supplies or instruments accessible.
4. Dispose of "sharps" properly and quickly. Count "sharps" at end and start of each shift with a co-worker.	Don't leave "sharps" lying around. Never take the word of a co-worker that the sharps count is correct.
5. Have a deputy present during inmate exams involving the genitorectal area.	Don't examine an inmate involving the genitorectal area without a chaperone.
6. Ask an inmate to leave the room and Lock the door if you must go to another area.	Don't leave an inmate in an examination room unattended.
7. Leave the office door open and accessible while an inmate is present.	Don't barricade yourself inside a room or hallway with an inmate.
8. Concern yourself with health issues only.	Don't interfere with security matters.
9. If you suspect an inmate knows of a scheduled appointment day or times notify your supervisor and the HSA and the schedule will be changed.	Don't tell an inmate, his relatives, or others of an impending outside appointment or trip. An escape can be planned, putting custody staff and inmate in danger.
10. Lock your valuables in a secured area, i.e., your vehicle.	Don't bring anything into the facility, which you don't need or which may be considered contraband. We are all subject to search.
11. Always have security check items you are unsure, ask the Sheriff's Office staff if an item is considered to be contraband.	Don't bring anything with you into the facility for an inmate no matter how trivial; this includes, but is not limited to, magazines, newspapers or clippings.
12. Check with the Sheriff's Office staff before giving an inmate something that may be considered contraband.	Don't give contraband to an inmate: gum, glue, metal articles, sharp instruments, pins, Q-tips, alcohol wipes, paper soufflé cups, etc.
13. Maintain a safe distance from inmates at all time. Distance should be greater than an arm's length. Walk around a group of inmates. Stand with your back against the wall if a group of inmates is being moved along a hallway and you are in the area.	Don't walk toward or into a group of inmates. Never get locked in an enclosed area with inmates.

14. Conversation with inmates should have a good balance between professional and business.	Don't carry a message from one inmate to another.
15. Be professional, courteous and cautious when responding to telephone calls. Refer inquiries to management.	Don't share or discuss information concerning an inmate with anyone over the phone. You never know to whom you are speaking.
16. Always refer the inmate to their Security officer if they make a seemingly minor request for something. Security makes the decision as to what an inmate is allowed to keep.	Don't sharpen a pencil, lend a pen, provide paper to write a letter, lend a lighter or match, provide extra tape for a bandage (adhesive or scotch tape), give them a cigarette, a paper cup, etc.
17. Follow all established policies and procedures.	Don't deviate from established policies and procedures.
18. Limit discussions with inmates to their health conditions.	Don't discuss the pros and cons of an inmate's case. In addition, do not discuss another inmate, a correctional staff member or a healthcare staff co-worker with an inmate.

QUALITY IMPROVEMENT PROGRAM

Prison Health Services has established a CQI program using a streamlined version of the QI implementation process as outlined by JCAHO. This process is applicable to correctional health services due to its flexibility approach and methodology for the following reasons:

- ◆ Facility can develop a CQI plan reflective of the unique needs and established systems of the healthcare services unit.
- ◆ Implementation is easy even if healthcare staff may not have had experience in healthcare CQI.
- ◆ A logical “starting point” for staff to address and resolve problems is provided.
- ◆ A continuous process for monitoring healthcare activities is provided even when there are staffing changes over time.

COMPONENTS OF THE CQI PROGRAM

RISK MANAGEMENT – The nature of the correctional setting makes correctional facilities more at risk than the average business for various health concerns. A comprehensive CQI program should include a risk management component designed to protect the financial assets of an organization by assuring appropriate insurance coverage, reducing the liability when an adverse event occurs, and preventing the occurrence of events that lead to increased liability. The risk management component of CQI program should be implemented to assist in the prevention of loss.

CLINICAL RISK MANAGEMENT – The concept of risk management should be applied to the clinical setting. In the clinical setting, risk management activities should focus on the identification of clinical events, which have or may have the potential of placing the patient, healthcare provider, or the facility at risk. The identified risk areas should be investigated and analyzed to develop policies and procedures that reduce risk and maintain a safe clinical environment.

ENVIRONMENTAL RISK MANAGEMENT – The CQI program should include a component addressing safety. A safety program is intended to provide a safe environment for inmates, employees and visitors. The safety program should be based on systematic monitoring and evaluation of the environment. All appropriate individuals should be informed of all accidents, injuries and potential hazards. This information can be used when determining area for evaluation. The CQI committee must work constantly to maintain a safe environment and reduce the risk of accidental injuries. An effective safety program will assist in the prevention of injuries, reducing the demand for health services, employee compensation claims, and accidents that can be attributed to the organization; and therefore, contribute to the organization’s cost containment efforts by reducing medical expenditures and protecting the organization against possible litigation. The safety program should contain the following elements:

- Identification, development, implementation and review of safety policies and procedures.
- A system for reporting and investigation all incidents that involve inmate, personnel, or visitor; occupational illness; or property damage.
- Documentation and summarization of all reports and follow-up action.

INFECTION CONTROL – The next component of the CQI program is infection control. Correctional facilities must have infection control policies and procedures for the surveillance, identification, treatment, documentation, and communication of infectious diseases. The primary functions of the infection control program are:

- Management of communicable diseases surveillance and treatment.
- Reporting of communicable diseases and conditions.
- Collection, reporting and evaluation of epidemiological data for trends and analysis.

UTILIZATION MANAGEMENT – Utilization management is the component of the CQI program that focuses on managing the utilization of healthcare resources in a cost-effective manner while maintaining the delivery of quality healthcare services. Utilization looks at the process through which healthcare services are delivered. Statistical data is collected on a routine basis and is used to detect potential problems. Any deviation in a pattern or trend may warrant further evaluation.

INMATE GRIEVANCES – In the correctional setting the inmate is the customer of the healthcare services provided. While it is realized that many grievances may be derived from unrealistic expectations, the grievances should be reviewed to identify potential problem areas and to determine if a pattern exists.

CONTINUOUS QUALITY MONITORING – A unit based CQI program is one which provides for monitoring, evaluation and improvement of the healthcare services by the healthcare providers who deliver the care. The primary assumption behind a unit-based program is that the healthcare providers who deliver the care are in the best position to monitor the delivery of the healthcare services. Prison Health Services has defined specific areas necessary for the success of unit based programs.

- Special Inmate Events
- Health Record Audits
- Focused Studies

PHYSICIAN HEALTH RECORD AUDITS – On a monthly basis the quality assurance nurse reviews the care provided by to inmates. Health records are chosen at random to insure that the care that has been provided is acceptable and appropriate.

EMERGENCY PLAN

The responsible health authority and the facility administrator will approve the healthcare aspects of the facility's Emergency Plan, which is used in the case of an internal or external disaster.

Prison Health Service's portion of the Emergency Plan is practiced at least annually.

All healthcare service personnel are to be familiar with the healthcare unit's responsibilities and response procedures in the event of an emergency.

Each PHS medical unit will establish a site specific Emergency Plan for the medical unit that addresses at least the following:

- a. The triaging process
- b. Locations identified where care will be provided.
- c. Procedures and location on call list of health personnel who are to be called in
- d. Phone numbers for ambulance and hospitals
- e. Evacuation plan for inmates should this become necessary
- f. Specific roles for healthcare personnel
- g. Back up plan

Each facility will develop a system for separate emergency supplies, which are stored in a location known to all healthcare staff and are regularly checked for completeness and for expiration dates on all items.

All healthcare service personnel will be oriented to the Emergency Plan during their initial new employee Sheriff's Orientation and annually during the annual drill.

Following the annual Emergency Plan drill, a critique will be completed and documented to identify any weakness or improvements needed in the Emergency Plan.

INFECTION CONTROL PROGRAM

Prison Health Services maintains an Infection Control Program at each facility.

This program includes, but is not limited to, concurrent surveillance of inmates and staff, prevention techniques, and treating and reporting infections in accordance with state and local laws.

An Infection Control Committee is established at each facility with membership consisting of the Health Services Administrator, the responsible physician, and other professionals on staff and/or from within the community or the facility.

- ◆ Surveillance will include, but is not be limited to the following:
 - a. *During the initial health screening, the nurse will observe and make*

inquiry into the possibility that the patient has signs and symptoms of infectious and/or communicable diseases.

- b. Any inmate suspected of having an infectious communicable disease will be housed in isolation; the responsible physician will be notified.
- c. All new employees will be tested for TB or provided evidence of testing within the past year. Each employee will be re-tested annually or semi-annually and results will be documented in the employee's file.

◆ Reporting to the appropriate parties:

- a. The nurse who first identifies a potential infectious disease will communicate in the manner determined by the Health Services Administrator or designee.
- b. The Health Services Administrator or designee will assume responsibility for reporting to the appropriate health authority (i.e. Public Health Department) any inmate having a reportable communicable disease such as hepatitis or a sexually transmitted disease, or a widespread documentation of diarrhea, staph infections, or varicella.
- c. The kitchen will be informed if disposable trays are required.

◆ Other measures to prevent the spread of infectious diseases will include:

- a. All staff will be constantly attentive to good hand washing technique and other Universal Precautions. Hand washing supplies are readily available in all clinical areas.
- b. The medical staff will reinforce hygiene with food handlers, correctional staff, etc. whenever possible.
- c. Regular in-service programs on infection control will be conducted at least annually.
- d. All reusable instruments including dental tools and instruments will be chemically disinfected before handling and then autoclaved.
- e. Upon discharge from medical isolation, the medical cell will be thoroughly disinfected by the designated inmate worker who will follow strict universal isolation precautions.
- f. All sharps and bio-hazardous waste is disposed of in appropriate containers and is picked up by a contacted bio-hazardous company.
- g. Appropriate measures are to be taken with contaminated linens and trash.
- h. Any condition resulting in the spread of infection will be addressed immediately by the Health Services Administrator, the responsible physician, and the facility administrator.

◆ TB Skin Tests:

- a. All inmates will be tested for TB during the receiving screening.
- b. Inmates known to be positive will be referred to TB clinic.
- c. All TB skin tests will be read by a qualified healthcare professional within 48-72 hours.
- d. All test results will be documented in the inmate's health record in millimeters (mm) of induration. + PPD = 10mm or greater.
- e. Positive skin tests, or those inmates who report they have tested positive to the skin test in the past, will have the following:

1. Interview the patient regarding past exposures and previous non-reactive test.
2. Assess for any signs and symptoms.
3. Document findings in the health record and record test results in mm.
4. Schedule for a chest x-ray.
5. If the inmate is symptomatic, or the healthcare professional suspects he/she is positive, the inmate will be moved to an area where respiratory isolation can be implemented, preferably with negative pressure air flow.
6. If X-ray is positive, the inmate will remain in respiratory isolation until see by the physician.
7. The physician will write orders for treatment and will determine when the patient can be released from isolation.
8. If the inmate was previously housed with other inmates, a list of inmates who have been exposed should be re-tested and/or reported to the local health authority.

◆ RPR testing

- a. All high risk inmates, including known drug users, prostitutes, and those who were previously living in an area known to be high risk, may be offered an RPR test during the receiving screening.
- b. Other inmates have the RPR test performed during the Health Assessment if indicated.
- c. Positive results (1:1 or greater) will be handled as follows:
 1. Interview the inmate to gather information on previous history and treatment
 2. Assess for signs and symptoms
 3. Document findings in the health record
 4. Schedule the patient to be seen by the physician, physician assistant, or nurse practitioner.
 5. Transcribe and carry out medical orders to treat the patient.
 6. Report the incident to the appropriate public health authority.

◆ HIV testing

- a. HIV testing may be offered to inmates at the time of Health Assessment.
- b. Pre and post-test counseling may be provided by qualified healthcare personnel.
- c. When test results are positive and the patient is not already being treated, the patient is scheduled for the next physician's sick call.
- d. Mental health referral may be made for all newly diagnosed HIV+ inmates.
- e. Make a referral to local providers as early as possible to ensure continued care for the inmate upon release.

STANDARD PRECAUTIONS (AKA: Universal Precautions)

Since medical history and examination cannot reliably identify all individuals infected with HIV or HepB or other blood-borne pathogens, standard precautions should be used consistently. This is of particular importance in emergent situations where the risk of blood exposure is increased and the infection status of the individual is unknown.

Standard precautions apply to:

- Blood
- Tissue
- Body fluids containing visible blood
- Semen
- Vaginal Secretions
- Cerebrospinal Fluid
- Synovial Fluid
- Pleural Fluid
- Pericardial Fluid
- Amniotic Fluid
- Saliva in dentistry

Standard precautions do not apply to the following unless they contain visible blood:

- Sweat
- Tears
- Nasal Secretions
- Sputum
- Urine
- Vomit
- Saliva
- Breast Milk

HAND WASHING

Hand washing is the single most important procedure for preventing nosocomial infections. It is defined as a vigorous rubbing together of all surfaces of lathered hands, followed by rinsing under a stream of water. Hand washing can be classified as mechanical or chemical depending on whether plain soap, detergents or antimicrobial-containing products are used.

Hand washing indications – personnel should always wash their hands: before performing invasive procedures; before and after taking care of inmates; before and after touching wounds; after exposure to bodily fluids; and between contacts with inmates.

PERSONAL PROTECTIVE EQUIPMENT

Healthcare personnel should wear personal protective equipment when there is a possibility of body fluid exposure. The protective equipment should be kept in medical areas where the most frequent need arises, generally the treatment room.

Protective equipment including, but not limited to the following, may be used as needed: gowns, gloves, goggles or surgical mask with or without plastic shield, caps, booties, one-way valves, or particulate respirators or facemasks.

GUIDELINES FOR PREVENTION OF TRANSMISSION OF THE HBV AND HIV EXAMPLES OF RECOMMENDED USE OF PERSONAL PROTECTIVE EQUIPMENT

ACTIVITY	GLOVES	GOWN	MASK	GOGGLE	CAPS/BOOTIES
Spurting Blood	Yes	Yes	Yes	Yes	Yes*
Minimal Bleeding	Yes	No	No	No	No
Emergency Childbirth	Yes	Yes	Yes	Yes	Yes*
Code	Yes	Yes	Yes	Yes	Yes*
Blood Drawing	Yes	No	No	No	No
Starting IV	Yes	No	No	No	No
Endotracheal Intubation	Yes	No	PR	Yes*	No
Oral/Nasal Suctioning	Yes	No	PR	Yes*	No
Handling/Cleaning Contaminated Instruments	Yes	Yes*	No	No	No
Measuring Blood Pressure	No	No	No	No	No
Measuring Temperature	No	No	No	No	No
Giving an Injection	Yes	No	No	No	No

*If splashing is likely.

PR: Particulate Respirator is recommended whenever sputum exposure is likely. A fluid resistant surgical mask is not sufficient.

ENVIRONMENTAL HEALTH AND SAFETY

The facility administrative staff in conjunction with the Health Services Administrator and the Medical Director develops Policies and Procedures to assure a safe, sanitary environment, for inmates and staff.

Regularly scheduled environmental inspections are conducted with written reports submitted to the Health Services Administrator and the facility administrator.

The Health Services Administrator will ensure that regularly scheduled environmental inspections are completed on at least a monthly basis.

The Health Services Administrator will keep written reports of the results of these inspections on file.

Identified problems will be addressed in Administrative Meetings with the facility administrator or designee and in Continuous Quality Improvement meetings when appropriate.

Immediate corrective action will be taken when an unsafe or unsanitary condition is noted.

At a minimum, areas that are included in the environmental inspection are:

- a. Inmate housing
- b. Kitchen and laundry
- c. Healthcare Unit
- d. Housekeeping
- e. Risk exposure areas including electrical outlets, fire retardant equipment, and barber and beauty shops
- f. Ventilation systems
- g. Appropriate personal protective equipment

KITCHEN SANITATION AND FOOD HANDLERS

Inmates and staff working in food services must submit to a pre-assignment physical examination to ensure freedom of illnesses transmissible by food.

The Health Services Administrator or designee will work cooperatively with the correctional authority responsible for food service to ensure that inspections are conducted and that corrective actions are taken when problem areas are identified.

All inmate kitchen workers are medically screened prior to beginning work in the food service area and are re-examined on an annual basis.

A Medical Clearance Form is completed for each inmate who is being considered for assignment to the food service area prior to their beginning work and annually. The original is forwarded for the inmate's classification file, and a copy may be filed in the medical record.

The food service supervisor is responsible for monitoring the health and cleanliness of inmate kitchen workers on a daily basis. The food service supervisor or designee will maintain documentation of these daily checks. Daily screening will include determining if the inmate is free from diarrhea, skin infections, and other illnesses that are transmissible by food or utensils.

Inmates who have diarrhea, skin infections, runny nose, and other illnesses transmissible by food or utensils will not be cleared to work in the food service area. Inmates who are already assigned to the food service area who develop any of these conditions will be relieved of their duties until such time as they are medically cleared to return to work.

All inmate and civilian kitchen workers who prepare or serve food are required to wear hair covers and gloves.

ECTOPARASITE CONTROL

The physician establishes and approves ectoparasitic control procedures that are used to treat inmates found to have ectoparasites including procedures for disinfecting of clothing and bedding.

All inmates are evaluated for the presence of ectoparasites during the receiving screening and anytime thereafter that it is indicated.

Prior to choosing treatment, consideration is given to the individual inmate regarding the presence of any open wounds, allergies, seizure disorders, pregnancy, respiratory ailments, or other conditions that may contraindicate use of the established treatment procedure.

It is the policy of Prison Health Services that each inmate is to be evaluated individually in regard to the need for ectoparasite treatment and that all inmates are not routinely treated upon admission.

- ◆ Each newly admitted inmate will be evaluated for the presence of ectoparasites at the time of the health screening.
- ◆ Inmates found to have ectoparasitic infestations will be instructed that all articles of clothing, bedding, and towels must be bagged and appropriately marked for disinfection.
- ◆ The patient should be instructed to take a shower, using hot water and soap.
- ◆ The treatment prescribed by the physician is then carried out.
- ◆ For body infestation, the lotion ordered by the physician is applied from the neck down on the whole body, except for the head and face and is generally left on for a prescribed period time before being removed by thorough washing in the shower or bath.
- ◆ For head and pubic infestations, the prescribed agent is given to the inmate to apply liberally to the affected areas and the inmate is given specific instructions regarding how long the solution is to remain on prior to rinsing.
- ◆ The inmate's clothing and bedding should be bagged up by the inmate and marked for delousing. The housing cell will also be disinfected and the inmate is issued new clothing and bedding.

- ◆ The inmate is instructed to return to the medical unit in seventy-two (72) hours for a follow-up visit.
- ◆ Physical findings and delousing instructions are documented in the medical record at the time of treatment. The inmate's condition and response to treatment is documented in the medical record when he is re-evaluated at seventy-two (72) hours.

BIOHAZARDOUS WASTE PLAN

The purpose of the biohazardous waste plan is to provide for the proper management of biochemical waste in a manner that is consistent with federal and state regulations.

Biomedical Waste – Biomedical waste is defined as any solid or liquid wastes that may present a threat of infection to humans. Examples of biochemical waste include:

- * Non-liquid tissue and body parts
- * Laboratory and veterinary waste which contain human disease causing agents
- * Discarded sharps
- * Blood and body fluids
- * Used, absorbent material saturated with blood, dried blood, body fluids, excretions or secretions, contaminated with blood
- * Disposable devices that may have been contaminated with blood, body fluids or blood contaminated excretions and secretions.
- * Other contaminated solid waste materials, which represent a significant risk because they are generated in medical facilities which care for persons suffering from diseases requiring strict isolation.

Segregation and Handling – Biomedical waste is identified, segregated from all other solid wastes and placed in to the appropriate biomedical waste receptacle at the point of origin. Point of origin is defined as the room or area where the biomedical waste is generated.

- * SHARPS – Sharps are discarded directly into leak-proof, puncture-resistant containers that have been designed for this purpose.
- * NON-SHARPS – All non-sharp biomedical waste are discarded directly into red impermeable bags located in the health services area.

Co-Mixing – Do not co-mix biomedical waste with hazardous waste.

Labeling – Because treatment and disposal of biomedical waste occurs off-site, all packages containing biomedical waste are labeled with:

- * Facility name and address
- * Date
- * “Biohazard, Biohazardous Waste, Infectious Waste, or Infectious Substance”

On-Site Storage – All on-site storage of biomedical waste is in a designated area, away from general traffic flow patterns and is accessible to authorized personnel only. Storage of biomedical waste shall not be for a period greater than 30 days.

Off-Site Transport – Biomedical waste is collected and transported for incineration.

Cleaning Solutions – Surfaces contaminated with spilled or leaked biomedical waste shall be cleaned with a solution of industrial strength detergent to remove visible soil before being disinfected with a 1:10 solution of bleach.

Records – All biomedical waste management records, including the documentation provided by the transporter, shall be maintained for a minimum of three years and will be made available for inspection, upon request. The records will be stored on-site.

Employee Training – All employees who are involved in the handling, disposal and/or management of biomedical waste shall receive training on the policy and procedure prior to initiating their duties and on an annual basis thereafter.

OSHA HAZARD COMMUNICATION

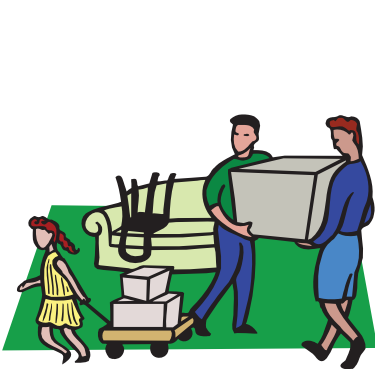
About 32 million workers are potentially exposed to one or more chemical hazards. There are an estimated 575,000 existing chemical products, and hundreds of new ones are being introduced annually. Chemical exposure may cause or contribute to many serious health effects such as heart ailments, kidney and lung damage, sterility, cancer, burns, and rashes. Some chemicals may also be safety hazards and have the potential to cause fires and explosions and other serious accidents.

The Occupational Safety and Health Administration (OSHA) issued, in 1983; a rule called “Hazard Communication” that applies to employers in the manufacturing sector of industry. The scope of the rule was expanded 1987 to include employers in the non-manufacturing sector. The basic goal of the standard is to ensure that employers and employees know about chemical hazards and how to protect themselves. This knowledge, in turn, should help to reduce the incidence of chemical source illness and injury.

The Hazard Communication Standard establishes uniform requirements to assure that the hazards of all chemicals used in the workplace are evaluated and that the resultant hazard information and recommended protective measures are provided to employers and potentially exposed employees.

PHS complies with the Hazard Communication Standard by complying with all directives from the Alameda County Sheriff’s Office with regard to hazardous materials. MSDS sheets are displayed throughout the jail for use as needed. Containers are labeled. Employees participate in OSHA training.

SAFE LIFTING & CARRYING



Plan To Prevent Injury

- Use a cart or trolley when possible
- Break down large or heavy loads
- Seek help if necessary
- Check your route is clear
- Take extra care with awkward tasks

Lift The Load Safely

- Stand close to it with feet apart
- Bend your knees, not your back
- Grip the load firmly
- Lift with your legs

Carry It Carefully

- Hold it close to your body
- Look where you are walking
- Take extra care carrying up and down stairs
- Don't twist our body, move your feet to turn
- Push carts in-line with your direction of travel (not across at 90°)

Put It Down Properly

- Bend your knees to lower the load
- Don't trap your fingers or toes
- Put it down first, then slide it into place
- Don't over-reach or stretch

TUBERCULOSIS REVIEW

TUBERCULOSIS (TB) DEFINED:

Tuberculosis is a disease caused by the bacterium *Mycobacterium Tuberculosis*, frequently called Tubercle Bacilli. TB can occur anywhere in the body but is most common in the lungs and larynx.

TUBERCULOSIS TRANSMISSION:

TB is spread through the air by tiny airborne particles called “droplet nuclei” which contain Tubercle Bacilli. Individuals produce “droplet nuclei” when they talk, sing, cough and sneeze. The droplet nuclei may remain suspended in the air and may be inhaled by others if the area is not properly vented to the outside. If an individual has infectious (active) TB of the lung or larynx the droplet nuclei may contain tubercle bacilli.

WHAT IS TB INFECTION:

When an individual breathes in air contaminated with tubercle bacilli the bacteria will multiply to some degree before the individual’s immune system obtains control of the growth. At this point, the individual has been exposed to TB and is considered to have the TB infection. However, this does not mean that the individual is infectious and can transmit TB to others. Once an individual has TB infection, the tubercle bacilli may remain dormant (inactive), or they may become active and cause clinical disease (infectious TB) at some point in the future.

A person who has TB infection without active disease:

- cannot spread TB infection to others,
- is not considered a case of TB
- usually has a negative x-ray and does not have symptoms of TB, but
- does have tubercle bacilli and may develop the disease at any point in the future.

TB DISEASE:

Once exposed, an individual may develop active disease. This can happen at the time of exposure or many years later. When the immune system is suppressed, the risk of developing TB increases. Factors, which suppress the immune system, include HIV infection, chemotherapy, and malnutrition and drug and alcohol abuse.

TB SYMPTOMS:

As previously stated, TB can occur anywhere in the body. The symptoms vary depending on the location of the disease. General symptoms of TB disease include:

- lethargy
- weakness
- weight loss
- loss of appetite
- fever
- night sweats

The most common location of TB is in one or both lungs. TB of the lungs is called "Primary TB." The symptoms of "Primary TB" include:

- persistent cough
- chest pain
- hemoptysis

TB CONTROL:

The Mantoux skin test is the standard method of identifying individuals infected with Tubercle Bacilli. Injecting a purified portion of the dead Tubercle Bacilli into the superficial layers of the skin performs the skin test. The test is interpreted in 48-72 hours. A positive test results in a firm or hard swelling which can be felt by gently rubbing the injection site. The firm, or indurated, area is measured in millimeters (mm). The reddened area at the injection site is not included in the measurement. A 5-10 mm or greater reaction is considered to be a positive reaction, depending on a prescribed set of criteria.

Individuals who have a positive skin test for TB should have a x-ray to be certain they do not have active TB. An individual who has a positive skin test and a negative chest x-ray, in most cases has been exposed to TB but does not have active or infectious TB. The exception would be an individual who is experiencing symptoms.

Individuals working in the correctional environment and having direct contact with the inmate population should be tested for TB prior to employment. Employees are tested for TB annually or by chest x-ray annually with history of + PPD.

TB THERAPY:

Preventive therapy substantially reduces the risk of developing clinically active TB in infected individuals. All individuals who have a positive skin test for TB should be considered for preventative therapy when active disease has been ruled out. The current preventative therapy regiment is 6 to 12 months Isoniazid and Vitamin B 6. Patients must be monitored monthly for symptoms of drug toxicity as well as to ensure

compliance. If the medication is not taken as prescribed, the tubercle bacilli may become resistant to the medication, and therefore, the medication is ineffective.

CONTACT INVESTIGATION:

Whenever a case of TB is suspected or diagnosed, all close contacts should be tested. However, individuals with a documented history of a positive skin test will not need to be re-tested. Close contacts include anyone who has shared air in an enclosed environment with a potentially infectious individual. Close contacts may include cellmates, pod mates, and health and correctional staff working in the area.

RULE OUT TB:

Inmates placed in the Outpatient Housing Unit (OPHU) for “Rule-out TB” may not be released from the unit until they have been cleared and released by the TB nurse. Specific protocols apply and need to be explicitly followed when determining the status of a potential Tuberculosis case.

HOW TO REPORT INMATE INCIDENTS

Incident reporting is a critical step in successful risk management programs. We rely heavily on this communication tool to alert us to the potential claims and lawsuits against the Company. Incident reporting is also key to prevention. By tracking and trending incidents with potential for injury to patients, we can evaluate our processes and implement corrective action measures as necessary. However, we can only do this effectively with your help.

An incident is defined as any unplanned or unexpected occurrence in the health services department or area that is not consistent with the routine care of a patient. The Prison Health Services, Inc.'s Incident Report form is available for your. An inmate incident should be reported to the nursing supervisor or designee as soon as possible (ASAP). An actual injury need not have occurred. The potential for injury is sufficient for an occurrence to be considered an incident. Therefore, we have developed the following list of types of incidents that you are required to report through our incident reporting system:

WHAT TO REPORT:

- ◆ All deaths
- ◆ Acute neurological deficits/injuries
- ◆ Delays in treatment or diagnosis
- ◆ Unplanned hospitalizations due to:
 - Cardio/respiratory arrests
 - Repeat visits to the ER for the same complaint or condition
 - Seizures
 - Suicide attempts
 - Head injuries
 - Detoxification
 - Miscarriages
 - Infections/sepsis
- ◆ Significant injuries such as:
 - Amputations
 - Loss of use of limb(s)
 - Spinal cord injuries
 - Visual/hearing impairment
 - Reproduction organ loss/impairment/burns (2nd and 3rd degree)
- ◆ Medication errors

WHAT TO DO FOLLOWING AN INMATE INCIDENT:

- 1. Notify the Nursing Supervisor as soon as possible.**
We consider an urgent matter to be a serious injury (i.e., death, amputation, neurological injury, etc.) or receipt of a lawsuit or claim. All other types of incidents do not require such prompt notification.
- 2. Complete the Incident Report.** When you are ready to complete the incident report, notice that in bold letters at the top of the report it states:
CONFIDENTIAL: THIS FORM IS NOT PART OF THE MEDICAL RECORD.
This is extremely important. As you will note, it also says at the top of the form that this document is privileged and confidential, for use by legal counsel, and may not be released without the consent of PHS' general counsel. For that reason, we ask that you do not keep a copy of the form at the site. If anyone requests a copy of the incident report form, you must contact PHS' general counsel for authorization.

The employee involved in responding to, observing or discovering the incident must complete the incident report form.

In completing the incident report, keep the description of the incident brief and concise. You will notice that our form provides only four lines to describe the incident, which has occurred. If more room is needed, continue on the back. The purpose of this form is to let us know that a particular incident has occurred and generally what treatment was provided (e.g., transfer to the hospital.) Details about the incident itself, assuming that it was a medical emergency of some sort, will be contained in the medical record.

- 3. Do not make reference to the existence of the incident report in the progress notes in the medical record.** Doing so may result in waiving any legal protection we may have available to us.
- 4. Sign the form and give it to the Nursing Supervisor or your supervisor for review. The supervisor will forward the original to the Health Services Administrator (HSA) or designee.**

HOW TO REPORT AN OCCUPATIONAL EXPOSURE OR INJURY

Incident reporting is a critical step in successful risk management programs. We rely heavily on this communication to alert us to occupational hazards present in the workplace, i.e., exposure to chemicals, bodily fluids, or physical plant hazards. Incident reporting is also key to prevention. By tracking and trending incidents with potential injury to staff, we can evaluate our processes and implement corrective action measures as necessary. However, we can only do this effectively with your help.

WHAT TO INJURIES TO REPORT:

- Any occupational incident resulting in employee injury.
- Any occupation-related injury or illness, i.e., needle stick, exposure to chemicals, exposure to bodily fluids, or an injury that you consider to be occupational in nature.

WHAT TO DO FOLLOWING AN OCCUPATIONAL INJURY OR EXPOSURE:

1. **Notify the Nursing Supervisor/your supervisor as soon as possible.** Do not delay reporting an occupational exposure or injury/illness. Nursing supervisor/your supervisor notifies HR or designee to facilitate prompt completion of appropriate Workers Compensation Claim documents.
2. **If a needle stick or occupational exposure to blood and body fluids, follow the PHS Needle Stick Policy.**
3. Attend an Occupational Medical Provider clinic for PHS Workers Compensation injuries. See www.mywcinfo.com for a current listing of providers in a geographic area convenient for you.

PHS NEEDLE STICK AND OCCUPATIONAL EXPOSURE TO BLOOD AND BODY FLUIDS POLICY

POLICY: It is the intent of Prison Health Services, Inc. to protect it's Healthcare Providers as much as possible from exposure to blood or body fluids parenterally. All exposures to blood and body fluids must be reported to your immediate supervisor for incident reporting, the completion of Worker Compensation reports and the post exposure evaluation and prophylaxis.

PROCEDURE: Whenever any employee is exposed to blood or other Potentially infectious fluids **the employee will:**

1. As soon as possible, following the incident, thoroughly wash the area in Running water with soap. Eyes will be washed with an appropriate eyewash or potable water for 15 minutes. Bleach or other suitable veridical may be used for non-mucus membrane exposures.
2. The exposure will be immediately reported to the immediate supervisor.
3. An incident report form will be completed, and the time the employee was sent off site for treatment will be noted on the incident report.
4. The employee will immediately be referred to a local treating facility so that the employee will receive treatment within 2 hours of such stick for evaluation, counseling, and possible institution of post exposure prophylaxis (PEP). Baseline evaluation of the employee should include HIV, HCV, VDRL/RPR, HbsAg, and/or HBV.
5. Another staff member will review the source patient's medical record for any evidence of HIV, HCV, and/or HBV with immediate notification to the supervisor.
6. Whatever available medical information regarding the source patient will be sent with the employee to the local healthcare provider.
7. If the source patient's HIV, HCV and HBV status is unknown, a blood sample will be requested for HIV, HCV and HBV.
8. The results of these blood tests will be shared with the employee and the employee's healthcare provider.
9. Initiating PEP should be decided on a case by case basis by the injured staff member and the treatment facility based on the exposure risk and the likelihood of HIV infection in the known or possible source patients. If additional information becomes available, decisions about PEP can be modified.
10. The employee should follow the site Worker's Compensation Policy and have follow up counseling and medical evaluation, including HIV antibody tests at baseline and periodically for at least six months post exposure (e.g., 6 weeks, 12 weeks, and 6 months), and should observe precautions to prevent possible secondary transmission.
11. The designated Worker Compensation provider will provide immunizations, medication, counseling (to include methods of preventing secondary transmission of HIV, HCV, syphilis and/pr HBV) and follow-up lab tests.

DEFINITIONS:

1. Healthcare Provider – all employees, members of the medical and dental Staff of the facility, and contracted professional personnel.
2. Isg – Immune Serum Globulin
3. HBIG – Hepatitis B Immune Globulin
4. HBsAg – Hepatitis B Surface Antigen
5. HbsAb – Hepatitis B Surface Antibody
6. HBVac – Hepatitis B Vaccine
7. HCV – Hepatitis C Virus
8. Baseline blood work for Hepatitis B consists of testing for Hepatitis B Surface Antigen (HbsAg) and Hepatitis B Surface Antibody (HbsAb).
9. An occupational exposure that may place a worker at risk for HIV, HCV and/or HBV infection is defined as a percutaneous injury, or contact of skin with blood, tissues or other body fluids to which Universal Precautions apply including:
 - a) Semen, vaginal secretions, cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids
 - b) Laboratory specimens that may contain HIV, HCV and/or HBV.
10. Percutaneous injury – a needle stick or cut, with a sharp object.
11. Skin contact – when the exposed skin is happed, abraded or affected with dermatitis or the contact is prolonged or involving an extensive area.

WORKERS COMPENSATION REPORTING OF INJURIES OR ILLNESS

All employee injuries, including needle sticks, at work must be reported to the PHS administrator or Supervisor and called in ASAP by the supervisor or PHS administrator to the worker's compensation carrier 1-800#, and specifying PHS. **DO NOT** report employee injuries using the inmate incident report form.

- If injury is a needle stick, follow the needle stick policy.
- A Supervisor's Accident Investigation Report shall be completed by Supervisor and forwarded to Human Resources or designee.
- The HSA must be informed of the injuries.
- PHS needs to be notified immediately if an employee misses time from work due to their injuries/illness. Human Resources shall prepare a PAF placing that employee on leave if they are absent longer than 3 days.
- When reporting the injury please make sure the correct site number is given (052 Santa Rita/Glenn Dyer).
- All surgeries or extenuating circumstances involving the claims should be processed and approved by the PHS corporate office. This is only to minimize confusion in the process and also maintain manageability within the program.
- The Worker's Compensation Insurance Company for Prison Health Services and America Service Group is posted.
- The medical providers for Occupational Medicine, Physical Therapy & Rehabilitation Services are posted and are listed on the workers' compensation website.

[Toll-free Claims Reporting Quick Reference Sheet for Worker's Compensation Claims.](#) Thank you for your prompt claims reporting!

To report a worker's compensation claims quickly and efficiently, please have the following information ready when for toll-free claims reporting service. This is a general listing for your quick reference. Additional information may be requested based on state requirements.

Policy Information:

- Insured Name (Prison Health Services, Inc., America Service Group)
- Policy number (if known)

Claimant Information:

- Employee name
- Social security number
- Address and home phone number
- Spouse's name
- Number of dependents
- Date of hire
- Gross pay per week

Accident Information:

- Exact date and time of injury
- Exact location or site code where injury occurred
- Specific description of injury (i.e., employee slipped and fell on wet floor)
- Name of any witnesses of the stated injury
- Safeguards or safety equipment provided to prevent injuries (where applicable)
- Name and address of claimant's physician
- Name and address of hospital

**SUPERVISOR'S ACCIDENT INVESTIGATION
REPORT**

Employee Name: _____ Date of Accident: _____

Location of Accident: _____ Time of Accident: _____

Occupation of Employee: _____ Injury: _____

Witness: _____

Employee's description of accident: _____

What acts failures to act and/or conditions contributed most directly to this accident?

Why did the above acts and/or conditions occur? _____

What is the plan of action to prevent recurrence? _____

Supervisor's Comments: _____

Investigated by: _____ Date: _____

Reviewed by: _____ Date: _____

INMATE HEALTH SERVICES

RECEIVING SCREENING

The receiving screening is intended to identify any potential critical needs among arrestees arriving at the jail. It is a process of structured inquiry and observation designed to prevent newly arrived inmates who pose a threat to their own or others' health or safety from being admitted to the jail's general population and to get them medical care. It occurs upon the inmate's admission (booking) to the facility and must be performed on all new arrivals to the jail system. Receiving screening must be considered using a form and language fully understood by the detainee who may not speak English and/or have a mental or physical impairment (e.g., speech, hearing, and sight). AT&T language line is available for translation services. The receiving screening findings are recorded on a form approved by the health authority.

Inmates who are transferred from another institution within the same correctional system accompanied by their initial health screening forms and a copy or summary of their medical record from the transferring institution may not need a new initial screening to be conducted. However, the medical information must still be reviewed and verified to ensure continuity of care.

It is extremely important for screeners to explore fully the inmate's suicide and alcohol and other drug (AOD) withdrawal potential. Reviewing with an inmate any history of suicidal behavior, and visually observing the inmate's behavior (delusions, hallucinations, communication difficulties, speech and posture, impaired level of consciousness, disorganization, memory defects, depression, or evidence of self-mutilations) are required. This approach, coupled with training staff in aspects of mental health and chemical dependency should enable staff members to intervene early to treat withdrawal and to prevent most suicides.

Particular attention should be paid to descriptions of signs of trauma. All staff members should be reminded of their responsibility for reporting suspected abuse of inmates to the appropriate authorities. Inmates arriving with signs of recent trauma should be referred to the medical staff immediately for observation and treatment.

Prison Health Services' policy and procedures require that receiving screening is performed by health trained or qualified healthcare personnel on all inmates upon their arrival at the jail system. Persons who are unconscious, semiconscious, bleeding, mentally unstable, or otherwise urgently in need of medical attention are referred for emergency care. If they are referred to a community hospital, their admission or return to jail is dependent upon written medical clearance.

ORAL SCREENING

Oral screening is performed on inmates when complaint is received from or voiced by the inmate during the Receiving Screening process, and on all inmates during the Health Assessment.

A dentist licensed in the state of the facility provides necessary dental care to patients.

Each inmate receives dental care/hygiene items at the time of admission to the facility and dental instructions during Health Assessment.

- ◆ Acute dental problems are referred to the dentist as soon as they are identified.
- ◆ The Health Assessment includes a dental screen.
- ◆ An inmate may receive dental hygiene instructions and dental health education during their initial intake process.

INFORMATION ON HEALTH SERVICES

Prison Health Services requires that all inmates be informed of the scope of care available and mechanism for accessing health services both verbally and in writing.

Verbal notification will be given to all inmates and will be documented on the Receiving Screening form. Additional verbal notification is given to the inmate at the Health Assessment.

The procedure for assessing health services is provided in writing in the Inmate Handbook provided by the Alameda County Sheriff's Office. The method for obtaining routine and emergency healthcare services are prominently posted in reception areas and housing units in bilingual signage.

The facility or Prison Health Services will provide interpretation services as needed to assist in information exchange between inmates and medical personnel.

- ◆ The nurse completing the Receiving Screening verbally informs all inmates of available healthcare during intake screening.
- ◆ Bilingual signs are posted in the receiving areas and in the housing units explaining how to access emergency and routine medical care.
- ◆ The inmate requesting routine or non-emergent healthcare will fill out the Sick Call slips, date and sign it, and return it to the sick call box located in the dining area of the housing unit.
- ◆ All inmates are to have access to Sick Call Slips on a daily basis. Sick Call Slips are placed in the sick call box located in the housing unit dining area and each inmate has the opportunity to present completed forms on a daily basis.

HEALTH ASSESSMENT

All newly committed inmates are required to have a Health Assessment (H&P) completed by qualified health staff within fourteen (14) days at jails. The Health Assessment consists of a complete medical history and physical examination.

The Health Assessment will be documented on the form approved by the health authority, which has and will become part of the permanent medical record.

Only an appropriately trained registered nurse, physician assistant, nurse practitioner, or physician performs physical examination.

The dentist will provide in-service training to all nursing staff who assigned to perform health assessments. The Health Assessment includes a dental screen.

Re-admitted inmates who have received a health appraisal within the last three months (90 days) and their receiving screening shows no changes in their health status may only require that their results be reviewed, and tests and examinations updated as needed.

- ◆ The medical history and physical examination provides the beginning database for the total comprehensive plan of care which is delivered according to the philosophy and objectives of Prison Health Services. The goal is to prevent deterioration of inmate's health during incarceration and to improve vital functions whenever possible.
- ◆ The health evaluation may include the following:
 - a. Review of the receiving screening form
 - b. Collection of additional data to complete the medical, dental, and psychiatric histories
 - c. Testing for communicable diseases, such as syphilis and tuberculosis
 - d. HIV testing may be offered to inmates who have related symptoms, high-risk behaviors or have requested a test. Informed consent is required.
 - e. Recording height, weight, and vital signs.
 - f. Physical examination of all major body systems that including mental status and dental screening
 - g. Completion of other clinically indicated tests and examinations
 - h. Review of all laboratory tests and referral to the physician when indicated
 - i. Initiation of appropriate treatment when indicated or ordered by the physician.
 - j. Make referrals for follow-up as needed.
 - k. Provide patient education.
- ◆ Health appraisals are updated on an annual basis with elements being repeated based upon the age, sex and the health need of the inmate.

**MENTAL HEALTH OBSERVATION TRAINING for clinical staff performing health assessments and physical examinations (H&P's).
Prepared and presented by Criminal Justice Mental Health**

Orientation (Person/Place/Time)

- Does the person know who he or she is? Have them state their name.
- Does the person know where he or she is? Have them tell you.
- Does the person know the time, day, year, month?
- Note: Most people will know who they are. Not knowing where they are and what the time, day, month year, etc can mean various things: dementia, delirium, confused thinking. If the patient answers, re: bizarre, it can indicate psychosis.

Appearance and attitude (Motor Behavior/Manner)

- Observe the general appearance: neat clean, dirty, malodorous, unkempt, etc.
- What is their attitude? Cooperative, hostile, mute, scared, nervous, etc.
- Observe any unusual behaviors, movements, gestures.

Affect & Mood

- Affect is the outward expression of how a person feels. Does their expression look sad, happy, flat, etc
- Mood is what they report about how they feel. If you ask them how are they feeling? When asked they report they felt angry, fearful, worried, sad etc.

Emotional Response to Incarceration

- How are they handling being arrested and housed in jail?
- Are they adjusting? What are their concerns?

Content of Thought

- Are they having any delusional thoughts (believing false ideas) such as they are being poisoned, they are the king of England, people can read their minds.
- Are they experiencing any hallucinations? Hearing things that are not really there; seeing things that are not really there? Etc.

History of Suicide, Present Thoughts of Suicide

- Do they have thoughts about harming themselves now?
- Have they felt suicidal in the past and/or made suicide attempts? in custody attempts?
- Has anyone in their family attempted or committed suicide?
- Do they feel depressed, hopeless now?
- Do they have any plan to hurt themselves in custody?

Record the patient's sex, age, race, and ethnic background. Document the patient's nutritional status by observing the patient's current body weight and appearance. Remember recording the exact time and date of this interview is important, especially since the mental status can change over time such as in delirium.

Recall how the patient first appeared upon entering the office for the interview. Note whether this posture has changed. Note whether the patient appears more relaxed. Record the patient's posture and motor activity. If nervousness was evident earlier, note whether the patient still seems nervous. Record notes on grooming and hygiene. Most of these documentations on appearance should be a mere transfer from mind to paper because mental notes of the actual observations were made when the patient was first encountered. Record whether the patient has maintained eye contact throughout the interview or if he or she has avoided eye contact as much as possible, scanning the room or staring at the floor or the ceiling.

Attitude toward the examiner

Next, record the patient's facial expressions and attitude toward the examiner. Note whether the patient appeared interested during the interview or, perhaps, if the patient appeared bored. Record whether the patient is hostile and defensive or friendly and cooperative. Note whether the patient seems guarded and whether the patient seems relaxed with the interview process or seems uncomfortable. This part of the examination is based solely on observations made by the health care professional.

Mood

The mood of the patient is defined as "sustained emotion that the patient is experiencing." Ask questions such as "How do you feel most days?" to trigger a response. Helpful answers include those that specifically describe the patient's mood, such as "depressed," "anxious," "good," and "tired." Elicited responses that are less helpful in determining a patient's mood adequately include "OK," "rough," and "don't know." These responses require further questioning for clarification.

Establishing accurate information pertaining to the length of a particular mood, if the mood has been reactive or not, and if the mood has been stable or unstable also is helpful.

Affect

A patient's affect is defined in the following terms: expansive (contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), and flat (no variation). A patient whose mood could be defined as expansive may be so cheerful and full of laughter that it is difficult to refrain from smiling while conducting the interview. A patient's affect is determined by the observations made by the interviewer during the course of the interview.

Speech

Document information on all aspects of the patient's speech, including quality, quantity, rate, and volume of speech during the interview. Paying attention to patients' responses to

determine how to rate their speech is important. Some things to keep in mind during the interview are whether patients raise their voice when responding, whether the replies to questions are one-word answers or elaborative, and how fast or slow they are speaking.

Thought process

Record the patient's thought process information. The process of thoughts can be described with the following terms: looseness of association (irrelevance), flight of ideas (change topics), racing (rapid thoughts), tangential (departure from topic with no return), circumstantial (being vague, ie, "beating around the bush"), word salad (nonsensical responses, ie, jabberwocky), derailment (extreme irrelevance), neologism (creating new words), clanging (rhyming words), punning (talking in riddles), thought blocking (speech is halted), and poverty (limited content).

Throughout the interview, very specific questions will be asked regarding the patient's history. Note whether the patient responds directly to the questions. For example, when asking for a date, note whether the response given is about the patient's favorite color. Document whether the patient deviates from the subject at hand and has to be guided back to the topic more than once. Take all of these things in to account when documenting the patient's thought process.

Thought content

To determine whether or not a patient is experiencing hallucinations, ask some of the following questions. "Do you hear voices when no one else is around?" "Can you see things that no one else can see?" "Do you have other unexplained sensations such as smells, sounds, or feelings?"

Importantly, always ask about command-type hallucinations and inquire what the patient will do in response to these commanding hallucinations. For example, ask "When the voices tell you do something, do you obey their instructions or ignore them?" Types of hallucinations include auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things).

To determine if a patient is having delusions, ask some of the following questions. "Do you have any thoughts that other people think are strange?" "Do you have any special powers or abilities?" "Does the television or radio give you special messages?" Types of delusions include grandiose (delusions of grandeur), religious (delusions of special status with God), persecution (belief that someone wants to cause them harm), erotomanic (belief that someone famous is in love with them), jealousy (belief that everyone wants what they have), thought insertion (belief that someone is putting ideas or thoughts into their mind), and ideas of reference (belief that everything refers to them).

Aspects of thought content are as follows:

- **Obsession and compulsions:** Ask the following questions to determine if a patient has any obsessions or compulsions. "Are you afraid of dirt?" "Do you wash your hands often or count things over and over?" "Do you perform specific acts to reduce certain thoughts?" Signs of ritualistic type behaviors should be explored further to determine the severity of the obsession or compulsion.

- Phobias: Determine if patients have any fears that cause them to avoid certain situations. The following are some possible questions to ask. "Do you have any fears, including fear of animals, needles, heights, snakes, public speaking, or crowds?"
- **Suicidal ideation** or intent: Inquiring about suicidal ideation at each visit is always important. In addition, the interviewer should inquire about past acts of self-harm or violence. Ask the following types of questions when determining suicidal ideation or intent. "Do you have any thoughts of wanting to harm or kill yourself?" "Do you have any thoughts that you would be better off dead?" If the reply is positive for these thoughts, inquire about specific plans, suicide notes, family history (anniversary reaction), and impulse control. Also, ask how the patient views suicide to determine if a suicidal gesture or act is ego-syntonic or ego-dystonic. Next, determine if the patient will contract for safety. For homicidal ideation, make similar inquiries.
- Homicidal ideation or intent: Inquiring about homicidal ideation or intent during each patient interview also is important. Ask the following types of questions to help determine homicidal ideation or intent. "Do you have any thoughts of wanting to hurt anyone?" "Do you have any feelings or thoughts that you wish someone were dead?" If the reply to one of these questions is positive, ask the patient if he or she has any specific plans to injure someone and how he or she plans to control these feelings if they occur again.
- Sensorium and cognition: Perform the Folstein Mini-Mental State Examination.
- Consciousness: Levels of consciousness are determined by the interviewer and are rated as (1) coma, characterized by unresponsiveness; (2) stuporous, characterized by response to pain; (3) lethargic, characterized by drowsiness; and (4) alert, characterized by full awareness.
- Orientation: To elicit responses concerning orientation, ask the patient questions, as follows. "What is your full name?" (ie, person). "Do you know where you are?" (ie, place). "What is the month, date, year, day of the week, and time?" (ie, time). "Do you know why you are here?" (ie, situation).
- Concentration and attention: Ask the patient to subtract 7 from 100, then to repeat the task from that response. This is known as "serial 7s." Next, ask the patient to spell the word "world" forward and backward.
- Reading and writing: Ask the patient to write a simple sentence (noun/verb). Then, ask patient to read a sentence (eg, "Close your eyes."). This part of the MSE evaluates the patient's ability to sequence.
- Visuospatial ability: Have the patient draw interlocking pentagons in order to determine constructional apraxia.
- Memory: To evaluate a patient's memory, have them respond to the following prompts. "What was the name of your first grade teacher?" (ie, for remote memory). "What did you eat for dinner last night?" (ie, for recent memory). "Repeat these 3 words: 'pen,' 'chair,' 'flag.'" (ie, for immediate memory). Tell the

patient to remember these words. Then, after 5 minutes, have the patient repeat the words.

- **Abstract thought:** Assess the patient's ability to determine similarities. Ask the patient how 2 items are alike. For example, an apple and an orange (good response is "fruit"; poor response is "round"), a fly and a tree (good response is "alive"; poor response is "nothing"), or a train and a car (good response is "modes of transportation"). Assess the patient's ability to understand proverbs. Ask the patient the meaning of certain proverbial phrases. Examples include the following. "A bird in the hand is worth 2 in the bush" (good response is "be grateful for what you already have"; poor response is "one bird in the hand"). "Don't cry over spilled milk" (good response is "don't get upset over the little things"; poor response is "spilling milk is bad").
- **General fund of knowledge:** Test the patient's knowledge by asking a question such as, "How many nickels are in \$1.15?" or asking the patient to list the last 5 presidents of the United States or to list 5 major US cities. Obviously, a higher number of correct answers is better; however, the interviewer always should take into consideration the patient's educational background and other training in evaluating answers and assigning scores.
- **Intelligence:** Based on the information provided by the patient throughout the interview, estimate the patient's intelligence quotient (ie, below average, average, above average).

Insight

Assess the patients' understanding of the illness. To assess patients' insight to their illness, the interviewer may ask patients if they need help or if they believe their feelings or conditions are normal.

Judgment

Estimate the patient's judgment based on the history or on an imaginary scenario. To elicit responses that evaluate a patient's judgment adequately, ask the following question. "What would you do if you smelled smoke in a crowded theater?" (good response is "call 911" or "get help"; poor response is "do nothing" or "light a cigarette").

Impulsivity

Estimate the degree of the patient's impulse control. Ask the patient about doing things without thinking or planning. Ask about hobbies such as coin collecting, golf, skydiving, or rock climbing.

Reliability

Estimate the patient's reliability. Determine if the patient seems reliable, unreliable, or if it is difficult to determine. This determination requires collateral information of an accurate assessment, diagnosis, and treatment.

SICK CALL

The backbone of any correctional health delivery system is its sick call process. Every jail and prison should have a mechanism in place that enables all inmates, including those in segregation, to request health services daily. PHS utilizes a written request system using medical request forms coupled with staff rounds of inmates in administrative segregation.

Regardless of which sick call procedure is used, it is important to ensure:

- ◆ inmates have an opportunity to make their health needs known on a daily basis.
- ◆ access is directly controlled by healthcare staff and not by correctional staff (which in a written request system, includes health staff only picking up the medical request form AKA: sick call slips).
- ◆ healthcare staff review (triage) all forms received daily and determine the appropriate disposition (e.g., “inmate to be seen immediately” or scheduled for next sick call” or “referred to dental department”.)
- ◆ inmate is notified of the healthcare unit’s response to their requests as appropriate.

Correctional facilities that have a written request system often use a multiple copy form. The yellow copy is returned to the inmate after his/her sick call visit. Thus latter step is important. Inmates frequently submit multiple requests for the same problem to the healthcare staff.

Sick call occurs when an inmate reports for and receives appropriate care. It is held in a clinical setting where adequate equipment and supplies are available. Nurses, physician assistants or other qualified health professionals, conduct sick call at least five days per week. Sick is available on the weekends when necessary. Additionally, while the frequency of physician clinics is dependent on institutional size and inmate needs, clinician sick call may be held five times per week.

Inmate requests for non-emergency care should be processed within 24 hours and they should be scheduled for sick call or referred as required. Nurses or physician extenders usually see the patient first to gather additional information, take vital signs and/or provide care within the scope of their licenses. Based on their review, they determine whether the inmate needs to be referred to a physician or another clinician.

NURSE SICK CALL SYSTEM – PROVIDER OVERVIEW

Inmates seeking medical attention fill out a Prison Health Services Medical Request Form. The housing unit nurse retrieves these forms daily.

- ◆ The Housing Unit Nurse reviews the Prison Health Services Medical Request Form and determines if the request is an emergency or routine.
- ◆ The Housing Unit Nurse documents the disposition on the Prison Health Services Medical Request Form) i.e., Nurse Sick Call, Clinician Sick Call, Dental, or Mental Health Clinic. All routine requests will be referred to Nurse Sick Call.
- ◆ All emergency requests (chest pain, SOB, etc.) will be evaluated as soon as possible.
- ◆ Upon seeing the inmate, the Housing Unit Nurse will sign, date, and time the request and give the yellow copy to the patient.
- ◆ Referrals for Mental Health and/or Dental services are delivered via mail boxes which are monitored by the intended recipient services.
- ◆ For those requests being referred to Nurse Sick Call, they should be addressed as soon as possible. The Sick Call nurse (who documents in the inmate's health record on Progress Notes using the SOAP charting format. It is important that the nurse document times as well as dates when charting SOAP notes.
- ◆ PHS employs a priority system categorizing receiving screeners as a Number 1, 2, or 3. During the nursing sick call orientation sessions the procedures pertaining to this system will be explained and used.
- ◆ Nurses have access to a clinician on-call or on-site for consultation and review of sick call.

EMERGENCY SERVICES

Prison Health Services staff responds to medical emergencies whenever a health staff member or a correctional staff member identifies an urgent medical need.

Nursing staff will respond to emergency calls within a few minutes by reporting to the area of the medical emergency with necessary emergency equipment and supplies for evaluation and possible treatment.

Emergency equipment and supplies area regularly maintained and accessible to healthcare staff at all times.

The patient will be stabilized on-site and then transferred to an appropriate healthcare unit if deemed necessary.

The on-call practitioner will be notified immediately, if possible, or soon after the incident.

The practitioner in charge will determine if the patient needs to be transported to a local emergency room. If no practitioner available, then the nurse in charge will determine based upon practitioner input and/or nursing assessment whether the patient needs to be transported. Correctional staff will be notified of this need so as to assure that an ambulance has been called and arrangements made for a deputy to escort the patient.

A list of names and telephone numbers of persons to be called in event of an emergency are readily available to healthcare staff at all times.

All healthcare staff personnel are oriented to Emergency Services at the time of their initial orientation as a new employee. Annual training is conducted as part of the in-service training program for all health service staff.

Emergency drugs, equipment, and supplies are readily available at all times and are replenished after each use and checked on a regular basis.

Ambulances are accessed through the appropriate Ambulance Company. The phone number is listed on the Emergency form at each site.

The correctional facility supervisor will be contacted and informed of any medical emergency.

In most cases decisions regarding the need for emergency transportation are made by medical staff.

Whenever possible, the physician on call should be notified prior to transporting the patient to the hospital. However, in the event of a life-threatening emergency, the patient is sent to the hospital in the most expedient way possible and this may require notifying the physician after the patient has been transported.

WRITTEN AND VERBAL/TELEPHONE ORDERS

Clinical treatment is performed pursuant to written or verbal/telephone orders signed by personnel who are authorized by state practice laws within the state where the facility is located to write medical orders.

Physicians, physician assistants, nurse practitioners, psychiatrists, and dentist are generally the individuals who are authorized to write medical orders. The physician will follow state law regarding whose orders require co-signature.

Verbal/telephone orders are signed in accordance with state law and accreditation standards:

- ◆ All orders for medical treatment are written on the physician order sheet.
- ◆ All medical orders include the date, time, location, inmate's name, date of birth, PFN, diagnosis, and known allergies. If the patient has no allergies NKDA is to be written on the order sheet.
- ◆ All medication orders require, in addition to the above requirements: name of the drug, the dosage, the route, frequency, and duration.

- ◆ All medical orders are noted and signed off along with **print/stamp on both copies** with the date and time by a licensed nurse in **red ink**.
- ◆ All medical orders if V.O or T.O. must be written V.O or T.O. Dr. _____ /
Nurse signature, title, print/stamp, date, and time noted the order. **Do not** write “*per protocol*” medical orders.

NURSING ASSESSMENT PROTOCOLS/STANDARDIZED PROCEDURES

Nursing Assessment protocols are developed by the Medical Director and the Director of Nursing or supervisor of the nursing staff.

The Nursing Protocol manual is reviewed periodically by the Medical Director and the Director of Nursing.

Assessment protocols shall be appropriate for the level of skill and preparation of the nursing personnel who will carry it out. Each assessment protocol is in compliance with the California State Nursing Practice Act.

Assessment protocols do not include any prescription medication use with the exception of those covering emergency or life-threatening situations.

Treatment with prescription medication is only initiated upon the written, verbal, or telephone order of a licensed clinician.

Standing orders are not used. Standing orders are defined as a written order that provides the same course of treatment for each patient suspected of having a given condition and that specify the use and amount of prescription medications.

Nurse practitioners and physician assistants may practice as mandated by their respective state boards and approved by the responsible physician.

- ◆ Prison Health Services has developed Nursing Assessment Protocols under the guidance of the Corporate Medical Director who serves as reference for the responsible site physician.
- ◆ The Medical Director will review the protocols, make any adjustments that he/she feels are necessary and signs off on the manual.
- ◆ The medical director will review, and when appropriate, revise the Nursing Assessment Protocols.
- ◆ The protocols include over the counter medications (OTC). When OTC medications are administered per protocol the nurse needs the name of the responsible physician or nurse practitioner on the order.

- ◆ Administration of OTC's by health personnel are to be documented in the Medication Administration Record (MAR).

HEALTH EVALUATION OF INMATES IN SEGREGATION

Healthcare staff will evaluate all inmates who are segregated from the general population at least daily.

The purpose of these evaluations is to monitor the health status of segregated inmates and to ensure that individuals in segregation have access to health services.

All medical complaints, treatments rendered, or changes in condition are noted in the individual patient health record.

The assessment rounds are to be documented and maintained in the files of the healthcare unit.

- ◆ Corrections staff notify health care staff of the placement of an inmate-patient in segregation.
- ◆ A designated health staff member will conduct medical rounds and document on segregated inmates daily.
- ◆ The medical rounds will include at least the following:
 - a. Observation of each inmate to determine obvious medical problems
 - b. Notation of any changes in the inmate's attitude and outlook
 - c. Identification of any cuts, bruises or other injuries indicating trauma
- ◆ Delivery of medications or other treatments that have been ordered by the practitioner will continue as ordered for any patient who is placed in segregation.

MEDICATION ADMINISTRATION

Administration and Storage of Medications:

PHS staff responsibilities in the administration of medication include these actions:

1. Obtaining the medication order from the physicians.
2. Ordering the prescription from the pharmacy.
3. Administering the medication.
4. Documenting the administration of the medication or the refusal of medication on the appropriate form.

Medications must be kept safely locked, forms must be completed, and administration of the medication must be documented. Medications must be given in a safe manner while protecting the dignity and confidentiality of the patient.

General Guidelines in Medication Administration:

Always ask questions if you don't understand the order or something doesn't make sense.

Wash hands before handling medications. It is particularly important to wash your hands:

- After using the toilet.
- Before handling food or medication.
- After handling food or medication.
- After using a Kleenex or handkerchief.

Maintain safety and accuracy. Work efficiently. Mistakes happen most often when you are in a hurry, distracted, or failing to document at the time of medication administration.

Concentrate on your work.

- Do not allow yourself to be interrupted.
- Ensure that you have good lighting.
- Check and re-check, remember the order may have changed.

Read the entire medication label three times.

- Prior to taking the medication out of the package.
- Prior to administering the medication.
- Prior to documenting the administration of the medication.

Remember the importance of the five "rights" of medication administration.

- Right patient (confirm identification by checking wrist-band)
- Right medication.

- Right dose.
- Right time.
- Right route.

Read the entire label for specific instructions about the medication such as:

- Give with water.
- Give with food.
- Avoid working with machines or driving.
- Avoid alcohol.
- Avoid sunlight.

Additional **“Do’s”**

- Do give the task your full attention.
- Do check the ID of the inmate before administering medication.
- Do remain with the inmate until the medication has been taken.
- Do prepare medications for only one inmate at a time.
- Do document immediately **after** giving the medication.

Additional **“Don’ts”**

- Don’t give a medication if you can’t clearly read the label.
- Don’t give a medication from another patient’s medications.
- Don’t give medications out to more than one inmate at a time.
- Don’t hide a medication error.
- Don’t change anything about a medication without a doctor’s order.

Do NOT give medications when:

There is no written order.

The label on the medication is illegible; the pharmacist must replace it.

The inmate exhibits a significant change in status:

- Difficulty breathing
- Change in level of consciousness
- Seizures
- Other changes that may be threatening to the patient’s health

The patient refuses to take the medication. Attempt to find out why the patient is refusing the medication then report it to the practitioner who prescribed the medication.

The patient has an allergic reaction to the medication. Common allergic reactions include rash, hives and difficulty breathing.

Routes of Administration:

Oral:

- ◆ The most common route of administration may be in the form of tablet, capsule, or liquid.
- ◆ Do not crush, dissolve, or split the dose without specific instructions to do so.
- ◆ Do not empty the contents of a capsule prior to administration.

- ◆ Do not dilute or mix liquid medications without specific instructions to do so.

Liquid Medications:

- ◆ Never pour ahead of time.
- ◆ Shake the bottle well before pouring.
- ◆ Hold the medicine cup at your eye level to measure correct dose.
- ◆ If a liquid and a pill are to be given at the same time, give the pill first and follow it with the liquid.
- ◆ Never mix different liquids in the same cup.
- ◆ If the liquid medication required refrigeration, return it to the refrigerator immediately after use.
- ◆ Never mix partially used bottles of medication even if they are the same medication as potency and dosage may not be identical.

Sublingual:

- ◆ Only medication clearly ordered to be given sublingually should be.
- ◆ Instruct the patient to place the medicine under their tongue and wait for it to dissolve.

Pulmonary Inhalant Medications:

- ◆ These medications are in a sealed container under pressure.
- ◆ Pressing down on the inhaler to release a measured administration dose.

Topical Medications:

- ◆ Respect the privacy of the patient by finding a private place.
- ◆ Wash hands prior to using.
- ◆ Wear gloves when administering.

Storage of Medications:

General Guidelines:

- ◆ All medications must be stored in the original container with the original label.
- ◆ Internal, external and indictable medications must be stored separately.
- ◆ Care must be taken so that label remains affixed and legible.
- ◆ Do not store large quantities of drugs – a thirty- (30) day supply is maximum.
- ◆ All medications must be stored away from food and toxic materials.
- ◆ Store all medications away from excessive heat, light and moisture.
- ◆ Maintain a sufficient storage space and adequate lighting.

Controlled Substances:

- ◆ Federal drug control agencies have identified some medications as being more likely to be abused. These medications are grouped in six categories called schedules according to their potential for abuse.
- ◆ These medications must be double locked at all times. They should also be counted by two licensed nurses at each change of shift to ensure that all medications can be accounted for.

Refusal of Medications:

If a patient refuses a medication, try to determine the reason for the refusal. Among the reasons the patient refuse are:

- ◆ An unpleasant side effect.
- ◆ Dislike of the taste, smell or feel of the medication.
- ◆ Difficulty swallowing the medication.
- ◆ For some reason the patient is afraid of the medication.
- ◆ The patient doesn't understand the reason for taking the medication.
- ◆ It is part of the patient's non-compliant behavior.

Document on the medication administration record (MAR) that the patient has refused the dose of medication. Have the inmate sign a release of responsibility form.

Report the inmate's refusal of medication to the practitioner and schedule that patient to return to the practitioner for further evaluation.

Medication Errors:

All medication errors must be reported when they are discovered or as soon as possible thereafter to the nursing supervisor.

A medication error has occurred if:

- ◆ Wrong patient was given the medication.
- ◆ Wrong drug was given to the patient.
- ◆ Wrong dose was given to the patient.
- ◆ Medication was given at the wrong time.
- ◆ Medication was not given at the time ordered.
- ◆ Medication was administered by the wrong route.

Medication errors should be reported on an incident report form and should include:

Who the patient(s) and staff were who were involved;
 What type of error was made;
 When the error occurred;
 The effect of the error on the patient if known; and
 The corrective action(s) taken by supervisor and/or physician as appropriate.

Medication Administration in Corrections:

- * It is a nursing responsibility to ensure that the patient has swallowed their medication. The “cheeking”, “hoarding”, “pawning” and “switching” medication with another inmate may ultimately result in death.**
- * Do not allow multiple inmates to obtain medications at the same time.**
- * Do not allow inmates access to your medication supplies or your cart.**
- * Check arm band on each inmate before administering medications. No identification means no medication given. (NO ID ≠ NO MEDS).**

SPECIAL NEEDS AND SERVICES

MENTAL HEALTH SERVICES

MENTAL HEALTH EVALUATIONS

Mental Health Records are subject to special Federal and California State Confidentiality laws. All mental health services at Santa Rita Jail/Glenn Dyer Detention Facility are now provided by Criminal Justice Mental Health (CJMH), a division of Alameda County Behavior Health Care Services. At intake, or at the first screening interview, a brief mental health history will be obtained. All inmates who report or who are known to have a history of mental care will be referred to CJMH for further evaluation and services as appropriate. Anyone whom the screening nurse believes to be in need of mental health services will be referred for mental health evaluation. CJMH will determine the need and extent of services required. Those inmates requiring intense services beyond the capability of CJMH will be referred to an acute care facility.

FORCED PSYCHOTROPIC MEDICATIONS

It is PHS policy not to use forced medications. PHS staff does not participate in the administration of forced medications.

CHEMICAL RESTRAINTS

It is PHS policy not to use Chemical Restraints.

SUICIDE PREVENTION PROGRAM

The PHS Medical Department and CJMH will follow the facility's collaborative plan for suicide prevention. CJMH trains corrections personnel on suicide prevention.

The plan will include, at a minimum, the following components:

1. Identification
2. Training
3. Assessment
4. Monitoring
5. Housing
6. Referral
7. Communication
8. Intervention
9. Notification
10. Reporting
11. Review
12. Critical incident debriefing

Every effort will be made to prevent suicidal gestures and attempts in the facility through surveillance and vigilant monitoring on the part of all health personnel and correctional personnel.

1. Identification:

- a. The receiving screening is the first opportunity for assessing each inmate's potential for suicide by asking specific questions regarding current suicidal ideation's and history previous attempts.
- b. If the is assessed as being at risk for suicide, the receiving nurse will notify the appropriate corrections staff member and arrange for housing that affords suicide watch for the inmate.
- c. The nurse will follow-up to ensure that appropriate housing and watch have been initiated.
- d. Patients who are assessed as being at risk for suicide at a later time by health or correctional staff will be relocated to a housing area that affords suicide watch.
- e. All inmates who are identified as being at risk for suicide will be referred to the psychiatrist or mental health professional for evaluation as soon as possible.

2. Training

- a. Healthcare personnel and correctional staff will be trained in all aspects of suicide prevention including the knowledge that a patient is particularly susceptible to becoming suicidal upon admission, after adjudication, upon return from court, following bad news about a family member or significant other, after suffering from some type of humiliation or rejection and when previous depression appears to be receding.
- b. All staff is initially trained regarding recognition of verbal or behavioral signs of suicidal ideation during their orientation program. Additional training will be provided annually.
- c. The following signs and symptoms of suicidal ideation should be reviewed at all training:
 1. Despair/hopelessness
 2. Poor self image/feelings of inadequacy
 3. Great concern regarding "What will happen to me"
 4. Past history of suicidal attempt
 5. Verbalization of a suicide plan
 6. Extreme restlessness exhibited by such behavior as continuous pacing
 7. Loss of interest in personal hygiene and daily activities
 8. Visitation refusals that previously were accepted.
 9. Depressed state indicated by crying, withdrawal, insomnia, lethargy, indifference to surroundings and other people.
 10. Sudden drastic changes in eating or sleeping habits.
 11. Hallucinations, delusions, or other manifestations of loss of touch with reality.
 12. Sudden marked improvement in mood following period of obvious depression.

3. Assessment and referral

- a. Immediately following recognition that a patient is at risk for suicide, placement in housing area (i.e., safety cell) that affords the closest monitoring is appropriate until

- the patient can be further assessed by the mental health professional or psychiatrist.
- b. Upon assessment by a mental health professional, the appropriate level of suicide precautions will be ordered.
 - c. If the facility is not equipped with housing and/or staff to maintain the patient's safety while he/she is suicidal, transfer should be arranged to the closest facility that can offer adequate protection for the patient.

4. Monitoring

- a. **15 minute Watch** – This requires 15-minute interval observations. This watch requires the patient be within full sight of the correctional officer when the 15-minute checks are done. Documentation on the Isolation Observation Log (IOL) is required.
- b. CJMH mental health staff continue to monitor patient as needed and determine when a patient is removed from suicide watch.

5. Housing

- a. Medical/mental health staff will follow the facility's plan for where inmates who are on suicide precautions are to be housed.
- b. Once an inmate is identified as being at risk for suicide, he/she should not be housed elsewhere or left alone.
- c. Rooms that are used for suicide watch should be made as suicide proof as possible.

6. Referrals

All inmates identified, as being suicidal will be evaluated by a mental health professional at the earliest possible time.

7. Communication

Daily communication made between designated healthcare and corrections staff is important to monitor the status of any inmate who is on suicide precautions.

8. Intervention

Any time a suicide attempt is identified, it is treated as a medical emergency and medical staff responds immediately. In the event of a hanging attempt, the body is supported while the patient is gently brought to the ground. As with any medical emergency, the ABC's are of utmost importance. Every effort should be made to stabilize and/or resuscitate a patient who has attempted suicide while emergency medical support is summoned for immediate transport if necessary.

9. Notification

All suicide attempts are reported immediately by the healthcare staff to the Mental Health Services Administrator or designee, Health Services Administrator, the Medical Director and the shift supervisor for corrections and medical. The Mental Health Administrator or designee will ensure that the facility administrator and the responsible physician is informed.

- 10. Reporting**
Medical staff and mental health staff will participate, as appropriate, in completing all reporting activities surrounding any suicide attempt or completion as required by the facility
- 11. Review**
As defined in the facility's suicide plan, appropriate medical personnel and mental health staff will participate in review of suicides or attempted suicide.
- 12. Critical Incident Debriefing**
The CJMH offers counseling and debriefing with mental health professionals who have been affected by a suicide or suicide attempt.

ASSESSMENT OF SUICIDE POTENTIAL

1. Has the detainee sustained a recent loss (loved one, friend, home, job) or a series of losses?
2. Is detainee depressed?
3. Does he/she have a religious and/or philosophical background that supports suicide?
4. Does he/she believe suicide is an acceptable release (from jail, life)?
5. Is he/she socially isolated from others detainees and staff (without friends and other social support systems)?
6. Is this the first time in jail?
7. Does he/she seem overly embarrassed, ashamed or guilty about the crime committed?
8. Has detainee been previously treated for mental illness, emotional disturbance?
9. Does detainee have a history of self-destructive acts?
10. Has a member of his/her family attempted suicide?
11. Does he/she think about suicide at this time?
12. Is he/she psychotic?
13. Is he/she hearing voices telling him to kill himself?
14. Has detainee-expressed wish to die or failed to perform life-saving acts?
15. Does detainee have terminal medical condition?
16. Does detainee talk or think about giving possessions away or writing a will?
17. Does detainee talk about a particular method/plan for killing himself?
18. Is that method/plan available?
19. Has there been an unexplained, marked improvement in mood?

NOTES: This list provides a method of organizing information regarding suicide potential. It is arranged so that, generally speaking, the questions towards the end of the list indicate a need for greater concern than the ones at the beginning. The more "Yes" marks there are the higher the potential for suicide. These guidelines are provided to assist in assessment, but the final determination is to be based on the judgment of the personnel in the situation.

PATIENT INFORMATION FACT SHEET – SUICIDE PREVENTION

“Your Brother’s Keeper”

WHAT IS SUICIDE PREVENTION?

- Suicide Prevention is keeping someone from dying by their own hand.
- It is everyone’s job.
- It means:
 - knowing the warning signals of suicide.
 - putting your own feelings aside to try to save another’s life.
 - knowing the facts.
 - listening to others.

WHAT SHOULD I DO IF I THINK SOMEONE MAY BE SUICIDAL?

- Do not be afraid to ask the person, “Are you thinking about suicide?”
- Stay with the person and ask someone to go for help.
- Do not worry about risking a friendship if you truly feel someone is suicidal.
- Ask for help from staff if the person talks about suicide or makes statements related to death.
- Ask for help from staff if someone you know:
 - has had something very stressful happen such as a death in the family, relationship break-up, or receiving bad news regarding their case or sentence.
 - is giving away their possessions along with suddenly acting as if they feel better.
 - seems to have lost interest in things they usually enjoyed.
- Take all threats seriously. Most everyone that attempts suicide or commits suicide has given some warning.

WHAT SHOULD I DO IF I AM THINKING ABOUT SUICIDE?

- Ask for help. Suicide is final. It is often a reaction to a temporary problem.
- Be aware of the warning signs.
- Ask questions of your health care provider.
- Ask for help if you:
 - have lost interest in things you usually enjoyed.
 - are having overwhelming feelings of shame, guilt, helplessness and hopelessness.
 - are thinking about your own death.
 - have had a very stressful thing happen to you.

EMERGENCY! TELL A CORRECTIONAL OFFICER OR DEPUTY TO CALL MEDICAL IF:

- You are having suicidal thoughts.
- You are concerned that someone you know may be suicidal.

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INTOXICATION AND WITHDRAWAL

Significant percentages of inmates admitted to correctional facilities have a history of alcohol or other drug abuse. Newly admitted individuals may enter intoxicated or develop symptoms of alcohol or other drug withdrawal. Alcohol withdrawal is the abstinence syndrome with the highest mortality rate, although opiate and tranquilizer withdrawal is life threatening.

The treatment of most non-threatening withdrawal consists of the amelioration of symptoms and can be managed in the convalescent or outpatient setting. All individuals experiencing withdrawal symptoms should be closely monitored for the development of potential life threatening symptoms.

Prison Health Services policies, procedures and protocols address inmates under the influence of alcohol and other drugs or those undergoing withdrawal. The PHS policies address the treatment and observation of individuals manifesting mild or moderate symptoms of intoxication or withdrawal. Individuals at risk for progression to more severe levels of intoxication or withdrawal are kept under observation. Inmates experiencing severe intoxication or withdrawal are immediately transferred to a licensed acute care facility. Medical detoxification is done only under medical supervision in accordance with local, state and federal laws. Alcohol and drug abuse records are subject to special Federal and California State Confidentiality Laws.

PRENATAL CARE

All pregnant inmates receive timely and appropriate prenatal care by qualified healthcare practitioners. Individuals who specialize in obstetrical care will provide on-site or off-site prenatal care.

Prenatal care will be scheduled on a regular basis and will include examinations, advice on appropriate levels of activity, safety precautions, nutritional guidance, and counseling.

- * If the inmate states she is pregnant or that she has missed two periods, urine for pregnancy testing will be collected at the time of receiving screening, or at the time the inmate informs a medical staff member of this information.
- * Pregnant inmates should ideally be followed during their pregnancy by the women's health practitioner.
- * Documentation should include prenatal history in which the following are addressed:
 - a. Medical, surgical, and obstetrical history
 - b. Family and social history
 - c. High risk factors including drug, tobacco, and alcohol use, infectious diseases, past obstetrical complications, and chronic medical conditions.

- * While the pregnant inmate is incarcerated, the following care are provided as appropriate:
 - a. Routine urine testing for ketones & protein, vital signs, fundal height, and fetal heart tones should be assessed at prenatal care visit
 - b. Vitamin with iron supplements are provided
 - c. Special diets with increased calories are provided
 - d. All staff will observe for signs of toxemia, including fever, hypertension, abdominal pain, uterine cramps, vaginal bleeding, severe headaches, visual changes, edema, or decreased in fetal movements.
 - e. Methadone maintenance treatment is provided for prenatal inmates who have been on methadone maintenance or who are addicted to opioids.

SEXUAL ASSAULT

Immediate response to an act of sexual assault is of utmost importance. Most jurisdictions define a sexual assault as a sexual act that is coercive or assaultive in nature and where there is the use or the threat of force.

Victims of sexual assault are assessed, medically stabilized, and referred to CJMH for mental health services as needed. Appropriate testing for sexually transmitted diseases are ordered.

SPECIAL NEEDS TREATMENT PLANS

The special needs program serves a broad range of health conditions and problems that require health personnel to design a program tailored to the individual inmate's needs.

Chronic illnesses require care and treatment over a long period of time and usually are not curable. The goal is to restore and maintain inmate health to the extent possible. Examples of chronic illnesses monitored include, but are not limited to asthma, diabetes, hypertension, HIV, and seizures.

Communicable diseases include those that are sexually transmitted (e.g., syphilis, gonorrhea, chlamydia, HIV), transmitted through the respiratory system (e.g. tuberculosis), or via infected blood (e.g., hepatitis).

Physical handicaps refer to mobility impairments or physical disabilities that limit an individual's normal function. These include, but are not limited to amputation, paraplegia, visual impairments, hearing impairments, or speech impairments.

Frail elderly inmates frequently suffer from chronic conditions that impair their ability to function (e.g., dress, and feed, use toilet) to the extent that they require special nursing care.

Terminally ill inmates (those with a life expectancy of less than one year due to illness) may require special health services to provide comfort, relief from pain, and special counseling and support in anticipation of death.

Criminal Justice Mental Health (CJMH) provides services to inmates with special mental health needs, i.e., self-mutilators, the aggressive or severely mentally ill, suicidal inmates, and sex offenders.

Developmentally disabled inmates may be in need of rehabilitation planning, assistance in accepting the limitations of their conditions, and special attention to their physical safety in the corrections environment.

A special needs treatment plan may be prepared on an individual basis. A treatment plan is a series of written statements specifying the particular course of therapy and the roles of qualified health care personnel in carrying it out. It is individualized, typically multidisciplinary, and based on an assessment of the patient's needs, a statement of short and long-term goals as well as the methods by which these goals will be pursued. When clinically indicated, the treatment plan gives inmates access to the range of support and rehabilitative services (such as physical therapy, individual or group counseling, and self-help groups) that the treating practitioner deems appropriate.

Individuals with special needs are followed during their incarceration. Regularly scheduled chronic care clinics are a good way to ensure continuity of care. Regularly scheduled chronic care clinics at SRJ include Asthma, Diabetes, HIV, Hypertension, and Seizure. A master problem list that includes conditions, treatments, and known drug allergies may be helpful.

OUTPATIENT HOUSING UNIT (OPHU) – A Medical Observation Unit

An Outpatient Housing Unit (previously called the “infirmary”) is an area within the confinement facility accommodating two or more inmates for a period of 24 hours. Expressly set up and operated for the purpose of caring for patients who are not in need of hospitalization or placement in a licensed nursing care facility. Patients are placed in the OPHU with an illness or disorder that requires nursing care and/or limited observation/management by a clinician. The level of health care services does not ordinarily exceed that which is provided by a home health care agency. A Licensed Registered Nurse (RN) is available in the OPHU twenty-four (24) hours per day, seven (7) days per week.

The number of patients, their levels of acuity determines the number of assigned healthcare personnel, and the level of care required for each patient. Being within sight or hearing of a registered nurse means that the inmate/patient can readily gain the person's attention. Call lights and buzzer systems are useful ways of ensuring this. All patients are within sight and sound of a health professional and the OPHU has within each patient room a call alarm button to notify and summon staff for assistance if the patient is experiences a medical or mental health problem.

To maintain and improve the quality of care in this setting begins with the assignment of responsibility to one physician. Depending upon the size of the out patient housing unit, this physician may be employed part or full-time. A full-time staff physician is assigned to the OPHU to provide primary care medical services to the non-pregnant patients housed in the unit. He/she provides supervision of all aspects of clinical and administrative operations within the unit.

Nursing care policies and procedures are consistent with professionally recognized standards of nursing practice and in accordance with the nursing practice act and licensing requirements of the State of California. Policies and procedures are developed on the basis of current scientific knowledge and current clinical practices.

The inmate's Outpatient Housing Unit health record includes admitting notes, a discharge plan including a summary if the patient has been discharged, and complete documentation of the care and treatment given. The OPHU record becomes part of the inmate's medical record file when he/she is discharged from the unit.

CONFIDENTIALITY AND HEALTH RECORDS

CONFIDENTIALITY OF INMATE HEALTH INFORMATION

Original health record(s) or portions of the health record(s) should not be removed from the facility, except as permitted by PHS policy or required by law. The health record is the official business record of the clinical care provided to the patient. The health record folder is the physical property of the facility, however the information enclosed belongs to the inmate. The inmate controls disclosure of that information unless otherwise required or permitted by law. Health information used or disclosed in violation of Federal or State regulations may result in fines assessed to the facility and/or the individual responsible. Fines for negligent disclosures may range from \$1,000 to \$25,000. Licensed health care professionals who knowingly and willingly make disclosures in violation for financial gain may be fined from \$5,000 to \$250,000.

CONFIDENTIALITY includes:

- ◆ Conversations concerning a patient should be in private areas, not in a public area or in the presence of other inmates.
- ◆ Converse only with those who have a need to know.
- ◆ Converse only about the current subject requiring attention.
- ◆ Keep the medical information in the health record confidential.
- ◆ Do not permit non-medical personnel to read the medical record with you, i.e. over your shoulder.
- ◆ For security reasons, do not discuss or confirm who may or may not be confined within the facility, either with anyone outside the facility or with anyone inquiring from outside the facility. Refer that type of inquiry to the correctional authority.
- ◆ Refer immediate health-issue calls from next-of-kin to the nursing supervisor, charge nurse, or AHSA for attention, i.e. pharmaceutical lists, incoming information from family to facilitate care of patient.

SHARING OF MEDICAL / MENTAL / CUSTODIAL INFORMATION is permitted within the facility for the purpose of continuing care and treatment of the patient.

- ◆ Medical information may be accessed as needed by PHS staff.
- ◆ Facility mental health practitioners can review medical information.
- ◆ Copies of mental health progress notes are in the health record for review as needed.

- ◆ Medical providers may request to review custodial records in order to facilitate treatment of the patient.
- ◆ Correctional personnel may obtain limited confidential information relevant to appropriately responding to the specific needs of the individual patient, i.e. chronic conditions, special needs, or physical limitations.
- ◆ Correctional personnel may obtain limited confidential information when the either safe operation of the jail or the safety and welfare of inmates, custody staff, or staff is in question.
- ◆ Medical transfer summaries are provided to correctional facilities and transportation officials as required by statute. Clarification or additional information may be provided as needed.

DISCLOSURE OF CONFIDENTIAL INFORMATION requires a valid authorization for disclosure signed by the patient or legal healthcare representative unless otherwise permitted by law. Federal and State regulations governing medical, psychiatric and drug & alcohol records are very complex. Refer all requests for protected health information to the Health Information Services Department (HISD), i.e. court orders, subpoenas, attorneys, SSI, insurance companies, medical care providers, correctional facilities, probation officers, treatment programs, and individual patients.

DISCLOSURES NOT REQUIRING VALID SIGNED AUTHORIZATION:

- ◆ Any reporting required by statute, i.e. public health reporting, imminent danger to public or an individual.
- ◆ Any requests from Coroner
- ◆ Any requests from a Hospital Emergency Department providing care for a life-threatening event of a patient.
- ◆ Medical transfer summaries for transportation of inmate to a different facility.
- ◆ Refer to Health Information Services Department.

OUR REQUESTS FOR PROTECTED HEALTH INFORMATION to other outside health providers: ‘Authorizations for Disclosure and Use of Protected Health Information’ forms are available in Health Information Services Department (HISD) for the purpose of obtaining confidential health information from outside medical providers. These forms must be completely filled out with the specific information needed, the purpose of the request, the exact name and location of the provider/agency, and the inmate’s initials, signature, and date. *Per PHS policy, authorizations are to be signed by the clinician.*

The Record That Defends Its Friends:
GUIDELINES FOR DOCUMENTATION

- ◆ **THE INMATES’S NAME MUST APPEAR ON EVERY PAGE.**
- ◆ **RECORD THE TIME, DATE, AND LOCATION OF ALL ENTRIES.**
- ◆ **SIGN AND PRINT OR STAMP EVERY ENTRY THAT YOU MAKE, AND INCLUDE YOUR PROFESSIONAL TITLE.**
- ◆ **MAKE ALL ENTRIES PERMANENT. USE BLACK INK. NEVER USE A PENCIL!**
- ◆ **MAKE GOOD ENTRIES THE FIRST TIME AROUND. ENTRIES SHOULD BE ACCURATE, TIMELY, OBJECTIVE, SPECIFIC, CONCISE, CONSISTENT, COMPREHENSIVE, LOGICAL, LEGIBLE, CLEAR, DESCRIPTIVE, AND REFLECTIVE OF THOUGHT PROCESSES AS YOU ARE MAKING THEM.**
- ◆ **BE SPECIFIC.**
- ◆ **BE OBJECTIVE. AVOID TENTATIVE PHRASES SUCH AS “APPEARS TO BE”, “LOOKS LIKE IT MIGHT”, ETC.**
- ◆ **BE COMPLETE:**
 - Document everything significant to the inmate’s condition and course of treatment (physical, psychological and emotional status; deviations from previous status reports) is recorded. When in doubt, write it down!
 - Be careful to document any deviation from standard treatment and the reason why. A plaintiff’s attorney can find a dozen “expert” witnesses to testify, “That is not the way you normally treat this condition.”
 - Enter any unusual occurrence, such as a fall, with the responsive or remedial steps taken and the inmate’s condition. However, **do not** enter “INCIDENT REPORT FILED”. This immediately notifies a plaintiff’s attorney that vulnerable party may exist in the facility. Do not file any incident report in the record.
- ◆ **MAKE ALL ENTRIES PROMPTLY**
- ◆ **ABBREVIATE CORRECTLY AND WRITE LEGIBLY**

- ◆ **MAKE ENTRIES CONTINUOUS**
- ◆ **Make Entries Consistent, And Avoid Contradictions**
- ◆ **Make and Sign Your Own Entries (An order in two different types of handwriting is NOT GOOD)**
- ◆ **COUNTERSIGN CAREFULLY**
- ◆ **PROVIDE AND DOCUMENT INMATE EDUCATION**
 - * The topics discussed
 - * A statement of the inmate's understanding
 - * If written materials were provided
- ◆ **DOCUMENT INFORMED CONSENT WHENEVER APPLICABLE**
- ◆ **DOCUMENT INMATE REFUSALS**
 - * If the inmate refuses to sign use the Release of Responsibility form. The healthcare provider should document "Inmate Refuses to Sign" in the progress notes. The healthcare provider and a witness sign the form.
- ◆ **MAKE CORRECTIONS AND AMENDMENTS CAREFULLY**

When changes in the record are absolutely necessary, utilize the following procedures:

 - √ Draw a single, thin pen line through each line of the entry making sure the inaccurate material is still legible.
 - √ Date and initial change.
 - √ Add a note in the margin stating why the entry has been replaced.
 - √ Fit the change into the correct chronological order, if possible.
 - √ Make sure to indicate which entry the correction is replacing.
 - √ Cross reference amendments to the record.
 - √ In some situations it may be wise to have the corrected notation witnessed by a colleague.
- ◆ **DOCUMENT ON ORIGINALS - DO NOT DOCUMENT ON FAXES OR COPIES**
- ◆ **DELETIONS ARE A PROSECUTOR'S PLAYGROUND**
 - * Never delete material on the record by scratching out, using "white out", and obliterating with a felt tip marker, typing XXXXXs, tearing off the page, etc. These are examples of mutilating the record.
- ◆ **AVOID OMISSIONS**
- ◆ **AVOID TIME GAPS**

◆ **TAMPERING CAN BE FATAL**

◆ **AVOID EXTRANEOUS REMARKS**

◆ **JOUSTING IS DEADLY**

- * Jousting is arguing, complaining, belittling, criticizing or blaming others to defend oneself. In the record, jousting is deadly not only because it can provide a plaintiff with a powerful “expert” witness against the facility and the joustee, but as one experienced attorney put it, “Jousting is about the only thing that will guarantee a lawsuit and raise the amounts awarded sky high.”

◆ **MAKE SURE THE RECORD PROVES YOU WERE THERE!**

◆ **DISPLAY YOUR THOUGHT PROCESSES**

- * The medical record sets forth the healthcare professional’s reasoning, especially if it leads to important treatment decisions. If the record shows that all available evidence was prudently weighed and a decision – even one with clinical risk to the inmate – was carefully made, the situation is defensible and exposure to legal risk will be minimized.

◆ **PROGRESS NOTES REQUIRE SPECIAL ATTENTION**

◆ **MAKE SURE THE HEALTH CARE RECORD IS COMPLETE**

- * Healthcare professionals in ambulatory settings are responsible for ensuring continuity of care and facilitating inmate compliance with self-care regimens. Consequently, the ambulatory care record must additionally demonstrate that:
 - √ Screening and testing are sensitive enough to detect the onset of acute episodes of illness, which may warrant hospitalization.
 - √ Healthcare professionals have devised follow-up plans, which anticipate inmates further needs.
 - √ Inmate education has been provided and inmate is willing and able to contribute to his or his own care.

◆ **LATE ENTRIES**

Progress notes written out of chronological order are considered to be late entries. Each late entry must be appropriately labeled “*Late Entry*”. It is unacceptable to add information to a previously written progress note. A late entry should not be written on a new form and added to the appropriate place. The late entry should refer to the date and time the original note was actually written and the date and time the events took place.

“IF IT WAS NOT DOCUMENTED, IT DIDN’T HAPPEN!”

Prison Health Services

POLICY ON DOCUMENTATION

Title: DOCUMENTATION

Policy: Employees are expected to complete all medical documents in accordance with PHS policies and procedures and with all accreditation standards and requirements.

Statement: Records and forms must be completed in a standardized and uniform fashion. This includes but is not limited to the following requirements:

1. All entries must include place, date, time and be legible. All entries must include signature and title.
2. Per PHS policy, all signatures must be accompanied by printed or stamped identification of the signature.
3. A progress note must record all encounters. Documentation of patients note seen and why they were not seen must be recorded on the progress note.
4. All forms must be completely filled out and each item addressed (i.e., transfers, public health, H&Ps, sick call requests, chronic care screeners). Special care must be taken with multiple forms – press hard for legibility.
5. All documents in the record must include the inmate's name, PFN number, housing unit, date of birth, allergies, and sex.
6. Master Problem List must be filled out completely with each problem, date of onset, treatment plan, status of each problem, any allergies, and initials of the health professional entering the data.
7. Progress notes must be in SOAP format.
8. All finding, diagnoses, treatments, dispositions must be recorded.
9. Reports of labs, x-rays, diagnostic studies and immunization records ordered must be in the patient's record.
10. Results of internal and external consultations must be completed and recorded.
11. Patients with major medical problems (i.e., infirmary patients) require a recorded treatment plan.

12. All physician orders must include all identifying information listed above and the status of the patient's allergies. Orders must be legible and include start and stop dates. Special attention must be taken to prevent error, misreading, improper abbreviations and prescribing non-formulary items without prior approval.
13. All verbal/telephone orders must be signed within 72 hours.
14. Any encounter that generates a physician's order must be cross-referenced to a progress note, written by the provider or the person taking the verbal/telephone order. The progress note must refer to the physician's order and the reason for the order.
15. Medication administration must have documentation of the names of the personnel administering or delivering the medication.
16. Consent for medical service forms or release of responsibility forms must be obtained and completed.
17. All medical records must be kept in the medical records department. Records must be removed from the medical records department consistent with record policies and procedures.

Revised/Effective Date: 4/6/04

PROBLEM ORIENTED PROGRESS NOTES

Problem oriented progress notes are written to match each problem documented on the Master Problem List and organized in a narrative form using the SOAP format. When writing a progress note, a separate SOAP note is needed for each problem. Different problems are better addressed in separate progress notes.

◆ ADVANTAGES OF PROBLEM ORIENTED PROGRESS NOTES

- * FOCUSES ON THE INMATE AND THEIR PROBLEMS
- * FOCUSES ON THE TOTAL INMATE BY INCORPORATING EMOTIONAL AND SOCIAL ASPECTS OF CARE ALONG WITH THE PHYSICAL COMPONENTS.
- * PROVIDES FOR CLEARER COMMUNICATION ABOUT THE INMATE BETWEEN ALL HEALTH TEAM MEMBERS.
- * PROVIDES FOR MEANINGFUL EVALUATION OF THE EFFECTIVENESS OF CARE.
- * PROVIDES A FEEDBACK SYSTEM FOR MONITORING QUALITY OF CARE.

◆ ADVANTAGES OF SOAP CHARTING

- * ORGANIZES DOCUMENTATION IN A CONCISE LOGICAL MANNER ACCORDING TO INMATE PROBLEMS.
- * ELIMINATES UNNECESSARY VERBIAGE.
- * INMATE FOCUSED.
- * PROVIDES FOR CLEARER COMMUNICATION WITH OTHER HEALTH CARE TEAM MEMBERS.
- * PROVIDES FOR AN ON-GOING EVALUATION OF INMATE'S PROGRESS.

◆ THE SOAP FORMAT

* S – Subjective

The inmate's self proclaimed symptoms and own description of the problem not perceptible to an observer.

Examples: Nausea, headache, cramps, and pain.

* O – Objective

Clinical findings, observations and factual data.

Examples: Vital signs, observations, and assessment findings.

Anatomical system charting is useful in the objective portion of a SOAP note.

* A – Assessment

Conclusions about the health condition based on the subjective and objective data. Nursing diagnoses may be used.

Examples: Nursing diagnoses; constipation related to immobility.

* P – Plan

Nursing interventions may be diagnostic (observe for increased drainage), therapeutic (implemented bowel program per protocol), or educational (instruct in finger stick process). The plan should include implementation of the interventions, evaluation, how the plan worked, and revision, changes to the plan if required. Inmate education may also be included in this section of the progress notes.

Examples: Referred to physician; instructed to increase fluids, and return to clinic in one week.

NOTE: RNs use SOAP format documentation. LVN's use SOI method (subjective, objective, and impression).

MARs

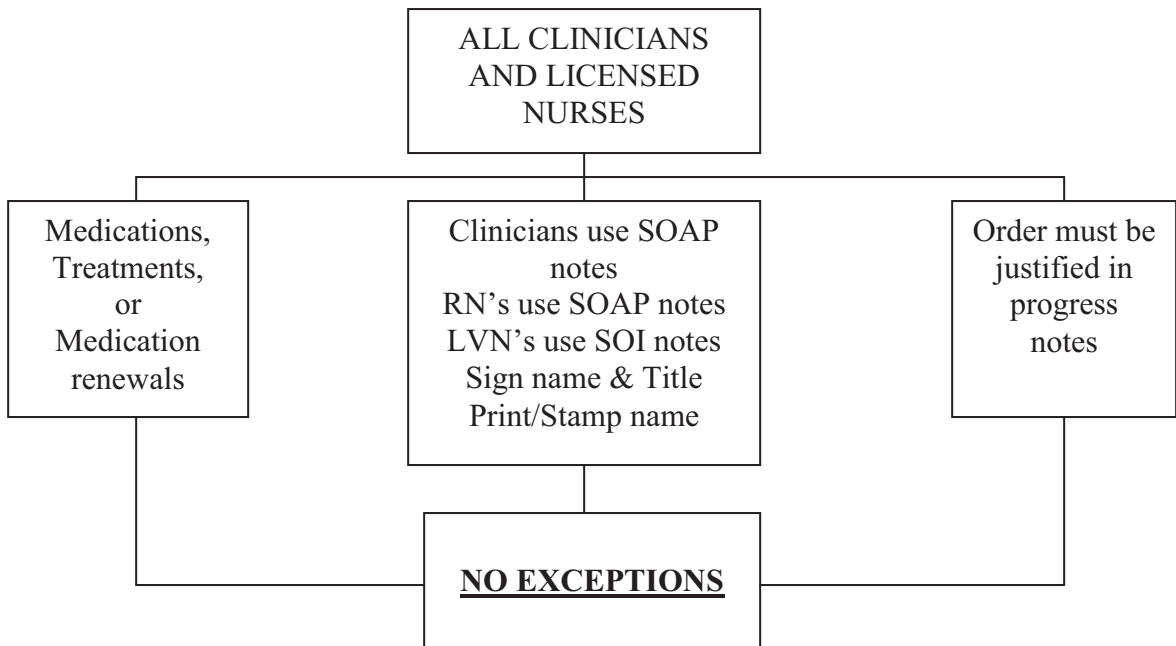
A correct MAR needs to show the following:

All documentation must be legible

1. Inmate name (correct name, not an alias)
2. Inmate PFN
3. Inmate location (within facility)
4. Facility name
5. Allergies to medications
6. Diagnosis
7. Month and year of MAR
8. Initials of person taking off order(s)
9. Start and stop date for each medication
10. Name of prescribing clinician for each order
11. Medication ordered, including dose and route
12. Time(s) medication is to be given
13. Lines to delineate start and stop of medication, yellow out section upon completion or discontinuation of medication
14. Identification of initials of person giving medication(s) (signature and stamp/print)
15. Initials of person giving medication(s), be sure to circle if not given and document reason on back of MAR
16. Document on MAR when medication is given, not before
17. Document on originals only – do NOT document on faxes or copies

Any Order Written on a Physician's Order Sheet

All documentation must be legible



MILITARY TIME USEAGE

All charting or documentation done by PHS staff is done in military time. Below is the break down of military time which starts after 12 noon.

1 or 0100 or 1300 hours

7 or 0700 or 1900 hours

2 or 0200 or 1400 hours

8 or 0800 or 2000 hours

3 or 0300 or 1500 hours

9 or 0900 or 2100 hours

4 or 0400 or 1600 hours

10 or 1000 or 2200 hours

5 or 0500 or 1700 hours

11 or 1100 or 2300 hours

6 or 0600 or 1800 hours

12 or 1200 or 2400 hours

NURSING DIAGNOSIS

Nursing diagnosis provides a useful mechanism for structuring nursing knowledge in an attempt to define the unique role and domain of nursing. PHS mandates that nursing staff practice within the constraints of their licensure. This would imply that nurses do not utilize or make medical diagnoses.

Nursing diagnosis can provide a solution to the quest of nursing because it serves to:

- ◆ Define nursing in its present state
- ◆ Classify the domain of nursing
- ◆ Differentiate nursing from medicine
- ◆ Identify nursing knowledge for students.

The Concept of Nursing Diagnosis

The word *diagnosis* evokes many responses in nurses – some positive, some negative. Because nurses have historically linked the word diagnosis exclusively with medicine, some may tend to overlook the fact that teachers diagnose learning disabilities, hairdressers diagnose hair problems, and mechanics diagnose automotive disorders. In addition, many nurses were taught to avoid making definitive statements when documenting and were advised to use terms such as “seems to be” or “appears to be.” This socialization process rewarded nurse for not diagnosing.

A nursing diagnosis is a statement that describes the human response (health state or actual/potential altered interaction pattern) of an individual or group which the nurse can legally identify and for which the nurse can order the definitive interventions to maintain the health state or to reduce, eliminate, or prevent alterations.

For a comprehensive list of nursing diagnoses, please refer to professional nursing literature and reference texts.

THE USE OF NAMES IN ORDER TO COMMUNICATE LETTERS

Procedure Name: Verbal communication with PFN Identification

Purpose: To ensure accurate identification of inmate information.

Procedure: The following phonetic alphabet is used for clarification of verbal communication of PFN numbers:

Letters used:

A – Adam

N – Nora

B – Boy

O – Ocean

C – Charles

P – Paul

D – David

Q – Queen

E – Edward

R – Robert

F – Frank

S – Sam

G – George

T – Tom

H – Henry

U – Union

I – Ida

V – Victor

J – John

W – William

K – King

X – X-ray

L – Lincoln

Y – Yellow

M – Mary

Z – Zebra

Numbers used:

1,2,3,4,5,6,7,8,9,0

COMMONLY USED ABBREVIATIONS

COMPUTER QUERY ABBREVIATIONS

JQCN.Last Name then Enter (Finds Complete Name, Date of Birth, PFN#)

JQCN.Last Name.I then Enter (Finds Inactive Name, Date of Birth, PFN#)

JPQN.Last Name.First Name then Enter (Finds Complete Name, Date of Birth, PFN#)

JPQS.PFN# then Enter (Finds All Aliases, Date of Birth)

JQCD.PFN# then Enter (Finds Active/Inactive, Receiving Date, Release Date)

JPQP.PFN# then Enter (Finds Address, Social Security #)

JQLA then Enter (Finds location)

JQLA.SPOD# then Enter (Finds Everyone in POD)

JASA then Enter (To Book Appointments)

JUMR.PFN# (Finds PPD & CxR information)

JUSA then Enter (to Correct/Cancl appointments)

JASD then Enter (To Enter a Diet)

JQSD. Diet Code or PFN then Enter (Query diet record)

JUSD.PFN then Enter (Update or Delete diet record)

JQMG.PFN# then Enter (Finds Appointments)

JQMN.Last Name or First Name then Enter (Finds Movement History)

JAMR then Enter PFN# (Finds Sex, Date of Birth, Medical Record Number)

EMPLOYEE USER ID = your 3 initials and the 4 last numbers of your social security number in all lower case (small letters)

TO LOGON: type cesn (or alaco) (space) user ID

TO LOGOFF: type cesf (space) logoff

Passwords chosen by the individual employee are restricted to only lower case letters or numbers.

COMMON ADMINISTRATIVE COMMUNICATIVE ABBREVIATIONS

PFN – Prisoner file number (ID#) SO – Sheriff’s Office
DOB – Date of birth CDC – CA Department of Corrections
NIC – Not in custody USM – US Marshall Service
OTA – Out to appointment DOJ – Department of Justice
OTC – Out to court ACSO – Alameda County SO
SRJ – Santa Rita Jail SOID15 – SRJ HU1 PodD Cell15
GDDF (NCJ) – Glenn Dyer (North County) NOIE05 – GDDF Flr1 PodE Cell5
SEEN
REFUSED

COMPUTER CODES – CHART LOCATOR SYSTEM

AS – ACTIVE SRJ
IS – INACTIVE SRJ
AN – ACTIVE GDDF (NCJ)
IN – INACTIVE GDDF
IF – OFF-SITE STORAGE CHART
CS – CONFIDENTIAL SRJ
CN – CONFIDENTIAL GDDF

COMMONLY USED OTHER FACILITY ABBREVIATIONS

VSPW – Valley State Prison for Women Names by county (i.e., Santa Cruz)
SQ – San Quentin State Prison DVI – Deuell Vocational Institute
FCI – DUBLIN (Federal Correctional Institute at Camp Parks, Dublin)
CDC – California Department of Corrections (PRISONS)

FINDING HEALTH INFORMATION: CHARTS, SCREENERS, AND LOOSE FILING PAPERS

Health Information Services Department consists of two medical record rooms, one known as Active and one known as Inactive.

The Active Room contains active shelving, prenatal shelf, clerks' analysis shelves, MD signing shelves, returns shelves, Outpatient Housing Unit (OPHU) Discharge shelf, and small computer room. Blank forms, labeled boxes for returning loose filing paper, mail boxes, fax machine, and bins for scheduling clinics are located in this room. The Active room also in the location for the court order and +PPD logs. (PPD readings from nurses are usually kept in PHS administration.)

The Inactive Room contains inactive shelving, screener boxes labeled by month, and copies of screeners labeled by month. Often there will be baskets in the inactive room hallway with charts specifically pulled for a variety of reasons, such as: Annual H&Ps, Accreditation Audits, Quality Assurance Audits, etc.

In these rooms, charts are most likely found on inactive file shelving, active file shelving, clerk analysis shelves, and MD signature shelves. Screeners are most likely found in boxes labeled by month or in the "Charts –to-be-made" cue. Loose filing paper with medical record numbers are most likely found on clerks' desks or in the sorter. Each clerk has an assigned number of terminal digits. In your daily work situation, all nurses are expected to look in all of these locations first before requesting assistance from health information personnel.

All nurses, medical assistants, and lab technicians are expected to find a chart, a screener, and/or loose paper filing if they need it. The health information staff is willing to help find charts once the nurse has tried all obvious locations.

Screeners without medical record numbers are kept in strict alphabetical order within the month of booking.

Screeners that are in cue for medical record number assignment are loosely by letters in "Charts-to-be-made" cue.

New booking screeners may be on clerks' desks waiting to be matched with preexisting chart folder or may be waiting to be matched with chart ordered from off-site storage.

Loose filing paper with medical record numbers may be on clerks' desks or in the sorter.

Charts may be found on inactive or active shelving. They may be found on clerks' analysis shelves or MD signing shelves. All of these areas are filed in strict terminal digit filing.

Returning or arriving loose filing paper needs to go to the appropriately labeled boxes and bins. *PLEASE, MAKE SURE TO PLACE LOOSE FILING (screeners, orders, etc.) IN THE CORRECT BOX.* This saves time and enables these items to be found in a timely manner.

Court Orders are logged in logbook and matched with chart if possible for the housing unit nurse. All court orders must be addressed appropriately, completed (with written court order response if required), and returned directly to Health Information Supervisor (Supervisor In-Box or Office only).

Terminal Digit Filing System Instructions

The filing system used at Santa Rita and at Glenn Dyer is **terminal digit**. The system uses a color-coded system in conjunction with a medical record number that consists of three pairs of numbers connected with *dashes* (i.e. 12-06-45). These are not to be confused with a Date of Birth (i.e. 12/6/45).

The color coding is as follows:

Zero = Red, One = Gray, Two = Blue, Three = Orange, Four = Purple, Five = Black, Six = Yellow, Seven = Brown, Eight = Pink, and Nine = Green.

Looking at the vertical numbering on the side of the folder, if the chart number is 03-06-12; you start with the 12, which are the bottom pair of two numbers, then 06, and finishing with 03, the top two numbers.

Using the color-coded system, in looking for 03-06-12, first, you would look for the bottom pair of numbers, a blue sticker signifying 2, and then a gray signifying 1. Then you would look for the middle pair of numbers, red signifying 0 (the first number of the middle pair). At this point you have to complete the middle pair 06, and then look finally for the top pair 03.

CHART ORDER

A standardized source oriented chart order is used to maintain a standardized order within an inmate's health record.

See enclosed sample of chart order.

CHART ORDER - PRISON HEALTH SERVICES – ALAMEDA COUNTY JAILS
LEFT SIDE

- MASTER PROBLEM LIST
- DISEASE CODE SHEET (JUMR screen)

- ANY OF THE FOLLOWING IN REVERSE CHRONOLOGICAL ORDER:
 - Court Orders and/or Subpoenas
 - Authorizations for Release of Information
 - Records received from other facilities
 - Requests for Health Information
 - Other Correspondence
 - *HIV Consent (place on top of Master Problem List only when all appropriate signatures are not completed, after completion file on right in consents)

TAB ORDER FOR RIGHT SIDE OF CHART:

CURRENT ADMISSION ONLY (right side of chart):

PRENATAL (Green)

METHADONE (Brown)

INFIRMARY (Blue)

LAB/X-RAY (Yellow)

OUTSIDE HOSPITAL (Purple)

NEW ADMISSIONS (Pink)

NON-ADMISSION SENSITIVE (at bottom of right side of chart):

DENTAL (Red)

MENTAL (Grey)

ASSEMBLY NOTES:

All documents (*except Prenatal Tab section*) are affixed to chart in their respective sections in ***REVERSE CHRONOLOGICAL ORDER***, oldest date first moving forward to more recent dates.

When the patient is released from the facility (NIC = not in custody), a blue paper is placed on top of that admission with the NIC date and clerk ID on the lower right corner and all Tabs are removed except for Dental and Mental. (*Tab removal is new as of 1/28/03*)

When a subsequent volume is created (ex: VOL II of II) the Dental (red) and Mental (grey) sections are moved to the current volume being created. All coding and allergy labels need to be added to new folder.

If 295.0 coding is present, this indicates the presence of a separate Psychiatric Volume. 295.0 is a Historical system and is not currently used by HISD.

If 39.95 coding is present, this indicates the presence of a separate Dialysis Volume. If not already made, a Dialysis volume needs to be made for every Dialysis patient.

An in-custody death chart is coded 798.2 and update to/filed in SRJ CS.

Refer to “John/Jane Sample.”

**Chart Order as of 2009

CHART ORDER – PRISON HEALTH SERVICES – ALAMEDA COUNTY JAILS
RIGHT SIDE

BLUE SHEET (dated and initialed to close admission/incarceration)

TRANSFER SHEET TO OTHER FACILITY

PHYSICIANS ORDERS

PROGRESS NOTES

INTERNAL CONSULTATIONS

PRE-NATAL TAB (Green)

Prenatal Records

METHADONE TAB (Brown)

Prenatal Methadone Records

INFIRMARY TAB (Blue)

Outpatient Housing Unit Records

FLOW SHEETS: HIV or any CCC Flow Sheet

CIWA-Ar RECORD

COWS RECORD

WEIGHT RECORD

BLOOD PRESSURE RECORD

WOUND TREATMENT RECORD

DIABETIC RECORD

HISTORY AND PHYSICAL

FORMULARY EXCEPTION REQUEST

METHADONE ADMINISTRATION RECORD

MEDICATION RECORD (MAR)

LAB/X-RAY TAB (Yellow)

Labs, X-Rays, Ultrasound Reports, Morbidity Reports

GYN LAB ASSESSMENT

PPD REPORT/INH EVALUATION

OUTSIDE HOSPITAL TAB (Purple)

Outside Hospital Records

DIET SHEET

DETAIL OFFICE SPECIAL REQUESTS

PERSONAL PROPERTY RECEIPT

SICK CALL REQUESTS

METHADONE VERIFICATION FORM

KITCHEN ASSESSMENTS

RELEASES OF RESPONSIBILITY

CONSENTS

TRANSFER FORMS FROM OTHER AGENCIES/FACILITIES

RECEIVING SCREENER (Opens the chart/current admission)

NEW ADMISSIONS TAB (Pink)

BLUE SHEET OVER ANY PREVIOUS ADMISSIONS

DENTAL TAB (Red)

Dental Records

MENTAL TAB (Grey)

Mental Health Records

CONFIDENTIAL ENVELOPE (HIV Antibody Test)

Peapods (Chronological order OK in Prenatal Section only)
 OB/GYN H&P (on prenatal progress note)
 Progress notes, copies of labs and studies, and internal consults – stamped “prenatal”
 Prenatal Counseling, Social Services, and Education

Prenatal Methadone Counseling

Infirmary discharge plan
 Physician’s orders
 Provider Notes (stamped as such)
 Infirmary nursing progress notes
 Intake/output record
 Neurological assessment
 Vital signs flow chart
 Infirmary record (opens each infirmary admission)

NOTE: Multiple Infirmary admissions/discharges are placed in

ER Room Referral
 ER Referral to Hospital
 Hospital Records
 Utilization
 ER or Outpatient Consultation Referral

GLOSSARY OF TERMS

ADMINISTRATION OF MEDICATION is the act in which a single dose of identified drug is given to a patient.

ADMINISTRATIVE MEETING of the jail are meetings of the health staff, security personnel; and administration, as appropriate.

ADMINISTRATIVE SEGREGATION: see Segregation

ALCOHOL DETOXIFICATION: See Detoxification.

ANNUAL STATISTICAL REPORT is a compilation of information concerning the number of inmates receiving health services by category of service, as well as other relevant information (e.g., operative procedures, referrals to specialists, ambulance services).

ASSESSMENT PROTOCOLS are written instructions or guidelines that specify the steps to be taken in appraising a patient's physical status. Assessment protocols should not include any directions regarding dosages of prescription medication except for those covering emergency, life-threatening situations (e.g., nitroglycerin, epinephrine).

CHEMICAL DEPENDENCY refers to the state of physiological and/or psychological dependence of alcohol, opium derivatives, synthetic drugs with morphine-like properties (opiates), stimulants, and depressants.

CHRONIC ILLNESS requires care and treatment over a long period of time and usually is not cured (e.g., asthma, heart disease, diabetes, hypertension, and chronic obstructive pulmonary disease).

CLINIC CARE is medical service rendered to an ambulatory patient with healthcare complaints that are evaluated and treated at sick call or by special appointment.

CLINICAL ENCOUNTER refers to any health encounter with a qualified health professional where some type of diagnostic test or treatment is provided.

COMMUNICABLE DISEASES include those diseases that are sexually transmitted (e.g., syphilis, gonorrhea, chlamydia, HIV), transmitted through the respiratory system (e.g., tuberculosis), or via infected blood (e.g., hepatitis).

CORRECTIONAL HEALTH COORDINATOR is an individual who coordinates the health delivery services under the joint supervision of the responsible physician and the jail administrator in jails without any full-time qualified healthcare personnel. This individual is trained in limited aspects of health care, as determined by the responsible physician, and may include correctional officers and other personnel.

CRITICAL INCIDENT DEBRIEFING is a process whereby individuals are provided an opportunity to express their thoughts and feelings about a critical incident (e.g., a serious injury/death of a staff member or inmate), develop an understanding of critical stress symptoms, and develop ways of dealing with those symptoms. Critical incident stress is a normal reaction to an abnormal event that causes individuals to experience unusually strong emotional reactions. Absent the opportunity for debriefing, critical incident stress has the potential for interfering with an individual's ability to function now or some time in the future.

A DEA CONTROLLED SUBSTANCE is a drug regulated by the Drug Enforcement Administration under the authority of the Federal Controlled Substances Act.

The **DENTAL EXAMINATION** should include the taking or reviewing of the patient's dental history; charting of teeth; examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination. X-ray studies for diagnostic purposes should be taken if necessary.

DENTAL SCREENING: See ORAL SCREENING.

DETOXIFICATION refers to the process by which an individual is gradually withdrawn from a drug to which the person is physically dependent and/or the treatment of the condition which results from the withdrawal of the drug (the abstinence syndrome). This process is usually accomplished by the administration of decreasing doses of the drug upon which the person is physiologically dependent, one that is cross-tolerant to it, or a drug that has been demonstrated to be effective on the basis of medical research.

DIASTER PLAN: See EMERGENCY PLAN

DISPENSING OF MEDICATION refers to the distribution of one or more doses of a prescribed medication in containers that are correctly labeled with the name of the patient; the contents of the container and all other vital information needed to facilitate correct drug administration.

DISTRIBUTION OF MEDICATION is the system of delivering, storing, and accounting for drugs from the source of supply to the nursing station or point where they are administered to the patient.

DOCUMENTED HEALTH REQUESTS health requests include such examples as (1) the recording on the request slip of the action taken regarding triaging and the filing of such slips in the patient's medical record, and (2) the use of a log to record the request and its disposition.

DRUG DETOXIFICATION: See DETOXIFICATION.

ECTOPARASITES are animals or insects, such as pediculosis and scabies that are skin infestations. They are communicable and may lead to secondary infections.

EMERGENCY CARE (MEDICAL, DENTAL, AND MENTAL HEALTH) is care for an acute illness or unexpected healthcare needs that cannot be deferred until the next scheduled sick call or clinic.

EMERGENCY PLAN is the plan developed to respond to manmade or natural, internal or external disasters. Health aspects of an emergency plan, among other items, include the triaging process, outlining where care can be provided, and laying out a backup plan.

FORMULARY is a written list of prescribed and non-prescribed medication stocked within the facility.

FRAIL ELDERLY inmates are those who frequently suffer from chronic conditions and that impair their ability to function (e.g., dress, fed, and toilet) to the extent that they require special nursing care.

HEALTH ADMINISTRATOR is a person who by education (RN, MPH, MHA, or a related discipline), experience, or certification (e.g., CCHP, Fellow in the American College of Healthcare Executives) is capable of assuming responsibility for arranging for all levels of healthcare and providing quality and accessibility of all services provided to inmates.

HEALTH ASSESSMENT is the process whereby the health status of an individual is evaluated. The responsible physician defines the extent of the health appraisal, including medical examination, but include at least the items noted in standard J-33.

HEALTH AUTHORITY is the individual to whom has been delegated the responsibility for the facility's healthcare services, including arrangements for all levels of healthcare and the ensuring of quality and accessibility of all health services provided to inmates.

HEALTHCARE is the sum of all actions taken, preventive and therapeutic, to provide for the physical and mental well being of a population. Healthcare, among other aspects, includes medical, psychiatric, and dental services, personal hygiene, dietary and food services, and environmental conditions.

HEALTH SERVICES STAFF are qualified healthcare personnel and all personnel without healthcare licenses who are trained in some aspects of healthcare delivery (e.g., health services administrators, nursing assistants, record administrators, laboratory and clerical workers).

INFORMED CONSENT is the agreement by the patient to a treatment, examination, or procedure after the patient receives the material facts regarding the nature or, consequences of, risks of, and alternatives to the proposed treatment, examination, or procedure. The right to refuse treatment is inherent in this concept.

INITIAL HEALTH SCREENING: See RECEIVING SCREENING.

INTERNAL QUALITY IMPROVEMENT: See MONITORING OF SERVICES

KEEP-ON-PERSON (KOP) refers to an inmate keeping his medication on his person.

LARGE-MUSCLE ACTIVITY are those activities involving large muscle groups such as walking, jogging in place, basketball, Ping-Pong, and isometrics.

A **LICENSED NURSING FACILITY** provides long term or rehabilitative care to patients with chronic physical or mental disabilities.

MEDICAL PREVENTIVE MAINTENANCE: See PREVENTIVE MAINTENANCE.

MEDICAL RESTRAINTS: See RESTRAINTS.

MEDICATION ACCOUNTING is the system of recording, summarizing, analyzing, verifying, and reporting medication usage.

MONITORING OF SERVICES is the process for ensuring that all providers are rendering high-quality healthcare services in the facility. On-site observation and review (e.g., study of inmates' complaints about care; review of health records, pharmaceutical process, standing orders, and performance of care) accomplish the monitoring.

MORTALITY REVIEW is a process that involves physicians, nurses and others seeking to determine in the case of death if there was a pattern of symptoms that might have resulted in earlier diagnosis and intervention. Additionally, the review examines events immediately surrounding a death to determine if appropriate interventions were undertaken. Each inmate death should be compared with other inmate deaths to determine if there is an emerging pattern.

NURSING PROTOCOLS: See ASSESSMENT PROTOCOLS.

OPIATES are derivatives of opium, (e.g., morphine and codeine), and synthetic drugs with morphine-like properties.

ORAL HYGIENE by standard definition includes clinical procedures taken to protect the health of the mouth and chewing apparatus, minimum compliance is met by instruction in proper brushing of teeth.

ORAL SCREENING is a visual observation of the teeth and gums performed by a dentist or healthcare personnel who are properly trained and designated by the dentist.

ORTHOSES as specialized mechanical devices used to support or supplement weakened or abnormal joints or limbs, such as braces, foot inserts, or hand splints.

OUTPATIENT HOUSING UNIT is a medical observation unit.

OUTPATIENT HOUSING UNIT CARE is defined as care by or under the supervision of a registered nurse for an illness or diagnosis that requires limited observation and/or management but does not require admission to a licensed hospital or nursing care facility.

PHYSICAL HANDICAPS refer to physical disabilities that limit a person's normal functioning, including mobility impairments, visual impairments, hearing impairments, and speech impairments.

POLICY is a facility's official position on a particular issue related to an organization's operations.

PROCEDURE describes in detail, sometimes in sequence, how a policy is to be carried out.

PREVENTIVE MAINTENANCE refers to health promotion and disease prevention. This includes the provision of individual or group health education and medical services, such as inoculations and immunizations provided to take advance measures against disease, and instruction in self-care for chronic conditions.

PROTHESES are artificial devices to replace missing body parts or compensate for defective bodily functions. Examples are items such as artificial limbs, eyeglasses, and full and partial plates.

PSYCHIATRIC PERSONNEL or psychiatric services staff are psychiatrists, general family physicians with psychiatric orientation, psychologists, psychiatric nurses and social workers.

QUALIFIED HEALTH PERSONNEL are physicians, dentists, and other professional and technical workers who by state law engage in activities that support, complement, or supplement the functions of physicians and/or dentists, and who are licenses, registered, or certified as is appropriate to their qualifications to practice; further, they practice only within their license, certification, or registration.

QUALIFIED MENTAL HEALTH PERSONNEL include physicians, nurses, physician assistants, and other who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for mental health needs of patients.

QUALIFIED IMPROVEMENT COMMITTEE is a multi-disciplinary group of health providers working at the facility (the responsible physician and representatives of other departments) who meet on a fixed schedule to monitor and evaluate the healthcare services provided.

QUALIFIED IMPROVEMENT PROGRAMS ensure the quality and consistency of the health services provided in the facility, usually through periodic review of patients' charts and ongoing monitoring of clinical services.

RECEIVING SCREENING is a system of structured inquiry and observation designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population, and to identify those newly admitted inmates in need of medical care. This process is also referred to as INITIAL HEALTH SCREENING.

RESPONSIBLE PHYSICIAN is an individual physician who supervises medical judgments regarding the care provided to inmates at a specific facility.

RESTRAINTS are physical and chemical devices used to limit patient activity as a part of healthcare treatment. The kinds of restraints that are medically appropriate for the general population within the jurisdiction may likewise be used for medically restraining incarcerated individuals (e.g., leather or canvas hand and leg restraints, chemical restraints, and straightjackets).

SEGREGATION (Administrative Segregation) refers to inmates isolated from the general population and who receive services and activities apart from other inmates.

SELF-CARE is defined as care for a condition that can be treated by the patient; it may include over-the-counter-type medications.

SELF-MEDICATION programs permit responsible patients to carry and administer their own medications (e.g., “keep-on-person” programs).

SICK CALL is the system through which each inmate reports for and receives appropriate medical services for non-emergency illness and injury. Some people refer to sick call as a CLINIC VISIT.

SPECIAL MENTAL HEALTH NEEDS patients include self-mutilators, the aggressive mentally ill, suicidal inmates, and sex offenders.

SPECIAL NEEDS CARE refers to care developed for patients with certain medical conditions that dictate a need for close medical supervision (e.g., seizure disorder, diabetes, potential suicide, pregnancy, chemical dependency, and psychosis).

STANDARD PRECAUTIONS are recommendations by the Centers for Disease Control and Prevention (CDC) and the Occupation Safety and Health Administration (OSHA) that require healthcare workers to consider all patients as potentially infected with blood borne pathogens and to follow infection control precautions intended to minimize the risk of exposure to blood and certain other body fluids of patients. Also known as Universal Precautions.

STATISTICAL REPORTS summarize and monitor trends of inmates receiving health services by category of care, operative procedures, referrals to specialists, positive testing for HIV and tuberculosis infections, and emergency services provided patients.

TERMINALLY ILL patients are those with a life expectancy of less than one year due to illness and who may require special health services to provide comfort, relief from pain, and special counseling and support in anticipation of death.

THERAPEUTIC SECLUSION refers to the placement and retention (by qualified healthcare personnel) of an inmate/patient in a bare room for the purpose of containing a

clinical situation (e.g., extreme agitation, threatening or assaultive behavior) that may result in a state of emergency.

TREATMENT PLAN is a series of written statements that specify the particular course of therapy and the roles of medical and non-medical personnel in carrying out the current course of therapy. It is individualized and based on assessment of the individual patient's need, and includes a statement of the short and long-term goals and the methods by which the goals will be pursued.

TREATMENT PROTOCOL is pre-established written orders that specify the steps to be taken in appraising a patient's physical status. Treatment protocols do not have any directions regarding danger of prescription medications.

TRIAGE is the sorting out and classification of patient-inmate health complaints to determine priority of need and proper place of healthcare.

UNIVERSAL PRECAUTIONS: See STANDARD PRECAUTIONS

VERIFICATION OF CREDENTIALS may consist of copies of current credentials, letters from the state licensing or certifying bodies regarding the status of credentials for currently employed personnel, or personal observation of the document by an authenticating employee or similar means.

EMPLOYEE RIGHTS AND RESPONSIBILITIES

1. FIT Test (face mask) – One time.
2. Sheriff's Orientation – New Employee & Annual.
3. TB Testing – Annual.
4. CPR and Professional License – Every Two years (Licensed personnel). You are required to provide PHS with a copy of your current CPR card and current license (and DEA registration as appropriate).
5. Continuing Education Units (CEU's) –
Keep current with files located in the administrative office (filed in alphabetical order and by shift).
 - Personnel with inmate contact - ACA Accreditation requires 40 hours and NCCHC Accreditation requires 12 hours. Examples of professional skill maintenance and enhancement activities you may document: all-staff meetings, PHS sponsored CEU participation, outside educational activities, classes taken for college credit, lectures attended, etc. A minimum orientation of 40 hours is completed before taking an individual job assignment per ACA.
 - Other personnel – NCCHC Accreditation requires 12 hours of training time documentation. 40 hours of orientation is completed before taking an individual job assignment per ACA.
6. PRN Nurses – Turn in availability for scheduling in accordance with Collective Bargaining Agreement.
7. Swiping **In** and **Out** on the Time Clock – For **Accuracy**
8. Keep track of your sick time and paid vacation time. Vacations must be approved in advance. Payment slips must be completed by employee and signed by supervisor for all sick time, holidays, and vacations.

9. If you are injured on the job – notify your supervisor immediately. Follow Needle Stick Policy as required. Workers compensation injuries must be reported immediately or ASAP to your supervisor and/or PHS administrator.
10. If you are absent or late – notify your supervisor.
11. Employees are expected to be awake and alert at all times. Sleeping is NOT allowed on the job site, while working, and/or while on a break. Sleeping while on duty compromises care.
12. Telephones and computers are to be used for official PHS and Sheriff's Office business use only. Internet use (including browsing, checking your personal email account, streaming radio, and streaming video) is not authorized unless required to complete your PHS job duties.
13. PHS provides equal employment opportunities to all qualified employees and applicants for employment without regard to race, color, religion, sex, age, or national origin and extends to the disabled, disabled veterans, and veterans of the Vietnam era. Equal employment relates to all phases of employment, including but not limited to recruiting, placement, upgrading, demotion, transfer, termination, rates of pay or other forms of compensation, selection for training, educational assistance and use of all facilities and participation in company-sponsored employee activities.
14. Anyone who uses language or displays conduct (including any form of harassment) which reflects negatively on any race, color, religion, age, national origin, the disabled or veterans, including veterans of the Vietnam era may be subject to disciplinary actions up to and including discharge.
15. Employees must abide by the standards, rules, and regulations set forth in the PHS Business Ethics Manual and the Employee Handbook.

SCENARIOS

SCENARIO I:

REVIEW FREQUENTLY USED FORMS

(See Section 10)

SCENARIO II:

HEALTH RECORD SCAVENGER HUNT

- Finding a Health Record in Terminal Digit Filing
- Finding a Screeners
- Finding Loose Filing Paper

Rules: The trainer (i.e. Quality Coordinator or Supervisor of Health Information) will remind new employee of what possible areas a chart, screener, or loose filing may be filed and/or placed. In order to ensure a successful experience, the trainer should make sure that items for the test are placed available before the scenario begins.

You must find all charts, screeners, and loose filing paper without assistance. They may be in any location in any of the medical record rooms. Your skills in alphabetical order and terminal digit order will be utilized. Make sure that you study terminal digit and how to find a chart before your scavenger hunt begins.

- Three charts (pre-selected specially for training purposes) will be chosen for new employee to find.
- Five screeners (recently chosen by trainer) will be chosen for new employee to find.
- Three pieces of loose paper (recently chosen by trainer) will be chosen for new employee to find.

Any employee who has completed this exercise shall be considered capable of finding any loose filing papers, screeners, and charts for themselves. In the daily work environment, an employee must look first in all the obvious locations in medical records. For this test, you must find everything without assistance.

Find the following charts.

1. Active _____
2. Inactive _____
3. MD (other) _____

Find the following screeners (full name and date of screening provided).

1. Screener box _____
2. Charts-to-be-made cue _____
3. MRN# and not opened _____
4. IF (off-site) MRN# and chart not received yet _____
5. Other _____

Find the following loose filing papers (name and medical record number or screening date given).

1. MAR _____

2. Clinician's order _____

3. Other _____

ACKNOWLEDGMENT OF ABILITY TO LOCATE HEALTH RECORDS

Upon completion of the Medical Record Scavenger Hunt, the new employee has demonstrated knowledge of locating health records, screeners, and loose filing. The following documentation must be completed.

On _____, _____ has completed this Scenario.
(Date) (Print name of new employee)

Medical Record Scavenger Hunt for finding loose paper, screeners, and charts with **100% accuracy**.

New employee signature

Print name

Trainer signature

Date

(Orientation Instructions: The signature portion of this scenario is combined with closing signature pages of new employee orientation packet.)

CLOSING

**PRISON HEALTH SERVICES
NEW EMPLOYEE ORIENTATION CHECKLIST**

NAME: _____ **POSITION:** _____
(please print)

DATE: _____ **SITE/FACILITY:** _____

Comprehensive Knowledge Base
Overview of Correctional Health Care
Inmate Health Services and Special Needs
Confidentiality of Health Information and Health Records
Location of time clock and associated employment forms
Obtaining and Returning Keys to security
Facility Orientation – Santa Rita / Glenn Dyer Detention Facility
PHS Policy and Procedure Manual
Nursing Assessment Protocols, Diet Manual, Chronic Care Manual (as appropriate)
Pharmacy Manual – Formulary/Non-Formulary Rx’s (as appropriate)
Chronic Care and Specialty Clinics
Communications, phones, and directory
Health (Medical) Records – Chart Order
Documentation Requirements - Signatures
Daily assignments and work schedules
Nursing and Clinician Sick Call
Badge, its visibility, and dress code
Outpatient Housing Unit/ITR/Booking Orientation
Review of the Frequently Used Forms
Laboratory orientation (including lab form completion)
Continuing Education and Training Requirements
Pill Call and Medication Administration
Meetings – Monthly – All Staff and/or Provider
Employee Rights and Responsibilities
Universal/Standard Precautions
Occupation Exposure and Needle Stick Policy
Use of Personal Protective Equipment
Bio-hazardous Waste Disposal
Emergency Services and Suicide Prevention
<u>Other orientation:</u> Security procedures and regulations (safety procedures), Supervision of inmates, Signs of suicide risk and suicide precautions, Inmate rules and regulations, Key control, Rights and responsibilities of inmates, Emergency plans, Professional communication (interpersonal skills, communication skills and counseling techniques), Social/cultural lifestyles of the inmate population (Con Games), Cultural diversity, Safety procedures, Contraband regulations, Hostage Survival, History of ACSO, Illness and Injury Prevention, Fire Life Safety, ACSO Cardinal Sins, Sexual harassment and sexual misconduct awareness, Appropriate conduct with inmates, and Ethics.

I have reviewed the above referenced information. I had the opportunity to ask questions as needed to understand.

New Employee Signature

Witness/Orientation Instructor

PRISON HEALTH SERVICES – CRIMINAL JUSTICE MENTAL HEALTH

MENTAL HEALTH OBSERVATION TRAINING*

NAME: _____ **POSITION:** _____
(please print)

DATE: _____ **SITE/FACILITY:** _____

I have reviewed and have been trained in mental health observation. I have had the opportunity to ask questions as needed to understand. I acknowledge receipt of the Mental Health Observation Training handout prepared and presented by Criminal Justice Mental Health.

New Employee Signature

Witness/Orientation Instructor

**This training and signature is required for all RN's hired. LVN's may be given the same training in order for them to have a knowledge-base in mental health observation.*

SIGNATURE / STAMP RECORD

Record / Chart Signature: _____
(occupational signature and title)

Print Name: _____

Stamp Imprint: _____

Mar Initial: _____

Position / Shift Assigned: _____

Date of Information: _____
(today's date)

Computer Access

If needed, see PHS Administrative staff or designee for user ID assignment and password.

POLICY ON DOCUMENTATION FOR PRISON HEALTH SERVICES

Title: **DOCUMENTATION**

Policy: Employees are expected to complete all medical documents in accordance with PHS policies and procedures and with all accreditation standards and requirements.

Statement: Records and forms must be completed in a standardized and uniform fashion. This includes but is not limited to the following requirements:

- All entries must include place, date, time and be legible. All entries must include signature and title.
- Per PHS policy, all signatures must be accompanied by printed or stamped identification of the signature.
- A progress note must record all encounters. Documentation of patients note seen and why they were not seen must be recorded on the progress note.
- All forms must be completely filled out and each item addressed (i.e., transfers, public health, H&Ps, sick call requests, chronic care screeners). Special care must be taken with multiple forms – press hard for legibility.
- All documents in the record must include the inmate’s name, PFN number, housing unit, date of birth, allergies, and sex.
- Master Problem List must be filled out completely with each problem, date of onset, treatment plan, status of each problem, any allergies, and initials of the health professional entering the data.
- Progress notes must be in SOAP format.
- All finding, diagnoses, treatments, dispositions must be recorded.
- Reports of labs, x-rays, diagnostic studies and immunization records ordered must be in the patient’s record.
- Results of internal and external consultations must be completed and recorded.
- Patients with major medical problems (i.e., infirmity patients) require a recorded treatment plan.
- All physician orders must include all identifying information listed above and the status of the patient’s allergies. Orders must be legible and include start and stop dates. Special attention must be taken to prevent error, misreading, improper abbreviations and prescribing non-formulary items without prior approval.
- All verbal/telephone orders must be signed within 72 hours.
- Any encounter that generates a physician’s order must be cross-referenced to a progress note, written by the provider or the person taking the verbal/telephone order. The progress note must refer to the physician’s order and the reason for the order.
- Medication administration must have documentation of the names of the personnel administering or delivering the medication.
- Consent for medical service forms or release of responsibility forms must be obtained and completed.
- All medical records must be kept in the medical records department. Records must be removed from the medical records department consistent with record policies and procedures.

Orientation Manual

Employee Signature: _____ **Date:** _____

Print or Stamp Name: _____

MANTOUX TUBERCULIN SKIN TEST VIDEO

I have viewed the above video as a review on TB Skin testing which includes:

- 1 – Administer a Tuberculin Skin Test
- 2 – Read a Tuberculin Skin Test
- 3 – Interpretation of the Tuberculin Skin Test

I have received the above referenced information. I have had the opportunity to ask questions as needed to understand.

Date

Signature

Print/Stamp

ORIENTATION PROGRAM EVALUATION

NAME: _____ DATE: _____

Instruction Key: 4 = Excellent, 3 = Good, 2 = Fair, 1 = Poor

1. Did the program meet your educational needs? 4 3 2 1

If no, what particular needs were not met? _____

3. Where the scenarios helpful as learning tools? 4 3 2 1

4. How would you rate the program content? 4 3 2 1

5. How would you rate the time allotted for the program? 4 3 2 1

6. What did you enjoy most about the program? _____

7. What did you like least about the program? _____

8. Please provide any suggestions that you may have to improve the program.

Housing Unit Orientation Checklist

Each new employee is responsible for the items listed below.

Housing Unit Items to be Checked and Inventory
Manuals – Nursing Protocols, PHS Policy & Procedure Manual, Pharmacy Formulary, Diet Manual, and Chronic Care Manual
Pill Call, Sick Call, and documentation requirements
Emergency Services
AED Machine – under sink or standard location per site or area
Refrigerator Log – to be checked weekly and log completed
Emergency boxes – Grey (Pharmacy) Orange (Nursing Supply) check monthly and sign and date card on top of box
Descending Count Logs – to be checked Tuesdays and kept updated (staple removal kit, suture removal kit, Betadine bottle and alcohol bottle)
O2 Tank w/Log and Ambu-Bag – to be checked and logged on Tuesdays
Lab Supplies – in exam table drawers checked monthly
Wheelchair/gurney – either in each housing unit
1 pr crutches and 1 cane kept in bathroom
Signature/print/stamp name on all documents
AD-SEG Logs (i.e., HU 1, 2, 9, 24)– observations and documentation required daily
Blood Pressure Flow Sheets – kept up to date
Diabetic Finger Stick Flow Sheets – kept up to date
Master Problem List (kept updated)
Access to Health Care Signs (posted)
CPR mask on bulletin board
Check all open bottles for dates and initials (Normal Saline, Hydrogen Peroxide, Sterile Water, Betadine, Alcohol, Podofolin, Insulin-in refrigerator). All open bottles expire after 30 days.

Date Housing Unit Orientation completed: _____

New employee signature

Print/Stamp

I attest that the new employee named above has been oriented on all referenced activities, documentation, and inventory requirements. He/she has had an opportunity to observe and to ask questions as needed to understand obligations and requirements.

Scheduling Nurse/Supervisor/Designee

Print/Stamp

Prison Health Services, Inc.

New Employee Orientation

POST-TEST

Employee Name: _____
(please print)

Date: _____

Site Name: _____

1. Prison Health Services, Inc. (PHS) is the industry leader of the correctional managed healthcare industry. Since 1978, PHS has delivered value driven healthcare to numerous jails, prisons, and juvenile facilities across the United States.
 - a. True
 - b. False

2. “Privatization” of governmental functions or services has found growing favor at all levels and has taken on many forms. One of the more unusual forms of privatization involves the provision of healthcare services to inmates in prisons and jails.
 - a. True
 - b. False

3. The benefits to healthcare contracting can generally be grouped into three categories:
 - a. _____
 - b. _____
 - c. _____

4. The terms “jail” and “prison” are largely interchangeable.
 - a. True
 - b. False

5. Which of the following best describes the comparison of “jails to prisons”?
 - a. Small to big
 - b. New to old
 - c. Short to long
 - d. Good to bad

6. The term “standard precautions” are:
 - a. AKA “universal precautions”
 - b. Infection control precautions intended to minimize risk of exposure to bodily fluids and blood borne pathogens
 - c. Recommended by CDC and OSHA for all health care workers
 - d. All of the above

7. Examples of contraband include, but are not limited to the following: needles, syringes, Q-tips, tongue blades, alcohol wipes, any metal, and/or any glass.
 - a. True
 - b. False

8. Inmates working in the kitchen should not have:
 - a. Diarrhea
 - b. Skin infections
 - c. Runny nose
 - d. Hepatitis A or other infections transmissible by food or utensils
 - e. All of the above

9. Each site has an Emergency Plan. Emergency drills are executed:
 - a. Semiannually
 - b. Biannually
 - c. Annually
 - d. Quarterly

10. Which of the following is not reportable via an incident report?
 - a. Death of an inmate
 - b. Medication error
 - c. Employee injury
 - d. Injury of an inmate

11. Hand washing is considered the single most important procedure for preventing the transmission of germs.
 - a. True
 - b. False

12. The results of TB skin tests are recorded in:
 - a. Millimeters
 - b. Centimeters
 - c. Inches
 - d. Meters

13. Hazardous communication is accomplished by employee training and written materials in Material Safety Data Sheets (MSDS) for all chemical substances. The Sheriff's Office maintains these sheets and has them prominently displayed throughout the jail.
 - a. True
 - b. False

14. Examples of bio-hazardous waste include: body tissue, discarded sharps, contaminated solid waste, blood, body fluids, absorbent materials saturated with body fluids, and laboratory waste containing human disease causing agents.
 - a. True
 - b. False

15. The U.S. Supreme Court decisions in the 1970's determined that the right to adequate healthcare for inmates is protected by the 8th Amendment of the U.S. Constitution.
 - a. True
 - b. False

16. Regarding the "Right to Refuse Treatment," all of the following are true EXCEPT:
 - a. It is the responsibility of the healthcare staff to assure that inmates who refuse medical treatment understand the purpose of the proposed care, how the care will be provided, and the consequences and risk of their refusal.
 - b. In situations where the inmate refuses care and refuses to sign a Release of Responsibility Form (ROR), the nurse will document on the form and in a progress note that the inmate has refused treatment and refused to sign the release form. In addition, the nurse will obtain a witness signature attesting to the inmate's refusal to sign.
 - c. Inmates who refuse prescribed medication or treatment are not "entitled" to further access to healthcare.
 - d. A refusal of care, which could endanger the patient, should be reported to the medical director or designee for follow-up.

17. In the event of a medical emergency, as a good Samaritan, the on-site PHS healthcare staff may provide healthcare services to correctional staff and visitors within the facility to stabilize their health condition until EMS services arrive. PHS healthcare personnel should not be involved in providing routine services to anyone other than the inmate population.
 - a. True
 - b. False

18. All staff should be concerned with minimizing exposure of self and others to potentially dangerous situations and preventing accidents and injuries to staff and inmates. Which of the following is not true regarding safety issues?
- The healthcare service area must be locked when unoccupied.
 - Healthcare personnel are required to dress professionally. Revealing and tight clothing should be worn ONLY in maximum-security setting.
 - Healthcare personnel must maintain control of all keys and equipment. All keys must be returned before leaving the facility.
 - Never tell an inmate, his relatives, or others of an impending outside medical appointment or trip.
19. Which of the following is true of a person who has TB infection without active disease?
- Is not considered a case of active TB
 - Usually has a negative CXR
 - May develop the disease at any point in the future
 - All of the above
20. The following are examples of personal protective equipment that may be used to prevent the transmission of disease or germs: disposable gloves, gowns, masks, goggles, caps, and/or booties.
- True
 - False
21. In an effort to control massive lice outbreaks, all inmates upon intake into the facility should receive prophylactic treatment for ectoparasites.
- True
 - False
22. An employee safety manual including exposure categories and post-exposure instructions (MSDS) is available on the unit.
- True
 - False
23. Which of the following is not a sign of TB?
- Weight gain
 - Lethargy
 - Night sweats
 - Fever
24. All inmates upon initial intake into the facility must receive an intake screening. Which of the following would not be relevant to the screening?
- Current medications
 - Previous suicidal history
 - Recent injuries
 - Reason(s) for arrest or incarceration

25. PHS requires that all inmates be informed of the availability of healthcare and the mechanism for accessing health services both verbally and in writing. Which of the following is not true?
- The nurse completing the Receiving Screening Form verbally informs all inmates of available healthcare, during intake screening.
 - Any non-English/non-Spanish speaking inmates must rely on finding a fellow inmate for language translation services.
 - Bilingual signs are posted in the receiving area and in the housing units that explain how to access emergency and routine medical care.
 - The inmate requesting routine, non-emergent health care will fill out a Sick Call Slip (Medical Request), date and sign it, and return it to healthcare personnel for triage.
26. Correctional officers are responsible for ensuring that administered medications are actually swallowed.
- True
 - False
27. The special needs program serves a broad range of health conditions and problems that require personnel to design a program tailored to the individual inmate's needs. Individuals are followed and scheduled for chronic care clinics per procedure and/or as needed. All of the following illnesses should be followed except:
- Diabetes (DM)
 - HIV
 - Pregnant inmates
 - Hypertension (HTN)
 - Seizures (SZ)
28. Health records (medical records) should NEVER be removed from a facility or system except in accordance with the institutional policies or as required by law.
- True
 - False
29. All of the following are true regarding documentation in the inmate health record EXCEPT:
- Make all entries in pencil
 - The inmate's name, PFN (ID), and location must appear on every page
 - The time and date of all entries must be included
 - Sign, print, and stamp every entry that author, including professional title
30. When documenting an inmate encounter in SOAP format, the nurse should include a inmate's complaints in the "A" section.
- True
 - False

31. Inmates should be assessed for suicide ideation upon intake into the facility.
- True
 - False
32. Healthcare staff will evaluate all inmates who are segregated from the general population as often as required by the facility but not less than three times per week.
- True
 - False
33. Which of the following is in exact alphabetical order?
- Garcia, Jose; Garciapadilla, Manuel; Gardner, Michael; Gaines, Victor
 - Gonzalez, Juan H.; Gonzales, Juan L.; Lopez, Ricardo V.; Lopes, Richard
 - Miller, Joseph A; Miller, John A; McDonald, Lawrence; McDonald, Larry
 - Smit, Eduard A; Smith, Edward Allen; Smythe, Victor; Smythe, Valerie
34. Which of the following is an example of an inmate's prisoner identification (PFN)?
- S06A15
 - UKA743
 - P47707
 - ATI846
 - Answers b and d
35. Which of the following is NOT an example of a medical record number?
- 12-31-52
 - 11/24/63
 - 11-24-63
 - 09-08-03
36. Nurses, laboratory technicians, and medical assistants are trained and expected to find a chart, a screener, or loose filing paper if they need it.
- True
 - False
37. When you are looking for a chart, from left to right on the shelving, which of the following Terminal Digit number sequences is in correct filing order?
- 12-95-04; 08-95-08; 05-51-25; 11-24-25
 - 07-54-92; 08-54-92; 09-53-94; 08-53-94
 - 10-25-56; 11-25-56; 08-25-57; 09-25-56
 - 09-36-54; 08-37-54; 09-37-55; 10-36-57

38. Which of the following are signs and symptoms of suicidal ideation?
- Despair and hopelessness
 - Past history of suicidal attempt(s)
 - Verbalization of a suicide plan
 - Depression, withdrawal, lethargy, indifference to surroundings
 - Sudden improvement in mood following a period of depression
 - Loss of interest in personal hygiene and daily activities
 - All of the above
39. At facilities operated by the Alameda County Sheriff's Office, mental health services are provided by Criminal Justice Mental Health, an Alameda County agency.
- True
 - False
40. Alcohol withdrawal is the abstinence syndrome with the highest mortality rate.
- True
 - False
41. Prenatal inmates are not provided healthcare by a qualified healthcare practitioner.
- True
 - False
42. Confidentiality includes:
- Conversing about inmate's health in private areas and not in the presence of other inmates
 - Conversing with only those who have a need to know
 - Not revealing who is in the jail or the dates and times of their appointments for medical care
 - Sharing with Sheriff's Office staff only that information for which there is need to know.
 - All of the above
43. Unless otherwise required by law, a signed authorization for release of health information is required before any inmate health information can be shared or released.
- True
 - False
44. In regard to an inmate's health record, is this statement true? "If it was not documented, it didn't happen"
- True
 - False

New Employee Orientation

Post – Test Answer Key

- | | |
|---------------------------------------|-----------|
| 1. True | 23. A |
| 2. True | 24. D |
| 3. Operational, Managerial, Financial | 25. B |
| 4. False | 26. False |
| 5. C | 27. C |
| 6. D | 28. True |
| 7. True | 29. A |
| 8. E | 30. False |
| 9. C | 31. True |
| 10. C | 32. True |
| 11. True | 33. D |
| 12. A | 34. E |
| 13. True | 35. B |
| 14. True | 36. True |
| 15. True | 37. D |
| 16. C | 38. G |
| 17. True | 39. True |
| 18. B | 40. True |
| 19. D | 41. False |
| 20. True | 42. E |
| 21. False | 43. True |
| 22. True | 44. True |

FREQUENTLY USED FORMS
(SCENARIO I)