**HEALTH CARE**

Policy & Procedure Manual

*Note:* Proactive Health Care Medicine, PLLC maintains a contractual relationship with NaphCare, Inc. to provide administrative and management services on behalf of Proactive Health Care Medicine, PLLC. As part of the services rendered by NaphCare, Inc., there are various NaphCare, Inc. contacts listed within these policies and procedures to assist Proactive Health Care Medicine, PLLC personnel in providing necessary health care services.
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GLOSSARY
INTRODUCTION

About Proactive Health Care Medicine, PLLC
Proactive Health Care Medicine, PLLC (“Proactive”) is a physician owned New York Company formed in 2019 providing comprehensive healthcare programs in correctional settings with a primary goal of ensuring quality of health care in compliance with the National Commission of Correctional Health Care (NCCHC), the American Correctional Association (ACA), and all applicable local, state and federal regulations.

Approval of Policies and Procedures
This policy and procedure manual has been developed by administrative, legal, and clinical staff, in conjunction with the on-site Medical Director and Health Services Administrator. This manual constitutes a composite of policies and procedures, which are applicable to the total operation of the healthcare unit. Accordingly, they are hereby set forth as guidelines, which are to be used by Proactive personnel in dealing with routine and non-routine activities.

Core Values
Integrity: We will conduct ourselves in an honest, fair and ethical manner in our dealings with each other, our clients, and the inmates entrusted to our care.

Respect for the Individual: We value human dignity, recognize individual contributions, and encourage professional and personal growth.

Commitment to Excellence: We provide high-quality care, personalized support, and cost-saving solutions while always meeting or exceeding constitutional standards.

Accountability: We hold each other and ourselves responsible for our actions.

Innovation: We endeavor to find creative and efficient ways to advance our services while reducing costs to our business partners and consumers.

Mission Statement
Proactive is a governmental contractor supplying healthcare professionals and state of the art technology for the delivery of budget conscious correctional healthcare.

Proactive Health Care Medicine, PLLC Philosophy
Proactive delivers customized healthcare solutions for our prison and jail partners by continuously evaluating and enhancing our program to adapt to each facility's unique, as well as evolving, medical standards.

The Foundation of Quality Health Care Services
Proactive is dedicated to having a strong foundation from which to provide quality health care at each facility we serve. Our model of health care is patient-centered and evidence-based, emphasizing prevention, continuity of care, and partnership. Our policies and procedures are written to ensure compliance with NCCHC and ACA standards.
We understand, however, that the foundation is not complete without the skills of qualified healthcare staff. Proactive is proud of our staff. We hire licensed, qualified healthcare staff that exemplify the characteristics we want to represent Proactive. We want our employees to reach their full potential with Proactive, so we provide comprehensive, correctional-specific education that complies with NCCHC and ACA education standards for certification. Proactive offers the opportunity to work in an environment in which healthcare personnel are afforded the tools they need to perform at a high level of competence.

The combination of our medical program with our personnel provides the optimum level of care, efficiency, accountability, and compliance for our clients.

Using This Manual
This policy and procedure manual is structured to be user friendly and easily accessible concerning Proactive policies, procedures, and forms. Corporate policies are integrated with applicable procedures, which may also be followed, by site-specific policy supplements or addendums.

Proactive health care staff credentialed to provide services in that specified field of care, will only use these policies, procedures, and forms. In the event Proactive does not provide a specific discipline of service, Proactive staff will not enact the aspect of the policy and procedure pertaining to that specified discipline. These policies, procedures, and forms are confidential and will not be provided to non-Proactive staff unless explicitly stated in a procedure approved by the corporate office.

Updates to any aspect of this manual will be provided to each facility identifying the change and effective date of such change. All Proactive health care staff must review and sign off on the Policy and Procedure Review Sheet.

Relevant Forms
- Policy and Procedure Sheet
Section A: Governance and Administration

J-A-01 Access to Care

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Access to Care (J-A-01)
NCCHC MH Standard: Access to Care (MH-A-01)
NCCHC Opioid Standard: Access to Care (O-A-01)
ACA Standard: Access to Care (4-ALDF-4C-01-02)

Purpose

To ensure that all patients have access to health care for serious medical, dental, and mental health needs in a timely fashion to include treatment for opioid and other substance use disorders as clinically indicated.

Policy

It is the policy of Proactive to provide health care to patients in a timely manner and with privacy while practicing within the scope of each employee’s professional licensure.

Procedure

1) Unreasonable barriers to a patient’s access to health care services will be identified and eliminated by the responsible health authority. Those barriers may include, but are not limited to:
   a) Punishing patients for seeking care for their serious health needs;
   b) Deterring patients from seeking care for their serious health needs;
   c) Permitting unreasonable delays before patients are seen by prescribing providers or outside consultants to obtain necessary diagnostic work or treatment for their serious health needs;
   d) Interfering with prompt transmittal to health care staff of a patient’s oral or written request for care; and
   e) Making pill lines excessively long, delaying sick call appointments unreasonably, or creating ongoing conflicts between sick call or appointments and other programmatic schedules.
2) The Health Services Administrator/designee will notify the corporate office of any potential barriers to access of care.
3) Proactive will work with custody to address any facility access to care issues, such as centralizing patients undergoing withdrawal.
4) If a fee-for-service program is in place, indigent patients will receive clinically appropriate care regardless of ability to pay.

Related Forms

No relevant forms for this policy,

References


Section A: Governance and Administration

J-A-02 Responsible Health Authority

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Responsible Health Authority (J-A-02)
NCCHC Opioid Standard: Responsible Health Authority (O-A-02)
NCCHC MH Standard: Responsible Mental Health Authority (MH-A-02)
ACA Standard: Health Authority (4-ALDF-4D-01)

Purpose
To establish the authority responsible for the provision of health care services within the correctional institution.

Policy
Pursuant to a contract Proactive is responsible for the coordination and provision of health care services at the correctional institution.

Procedure
1) The onsite Proactive Health Services Administrator (HSA) is typically designated the responsible health authority (RHA) and program sponsor, where applicable. He or she has responsibility for arranging all levels of quality health care ensuring accessibility of timely health care to all patients. The responsible health care authority is responsible for managing the delivery of contract services, supervision of personnel, and liaison services within the institution.
2) The responsibilities of the HSA are documented in written job descriptions.
3) The HSA is onsite at least weekly.
4) All licensed advanced clinical providers providing health care on site will maintain responsibility in all matters of clinical judgment in their specialty regarding the treatment provided to each patient; however, final clinical judgment rests solely with the Medical Director, regardless of specialty. Non-health care personnel will not make any medical decisions.
5) For instances in which there is a separate organization for mental health and substance abuse services, there is a designated mental health clinician.
6) In instances where Proactive’s Mental Health standards apply, the RHA is also the RMHA and is on site at a minimum of twice weekly.
7) In facilities with onsite Opioid Treatment Program Services, the HSA/program sponsor agrees on behalf of the site to adhere to federal regulations as set forth in 42 CFR 8.12.
8) Where there is a separate organization for dental services, there is a designated dental clinician.
9) The responsible physician and designated mental health and dental clinicians, when applicable, is available to the facility frequently enough to fulfill the positions’ clinical and administrative responsibilities.

Related Forms

No relevant forms for this policy,

References


Section A: Governance and Administration

J-A-03 Medical Autonomy

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medical Autonomy (J-A-03)

NCCHC Opioid Standard: Medical Autonomy (O-A-03)

NCCHC MH Standard: Clinical Autonomy (MH-A-03)

ACA Standard: Provision of Treatment (4-ALDF-4D-02)

Purpose

To ensure that health care decisions are made by qualified health care professionals for clinical purposes.

Policy

Health care delivery in the correctional environment is unique. Proactive will provide appropriate and timely health care services in an environment that encourages mutual trust and cooperation and conforms to security regulations.

Procedure

1) All decisions related to the safe and effective delivery of, access to, or the quality of health care services are made by qualified health care professionals in concurrence with the responsible health care authority.
   a) If the responsible health care authority is other than a physician, clinical judgments clinical decisions rest with the designated licensed Medical Director regardless of specialty;
   b) Decisions on the type of treatment and need for transfer to outside resources will be the responsibility of the advanced clinical provider.
2) Clinical decisions and their implementation related to mental health care is completed in a safe and effective manner, supported by custody staff.
3) All administrative decisions are coordinated, if necessary, with clinical needs so that patient care is not jeopardized.
4) Proactive staff will work in conjunction with the institutional authority for cases in which security concerns and medical management of the patient are in conflict to ensure that security considerations do not compromise decisions and actions regarding necessary health care for patients.
5) All medical, dental, and mental health staff are expected to understand and comply with all security regulations.
6) Proactive and the institutional authority will address any policies and procedures that deny direct medical orders. This includes all policies and procedures that interfere with the delivery of, the access to, or the quality of health care services deemed necessary by the Health Services Administrator and/or the advanced clinical provider.

Related Forms

No relevant forms for this policy,

References


Section A: Governance and Administration

J-A-04 Administrative Meetings and Reports

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Administrative Meetings and Reports (J-A-04)
NCCHC Opioid Standard: Administrative Meetings and Reports (O-A-04)
NCCHC MH Standard: Administrative Meetings and Reports (MH-A-04)
ACA Standard: Quarterly Meetings, Statistical Reports (4-ALDF-7D-26)

Purpose
To ensure ongoing communication and cooperative efforts between and among the institutional authority and Proactive professionals to enhance health care services.

Policy
All health care services are discussed at administrative meetings, including medical, mental health, dental, and substance abuse services where applicable. In addition, health care meetings are held to review administrative issues.

Procedure
MEETINGS
1) The Health Services Administrator and any appropriate Proactive staff, along with the institution staff as appropriate, will attend administrative meetings. If mental health operates under a structure separate from other health services, but does not attend institutional administrative meetings, a separate meeting between the responsible health authority and mental health will be conducted. The same applies for substance abuse services, including opioid treatment programs.
2) Administrative meetings will be held quarterly, at a minimum, and are to include:
   a) The Health Services Administrator as the chairperson of the meeting;
   b) The Medical Director, along with other key Proactive staff to include the Mental Health Authority;
   c) The institutional authority, along with other designated institutional staff;
   d) Any guests as deemed appropriate by the Medical Director, Health Services Administrator, Proactive corporate office, or institutional authority;
   e) Topics for review, include, but are not limited to:
      Review of quality improvement reports, as appropriate:
         i) Infection control;
ii) Patient grievances and concerns;
iii) Environmental inspection reports;
iv) Reports of unmet scheduled clinical appointments;
v) Review of recent emergency drills, as appropriate;
vi) Review of utilization reports, including onsite services, off-site services, status of pending consultations, access to health care issues, pharmacy audits, and all other utilization activities; and
vii) Monthly statistical reports are included and used to monitor trends in the delivery of health care.

f) Minutes of meetings are to be kept and forwarded to the corporate Utilization Management Nurse and the institutional authority, as requested, by the Health Services Administrator.

3) Proactive staff meetings will be held monthly, at a minimum, as follows:
   a) The Health Services Administrator will be the chairperson of the meeting.
   b) A regularly scheduled date will be established and attendance will be mandated for all onsite Proactive staff.
   c) Meetings will be held to accommodate shifts, each month (e.g., January – first shift, February – second shift, March – third shift, etc.) in order to allow all staff members access to administrative issues.
   d) Minutes will be kept and saved to the SharePoint NCCHC folder after submitting them to the corporate office. Minutes will also be available for review by all Proactive staff absent from the institution at the time of the meeting with an attendance sheet to sign.
   e) Each staff member will have input into the Monthly Staff Meetings by providing written information pertaining to staff issues, concerns, requests, and complaints to be given directly to the Health Services Administrator one (1) week prior to the scheduled meeting.
   f) Mental health staff will attend staff meetings and issues regarding mental health can be discussed at that time.
   g) Substance abuse services staff, including opioid treatment program staff, will attend staff meetings and issues regarding these services can be discussed at that time.

4) The Health Services Administrator will collect and maintain data for a monthly statistical report, which is essential to Proactive’s commitment to providing quality health care services to patients in correctional institutions.

5) Statistical reports should include:
   a) The use of health care services by category;
   b) Referrals to specialists;
   c) Deaths;
   d) Tracking of clinical data regarding infectious diseases (e.g., HIV, STDs, TB, and other high-risk populations);
e) Emergency services provided to patients, if applicable;
f) Dental procedures performed;
g) Laboratory tests completed;
h) Radiology tests completed;
i) Infirmary admissions, if applicable;
j) Observation admissions, if applicable;
k) Hospital admissions, if applicable;
l) Off-site transports;
m) Scheduling of chronic care patients;
n) Scheduling of required health assessments, PPD testing, OB/GYN or other periodic services;
o) Health services utilization;
p) Mental health services utilization, if applicable, with particular attention to diagnosis, medication profiles, involuntary medication, restraints; on-call schedules, etc.;
q) Substance abuse statistics including number of patients on withdrawal protocols, number of patients on medication assisted therapy, and referrals made to medication assisted programs;
r) Health care grievances;
s) Use of force examinations; and
t) Staffing analysis, including productivity.

STANDING COMMITTEES
1) Each institution will establish standing committees pertaining to the delivery of health care to include the following areas:
   a) Medical Administrative Committee;
   b) Continuous Quality Improvement Committee; and
   c) Infection Control.
2) Composition of standing committees will be as required by standard operating procedures and will meet at the indicated frequency. Minutes of meetings will be maintained for at least three (3) years.
3) Proactive’s corporate office or institution Health Services Administrator may establish other committees from time to time for purposes of improving communication, organizing more effective health care delivery, or addressing other needs as deemed necessary.
4) All Committee developed within an institution, involving Proactive staff, will be documented by policy and procedure addendum with composition, schedule, purpose, and minutes documented and maintained for two years.

Related Forms

Facility Meeting List
MAC Meeting Guidelines and Agenda

MAC Meeting Template

CQI Meeting Template

Staff Meeting Guidelines and Agenda

References


Section A: Governance and Administration

J-A-05 Policies and Procedures

Effective Date: 01/01/2020

Policy Revised:


NCCHC Opioid Standard: Policies and Procedures (O-A-05)


ACA Standard: Health Authority (4-ALDF-4D-01); Goals and Objectives (4-ALDF-7D-06)

Purpose

To establish a compilation of health care policies and procedures pertinent to the delivery of health care.

Policy

Proactive will utilize and make available to health care staff a compilation of health care policies and procedures to establish a uniform method for the delivery of health care to patients confined in correctional institutions.

Procedure

1) Proactive’s policies and procedures will include, but are not limited to, summaries of applicable laws and administrative rules relevant to the delivery of health care to patients. Proactive’s health care policies and standard operating procedures; and approved health care forms. The Health Services Administrator in conjunction with corporate staff will develop policy addendums as necessary to carry out the standard operating procedures (SOP) specific to each site. These addendums will ensure that health policies and procedures are congruent with institutional policies and procedures.

2) Any and all policy addendums, revisions, or additions must be submitted to and approved by the Corporate Policy and Procedure Committee prior to implementation. Committee members at a minimum include:
   a) Director of Accreditation
   b) Chief Medical Officer(s)
   c) Chief Operating Officer

3) In the event a site-specific addendum requires immediate implementation, the Director of Accreditation should be notified with all information needed. The addendum will be added by the Director of Accreditation and the information will be sent to the rest of the committee for review.
4) A site’s compilation of policies and addendums requires annual review by the Health Services Administrator/Program Sponsor and the onsite Medical Director. Mental health policies shall additionally be reviewed by the senior mental health staff member and the facility psychiatrist, if available, or Mental Health Authority. These individuals must sign the Policy and Procedure Review Sheet. Any revisions must be approved at the corporate level.

5) Policy addendums will be shown beneath their associated standard operating procedure.

6) Policy addendums may include the following:
   a) Orientation of health staff;
   b) Sick call;
   c) Emergency response;
   d) Infirmary care;
   e) Medication administration and distribution;
   f) Needle and sharps control;
   g) Dental emergencies;
   h) Infection control program;
   i) Chronic care;
   j) Access to pharmacy after hours;
   k) Therapeutic seclusion;
   l) Therapeutic restraint;
   m) Environment health and safety;
   n) Suicide prevention;
   o) Patient food service worker clearance; and
   p) Emergency contact, staff, local facility, and pharmacies telephone numbers.

7) Proactive will publish and review at least annually, and will update as necessary, the compilation of health care policies and procedures. Any new and/or revised components will be available to every institution and all involved staff will be notified of these changes. The compilation will bear the date of review. The Health Services Administrator and responsible physician will sign a policy and procedure manual review sheet following any revisions.

8) Policies are available for all health staff and can be accessed on NaphCare Online.

9) No individual facility will implement institutional health care policies and procedures or develop any additional form for the provision of health care services, which conflict with Proactive’s health care policies and procedures without the prior approval of Proactive’s Corporate Policy and Procedure Committee.

10) The compilation of health care policies and procedure will be made accessible to all health care staff. All staff members will indicate their review of the policies, procedures, and site-specific addendums by acknowledging their understanding on Proactive’s University Learning Center within the first thirty (30) days of their employment. A copy of this
acknowledgement will be kept electronically in the employee’s education file in Proactive University.

11) Policies will be reviewed by all health staff when a new policy is introduced or revisions are made. Policy and procedures are also reviewed annually by staff members. In the event only specific policies are revised, those policies may be introduced to staff during the monthly staff meeting and a signed acknowledgement will be obtained. A signature on a signed acknowledgement is acceptable documentation.

FORMS
1) Proactive’s health care policies and procedures will include references to forms that are to be used by health care staff in the delivery of care to patients.
2) All forms will be available to the facilities through NaphCare online.
3) An “emergency box” will be made available by the corporate office to each facility, which will contain copies of all pertinent forms to be used in the event of an emergency or natural disaster situation (i.e., tornado, hurricane, power outage, etc.). Should an emergency occur wherein the supplies are used, the facility is to contact the corporate office for restocking purposes.
4) Clinical information should be directly entered into TechCare. Printed forms should be used only when this is not feasible or when an analogous form or module is not available in TechCare.
   a) Any printed patient-specific forms will be signed and dated by the appropriate personnel, scanned and inserted into the patient’s TechCare record.

Related Forms

No relevant forms for this policy,

References


Section A: Governance and Administration

J-A-06 Continuous Quality Improvement Program

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Continuous Quality Improvement Program (J-A-06)
NCCHC Opioid Standard: Continuous Quality Improvement Program (O-A-06)
NCCHC MH Standard: Continuous Quality Improvement Program (MH-A-06); Patient Escort (MH-E-08)
ACA Standard: Health Care Internal Review and Quality Assurance (4-ALDF-4D-24)

Purpose
To establish and implement a continuous quality improvement (CQI) program to monitor, evaluate, and improve efficiency, cost-effectiveness, appropriateness, and quality of health care services.

Policy
The CQI program will monitor health care delivery objectively and systematically to improve patient care and resolve identified problems.

Procedure
INSTITUTIONAL CQI COMMITTEE

1) A CQI program is to be implemented in all institutions to identify problems, implement and monitor corrective action, and study its effectiveness.

2) The institutional CQI Committee will meet at least quarterly. Meetings can be held in conjunction with other meetings, such as monthly staff meetings or institutional MAC meetings, to allow maximum participation. This committee must keep minutes that should be sent to the corporate office to the “audits” email for review. Minutes will be reviewed by each committee member and results of the CQI findings will be shared with the medical staff during staff meetings. The minutes will be kept on file for three (3) years as confidential property of Proactive.

3) The institutional CQI committee will be responsible for:
   a) Identify aspects of health care in the facility to monitor and establish thresholds of performance;
   b) Design and complete quality improvement monitoring activities;
   c) Analyze the results of the findings of monitoring and determine any factors that may have contributed to results less than set thresholds;
d) Designs and implements a corrective action plan to correct identified problems; and,
e) Determine time frame to monitor implemented corrective action plan in the form of either a process and/or outcome quality improvement study.

4) CQI training will be provided to the Health Service Administrator by the Accreditation and Compliance Department. The Health Services Administrator will be responsible for ongoing training of all institutional staff.

5) The corporate Accreditation and Compliance Department will be available to each site and assist in both training and assisting in the development of monitoring templates for each site as needed.

6) All institutional Proactive staff will participate in CQI activities whether or not they are Institutional CQI Committee members.

7) The Health Services Administrator will chair the Institutional CQI Committee and will ensure that a monthly CQI report will be developed based on the activities and actions of the CQI Committee. This report is to include:
   a) Issues identified by the Institution CQI Committee; and
   b) Details of what has been done, what is being done, and what will be done to address identified needs, including preventative and problem-solving activities.

8) The institution CQI Committee will include (variances from this composition are allowed for institutions where some of these positions are not represented on staff):
   a) Institution Administrator/Designee;
   b) Institution security representative;
   c) Medical Director;
   d) Health Services Administrator;
   e) Director of nursing, if applicable;
   f) Medical Records Clerk, if applicable;
   g) Mental Health CQI staff;
   h) Substance Abuse/Opioid Treatment Program Staff, if applicable; and
   i) Other institutional staff as locally determined.

9) Health record reviews are done under the guidance of the responsible physician or designee to ensure that appropriate care is ordered and implemented and that care is coordinated with all staff, including medical, dental, mental health, and nursing.

10) The responsible physician is involved in the CQI program.

11) CQI activities will focus on:
   a) Establishing standards for clinical performance;
   b) Increasing clinical and operational productivity;
   c) Ensuring cost-effective processes;
   d) Monitoring utilization, resource consumption, and clinical practice patterns;
   e) Ensuring appropriate admissions to internal or external skilled nursing facilities, including community hospitals, with adequate justification for length of stay;
f) Ensuring timely collection and reposting of accurate information for clinical and financial decision-making;
g) Implementing discharge-planning efforts to streamline hospitalizations;
h) Identifying high-risk patients;
i) Trends regarding missed appointments due to unavailability of escort staff resulting in missed appointments;
j) Providing quality care;
k) Recommending quality issues that may be appropriate for clinical updates, policy and/or procedure change; and
l) At least one process and/or outcome study will be completed annually.

12) Components of the CQI program will include:
   a) Utilization management review;
   b) Health record review;
   c) Risk management activities;
   d) Mortality review; and
   e) Staff development

13) An annual review of the effectiveness of the CQI program will be done each January for the previous year. The committee will review the previous years’ CQI studies, CQI minutes, administrative and/or staff meetings and any other pertinent materials, to include an annual review of inmate deaths and serious incidents involving inmates with Mental illness and/or substance abuse and medication assisted therapy. The review will be documented in January’s CQI meeting minutes.

Related Forms

Corrective Action Plan

References


**Section A: Governance and Administration**

**J-A-07 Privacy of Care**

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Privacy of Care (J-A-07)
NCCHC Opioid Standard: Privacy of Care (O-A-07)
NCCHC MH Standard: Privacy of Care (MH-A-09)
ACA Standard: Privacy (4-ALDF-4D-20)

**Purpose**

To assure that health care is provided with consideration of patient dignity and feelings.

**Policy**

Health care staff will provide privacy as indicated by the nature of the health care issue, consistent with security requirements.

**Procedure**

1) Medical procedures and discussions will be performed in a private room whenever possible, with consideration for the safety and security of the health care provider, patient and security personnel. All medical services, including history taking, will be conducted in an area private enough to ensure the patient will feel free to discuss problems.

2) Privacy (e.g., privacy screen, curtain, private area) should be afforded during physical exams, with special considerations for pelvic, rectal, breast, or other genital exams.

3) Security personnel will be in the immediate area only when security is a concern. A security screen may be used as an additional privacy barrier.

4) Instruction on maintaining confidentiality will be given to interpreters who observe or hear health encounters.

5) When indicated, a chaperone, preferably of the opposite gender from an advanced clinical provider, will be present for personal body area exams (e.g., pelvic exam by male physician).

6) Mental health services should be conducted in private and not observed by security personnel unless the patient poses a safety risk to himself/herself or the providers of care.

7) If effective communication is compromised due to deficits in speech, hearing, or inability to communicate in the same language, arrangements should be made for an interpreter or assistive device. The selection process for a form of assistance or interpreter should reflect the patient’s communication preference and desire for privacy.
8) The use of other patients should be discouraged and used only in urgent and emergency situations.

Related Forms

No relevant forms for this policy,

References


Section A: Governance and Administration

J-A-08 Health Records - Documentation of Telemedicine for Inmate Care

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Health Records (J-A-08)

NCCHC Opioid Standard: OTP Record Format and Contents (O-H-01); Confidentiality of OTP Records and Information (O-H-02); Management of Health Records (O-H-03); Access to Custody Information (O-H-04)

NCCHC MH Standard: Clinical Record Format and Contents (MH-H-01); Confidentiality of Clinical Records and Information (MH-H-02); Management of Mental Health Information (MH-H-03); Access to custody Information (MH-H-04)

ACA Standard: None

Purpose

To ensure that proper guidelines are followed for all patients receiving health care treatment through the use of telemedicine.

Policy

The use of telemedicine technology will be utilized in a manner that ensures quality patient care, patient confidentiality, and timely access to providers.

Procedure

GENERAL PROCEDURES
1) Proactive staff at facilities participating in the use of telemedicine will be trained in all areas to include patient confidentiality and HIPAA compliance, use of technology, scheduling, and procedures for patient care.
2) Providers will have full access to the EHR prior to and during the encounter. All orders and documentation will be entered directly into the patient’s EHR.
3) Non-Comprehensive Proactive Sites – Providers will be allowed access to all requested patient health records prior to the telemedicine encounter. Documentation and orders will be faxed and mailed to the site and scanned into the patient’s health record and become part of the permanent record.
4) Care that is beyond the scope of telemedicine will be addressed at the site through onsite providers, Proactive’s specialist consultation network, or contracted Emergency Department’s if indicated.

PROCESS STANDARDS AND PROCEDURES FOR TELEMEDICINE ENCOUNTERS
1) Preparation
   a) On-site staff will perform the following functions:
      i) Explain the telemedicine concept to the patient and do an initial evaluation on the patient’s appropriateness for a telemedicine encounter;
      ii) Prepare the inmate in any way needed before the encounter;
      iii) Position the patient to maximize visualization by the provider, in accordance with the type of provider specialty.

2) Identification
   a) Onsite staff will verify the patient’s identity to the provider;
   b) The provider will identify him/herself to the patient, including name, provider type, specialty if any, and city and state of provider.

3) Consent and appropriateness for telemedicine
   a) The provider will obtain informed consent for the telemedicine encounter;
   b) The provider will confirm if the patient is appropriate for a telemedicine encounter.

4) Privacy/Physical environment
   a) All effort will be made to ensure privacy for the encounter, as appropriate for the nature of the encounter;
   b) If security or health care personnel must be in the room for the encounter, the reason for this will be explained to the patient.

5) Documentation
   a) Onsite health care personnel will document their end of the telemedicine encounter in TechCare.
   b) The provider will document the encounter in the appropriate manner in TechCare.

Related Forms
No relevant forms for this policy.

References


Clinical Record Format and Contents (MH-H-01); Confidentiality of Clinical Records and Information (MH-H-02); Management of Mental Health Information (MH-H-03); Access to

American Telemedicine Association
Section A: Governance and Administration

J-A-08 Health Records

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Health Records (J-A-08)

NCCHC Opioid Standard: OTP Record Format and Contents (O-H-01); Confidentiality of OTP Records and Information (O-H-02); Management of Health Records (O-H-03); Access to Custody Information (O-H-04)

NCCHC MH Standard: Clinical Record Format and Contents (MH-H-01); Confidentiality of Clinical Records and Information (MH-H-02); Management of Mental Health Information (MH-H-03); Access to custody Information (MH-H-04)

ACA Standard: None

Purpose

To ensure that appropriate health care documentation will be used and maintained in uniform order in the patient’s health record.

Policy

Proactive will develop and maintain an approved permanent health record for each patient who receives health care provided by Proactive using an electronic medical record system – TechCare – to documents all possible aspects of care.

Procedure

TECHCARE

1) The Health Services Administrator will be provided with a demo version of TechCare at the facility.
2) Access to health records and health information is controlled by the RHA.
3) All medical staff receive HIPAA training regarding privacy of medical information and patient records.
4) Announcements will be made to the facility by Proactive’s IT Department regarding any new additions, revisions, or programming changes to TechCare.
5) The facility will be provided with proper orientation and training on the current version of TechCare and updated as necessary by the corporate office.
6) Technical support for TechCare is available through email to HelpDesk@naphcare.com.
7) All patient health records and medication administration records are to be documented and managed through TechCare to the extent the system allows.
8) The computers used for electronic medication administration are to remain on the docking station until the medication administration procedures begin and should be returned to the docking station for syncing immediately following the administration of the medication, thus allowing the information to download into TechCare.

9) Each TechCare user will be issued a log-in username and password which will allow sign-on to the system. It is the user’s responsibility to keep login and password information confidential. Each login password will be changed every 90 days for security purposes.

10) A TechCare User Manual is available to all facilities for instruction on the use of the TechCare system.

11) Should the serve fail at the facility for any reason, TechCare will automatically run through the Proactive corporate server. A message will be displayed on the computer at the facility showing that the system is running through the corporate server. All functions will be available in TechCare except for printing and scanning. The facility will not have those capabilities through the Corporate Server.

HEALTH RECORD DOCUMENTATION

1) The responsible health authority or designee approves the method of recording entries in the health record, and the health record contents and format are consistent with corporate policies and procedures.

2) At a minimum, the patient’s health record shall contain all clinical documentation generated during the patient’s period of incarceration. This will include the following as applicable:
   a) Identifying information (e.g., name, documentation number, date of birth, sex);
   b) A problem list containing all diagnoses, treatments, and dispositions;
   c) A list of known allergies;
   d) Pre-booking triage documentation including medical and mental health screen/assessment and comprehensive nurse exam;
   e) All progress notes of findings, diagnoses, treatments and dispositions;
   f) Physician orders;
   g) Medication administration record to include all medications, new and old, and treatments;
   h) Laboratory, x-ray, and diagnostic reports;
   i) Flow sheets;
   j) Informed consent and/or release of responsibility forms;
   k) Authorizations for release of health information pursuant to HIPAA;
   l) Pending consultations;
   m) Off-site health care and emergency treatment referral and discharge summaries;
   n) Treatment plan and medical restrictions;
   o) Immunization record;
   p) Place, date, and time of each clinical encounter;
   q) Signature and title of each documenter;
r) Mental health evaluation;
s) Health assessment;
t) Use of force examination;
u) Eye examination or consults;
v) Dental intake examination; and
w) Any other miscellaneous records or treatment information.

3) Pertinent information contained in any prior paper or electronic chart will be integrate with or scanned and uploaded to TechCare. Any remaining paper chart will be maintained, pursuant to Proactive’s paper record filing procedures (below).

4) All mental health and dental records will be maintained in the patient’s health record. If mental health and/or dental services are provided by a separate vendor, a process to integrate or share needed information will be indicated in site-specific procedures.

5) All health records, either electronic or otherwise, will be maintained in a confidential and secure manner in a physically secure area under the immediate control of health care staff and will be kept separately from custody records.

6) Health records will be readily available to health care staff as needed to provide appropriate patient care.

Figure: Screenshot of main TechCare interface showing a patient summary, including medical history, diagnostics results, current medications, allergies, and patient flags.
ELECTRONIC RECORD INTAKE/BOOKING PROCEDURES

1) A uniform identification system approved by the correctional institution will be maintained for filing to ensure the prompt location of the patient’s health record.

2) Following screens/assessments performed at intake/booking, the patient will be flagged and cued up for administration of the health assessment as well as the mental health evaluation, if indicate, within fourteen (14) days.

3) An approval log will be generated to initiate a review of all intake/booking documentation that indicates a positive history of or current health issue to include mental health, substance abuse, and dental issues. This review of each flagged patient will occur by an objective health care staff member within twenty-four (24) hours to ensure appropriate treatment is or has been initiated for every patient identified.

4) All patients with a positive history of or current health issue will be scheduled, in intake/booking, or all indicated initial appointments with providers and chronic care clinics thereby ensuring continuity of health care services. Documentation will be generated and reviewed daily by the onsite health care staff regarding all appointments for which the patient is scheduled.

Related Forms
No relevant forms for this policy.

References


American Telemedicine Association
Section A: Governance and Administration

J-A-09 Procedure in the Event of an Inmate Death

Effective Date: 01/01/2020

Policy Revised:


NCCHC Opioid Standard: Procedure in the Event of an Inmate Death (O-A-10)

NCCHC MH Standard: Procedure in the Event of an Inmate Death

ACA Standard: Inmate Death (4-ALDF-4D-23)

Purpose

To ensure accurate information and timely reporting and investigation of any patient death that occurs within the correctional institution as well as ascertain appropriateness of clinical care and identify any trends requiring further study.

Policy

All patient deaths require the performance of a clinically thorough mortality review. Deaths that are unexpected or occur under unusual circumstances will also be investigated in accordance with state and local regulations.

Procedure

GENERAL PROCEDURES IN THE EVENT OF PATIENT DEATH

1) The HSA should notify the Vice President of Operation, Corporate Chief Medical Officer, and Corporate Legal Department immediately via email at notification@naphcare.com or telephone, if email is unavailable, of any patient death, including incident details.

2) A log will be maintained to include the following:
   a) Patient name or identification number;
   b) Age at time of death;
   c) Date of death;
   d) Date of clinical mortality review;
   e) Date of administrative review;
   f) Cause of death;
   g) Manner of death;
   h) Date pertinent findings or review(s) shared with staff; and
   i) Date of psychological autopsy.

3) The medical examiner or coroner is to be notified immediately and all steps will be taken to preserve the scene. The body is not to be removed without permission of the coroner,
medical examiner, or the institutional authority. After proper medical examination, the body will then be released to the appropriate facility.

4) Administrative review:
   a) Following the death of a patient, whether natural, homicide, accident, under suspicious circumstances, or in any other unusual manner, the Health Services Administrator (HSA) or designee will immediately notify the onsite Medical Director and institutional authority. Family members should be notified by the institution’s policies and procedures.
   b) The Medical Emergency Code Report, completed at the time of the incident, and death summaries, completed within three (3) days, should be forwarded to the corporate office via email at notification@naphcare.com.
   c) The medical record is to be closed with a final note entered stating “Patient expired, case closed.”
      i) The Death Summary – HSA should be filled out using the inmate record as reference.
      ii) The summary section should summarize the care provided to the inmate since incarceration in the facility.
      iii) If the Health Services Administrator is unavailable, a designee will be appointed to complete the death summary.
      iv) Referral consist of a referral within and outside of the facility.
   d) The advanced clinical provider in the patient’s overall treatment will complete a Death Summary – Physician within seven (7) business days of the death. The report should be forwarded to the corporate office via email at notification@naphcare.com.
      i) The death summary will review the clinical care received by the patient and make any suggestion for improvement in retrospect.
      ii) The advanced clinical provider should review the inmate medical record as well as any other documents during the review process.
   e) Completed summaries will not be placed in the patient’s record but placed in the site’s corresponding NCCHC folder within SharePoint.

DEATH DUE TO SUICIDE
   1) The HSA should notify the Vice President of Operations, Corporate Chief Medical Officer, and Corporate Legal Department via email at notification@naphcare.com or telephone, if email is unavailable, of any patient death, including incident details.
   2) Site Psychological Autopsy Case Report and Case Report Factual Summary:
      a) This report will provide a detailed, comprehensive documentation of all information and circumstances involved in the review of a suicide or serious suicide attempt to identify trends and opportunities for improvement. It is expected that the
primary psychiatric provider will gather input from the primary Medical Director or provider for completion of this report.

b) An administrative review, in the form of a Case Report Factual Summary, will be conducted by the Mental Health Director or psychiatric provider within seven (7) calendar days.

c) The Case Report Factual Summary and Psychological Autopsy report will be available for the Clinical Mortality Review Meeting and should not be made part of the patient’s health record. The documentation should be placed in the appropriate site folder within SharePoint.

3) Critical Incident Debriefing:
   a) Critical incident debriefings are available to all staff and inmates who may have been affected by a completed suicide.
   b) Critical incident debriefing provides affected staff and offenders an opportunity to process their feelings about the incident

CLINICAL MORTALITY REVIEW

1) A clinical mortality review must be completed within 30 days of the inmate death. The review should provide a summary of the facts surrounding the patient’s death in order to ascertain compliance with Proactive standard of care and to identify any deficiencies/training/policies that may have contributed to the patient death.

2) The clinical mortality review meeting minutes should follow the guidelines set forth in the Clinical Mortality Meeting Guidelines and Agenda.

3) The HSA death summary, the physician death summary, the Medical Emergency Code Sheet, any incident forms, hospital records (if applicable), ambulance records (if applicable), and autopsy report (if available) will be utilized during the clinical mortality review.

4) If all documentation is not available (e.g., autopsy report, hospital records, ambulance records), the review must still be done within the 30 day time frame and may be amended at a later date when the additional information is available.

5) During the clinical mortality review process, if it is determined that there is any indication that the decedent may have had an undiagnosed or untreated communicable disease, this finding must immediately be discussed with the responsible physician and Corporate Chief Medical Officer as these matters may require rapid action, such as appropriate communication with public health authorities.

6) For a case in which the cause of death is unclear or an undiagnosed communicable disease is suspected, all reasonable attempts will be made to obtain a complete autopsy to increase the understanding of the pathology of the disease.

7) For expected deaths, a modified death review process, which focuses on the relevant clinical aspects of the death and preceding treatment, may be followed.
8) Changes that are identified during the review process will be implemented and monitored through the facility CQI program in the form of a process quality improvement study. Results of the study will be documented in the facility CQI meeting minutes and should be shared with the treating staff.

9) The clinical mortality review will be documented and placed in SharePoint in the Patient Death NCCHC folder with the inmate’s name within five (5) days of the meeting. Results of the review will be shared with the treating staff at the next scheduled staff meeting.

10) The HSA and physician death summaries, and the clinical mortality review, will not be a part of the patient record.

Related Forms

Case Report Factual Summary

Death Summary – HSA

Death Summary – Physician

Incident Report

Medical Emergency Code Report

Site Psychological Autopsy Case Report

Patient Death Log

References


Section A: Governance and Administration

J-A-10 Grievance Process for Health Care Complaints

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Grievance Process for Health Care Complaints (J-A-10)
NCCHC Opioid Standard: Grievance Mechanism for OTP Services Complaints (O-A-11)
ACA Standard: Provision of Treatment (4-ALDF-4D-02); Grievance Procedure (4-ALDF-6B-01)

Purpose
To ensure that every inmate concern, complaint, or grievance is addressed by the Health Service Administrator or designee in a timely manner and in accordance with Proactive procedures.

Policy
Proactive maintains a complaint and grievance process available to all patients, which provides an open and meaningful forum for their concerns, the resolution of these complaints, and is subject to clear guidelines. The Corporate Clinical Department and Corporate Legal Department will provide clear oversight of the complaint process.

Procedure
1) Proactive’s complaints and grievances policy includes an informal process:
   a) Inmates shall always be encouraged to discuss health care concerns with the appropriate member of the health care staff.
   b) The Health Services Administrator, when possible, will encourage and make available informed mechanisms for the communication of, and potential resolution of, patient health care concerns.
   c) The Health Services Administrator is encouraged to meet informally with representatives of the department (e.g., chaplain) who may have input on the adequacy of health care delivery.
2) An emergency complaint is defined as a complaint filed by a patient citing impending or current harm to the health, safety, or welfare of the patient.
3) Other general information regarding health care complaints and grievances is as follows:
   a) Each detainee will receive information, verbal and written, pertaining to the mechanisms for health care concerns, complaints, and grievances system within twenty-four (24) hours of admission to the correctional institution.
b) All Proactive staff are required to read and utilize the complaint policy and procedure (unless a correctional facility’s policy and procedure supersedes Proactive’s policy and procedure). This will be documented on the Education Log with a copy sent to the corporate Human Resources Department.

c) Patients with special needs such as vision impairment or language barriers who request special assistance completing the complaint form will be provided assistance through the use of available resources.

d) No patient will be denied access to the mechanisms for health care concerns, complaints, and grievances processes, nor will they be prohibited from assisting other patients in completing complaint forms on behalf of another patient.

e) There will be no retaliation against a patient for filing a health care complaint or grievance.

f) All complaint and grievance forms and other related documents kept at the institution will be treated confidentially.

g) Complaint and grievance forms will not be placed in the patient’s health record.

h) Copies of complaints and grievance forms will not be provided to staff members named in the complaints.

i) Patient complaints and grievances will be evaluated to identify trends and opportunities to improve health care through corrective action.

j) Patient complaints and grievances are to be recorded in the Grievances section of TechCare, which is a separate database from the patient’s health care record.

k) The Proactive corporate office will conduct audits of onsite complaints and grievances.

4) The Health Services Administrator or designee is responsible for:

   a) Ensuring compliance with the patient complaint and grievance process for health care;

   b) Ensuring complaints are recorded in TechCare;

   c) Retaining all records and documentation relevant to complaints and grievances in a secure and confidential manner; and

   d) Coordinating the timely investigation of all complaints and grievances.

HEALTH CARE COMPLAINTS

1) The health care complaint processes are as follows:

   a) Each patient is permitted to file one Health Care Complaint Form each business week.

   b) A health care complaint that is deemed by the patient to be an emergency will be reviewed by the Health Services Administrator or designee to determine whether it qualifies as an emergency complaint. If the patient has an emergency complaint, it does not count toward the complaint limit.
c) The patient may grieve the determination that his complaint is not an emergency by filing a Health Care Grievance form. This grievance will be handled through the normal process set forth in the Health Care Grievance policy (below).
d) If the emergency complaint is determined to be a non-emergency complaint, it will be returned to the patient to file as a health care complaint.
e) Proactive encourages patient issues be resolved on an informed basis without the need for filing a format complaint. The health care complaint process is not intended to circumvent routine administrative processes.
f) A patient with a complaint that cannot be resolved through a discussion with the staff involved will first attempt to resolve the complaint with a Health Care Complaint form before filing a health care grievance.
g) The complaint must be a single issue or incident and the entire complaint must fit on the Health Care Complaint form.
h) The Health Care Complaint form will be available to all detainees in all living units. Detainees in isolation or segregation will be provided a form upon request.
i) The health care complaint must be filed no later than ten (10) days from the date the patient knew, or should have known, of the facts giving rise to the complaint.

2) Proactive staff will respond to patient complaints in a timely manner based on principles of adequate medical care. The process for response is as follows:
   a) Upon receipt of the Health Care Complaint form from the patient, the receiving health care staff will complete the “Date Received” section of the form in front of the patient, if possible.
   b) The health care staff involved or designee will respond verbally to the health care complain within five (5) business days unless the complaint is deemed an emergency.
   c) If deemed an emergency, the Health Services Administrator or designee will immediately take whatever action necessary to protect the health, safety, and welfare of the patient. This information will be documented on the Health Care Complaint form and the patient will receive a written response to the emergency health care complaint within five (5) days.
      i) Otherwise, the patient will receive a written response within ten (10) business days of the receipt of the Health Care Complaint form.
   d) Steps taken and a reasonable solution will be documented in the written response to the health care complaint.

HEALTH CARE GRIEVANCES

1) Proactive’s grievance policy includes a time frame for response and an appeal process. The health care grievance processes are as follows:
   a) After completing the health care complaint process, the patient may decide to appeal his complaint recommended resolution through the grievance process. At
the completion of the health care complaint, the inmate may request from health care staff a Health Care Grievance form, which will be provided at the time of the request.
b) The inmate must fill out, sign the Health Care Grievance form, and return it to the Health Services Administrator or designee within five (5) business days of the inmate’s receipt of the written resolution of the health care complaint. The Health Services Administrator or designee may waive this time limit for good cause.
c) A copy of the inmate’s Health Care Complaint form will be attached to the inmate’s Health Care Grievance form. If no Health Care Complaint form exists, the Health Care Grievance will be rejected.
d) Only one (1) issue may be addressed per Health Care Grievance form. Any grievance that attempts to address more than one (1) issue or which addresses an issue not identified in the health care complaint will be rejected (unless the facility maintains a separate policy in which Health Care Complaints are not utilized and a Health Care Grievance is the only complaint mechanism available to the inmate).
e) Only one (1) additional page will be attached by the inmate to the Health Care Grievance form. Grievances with additional pages will be rejected.
f) Each inmate is limited to two (2) pending grievances at a time. An inmate may dismiss a pending grievance to allow the resolution of another grievance.
g) Grievable issues are as follows:
   i) Any condition, policy, procedure or action or lack thereof that affects an inmate’s health care and is in the control of Proactive;
   ii) Notwithstanding the above, any grievance alleging retaliation, misconduct or harassment pertaining to Proactive services or staff is grievable.
h) Non-grievable issues include, but are not limited to, the following:
   i) Matters over which Proactive has no control;
   ii) Transfers of an inmate for off-site treatment;
   iii) Routine housing assignment changes, unless there is an alleged threat to the health and safety of the inmate; and
   iv) Co-pay charges assessed for health care which was actually provided to inmate, if applicable.
2) Proactive staff will respond to inmate grievances in a timely manner based on principles of adequate medical care. The process for response is as follows:
   a) Upon receipt of the Health Care Grievance form from the inmate, the receiving health care staff will complete the “Date Received” section of the form in front of the inmate.
   b) The Health Services Administrator or designee will then investigate the health care grievance including, if necessary, meeting with the inmate, interviewing witnesses, and taking statements.
c) The Health Services administrator will respond to the health care grievance in writing within ten (10) days.

d) The Health Services Administrator will record and scan the original Health Care Grievance form and any witness statements and attachments submitted by the inmate in TechCare (grievances section; not the medical record).

e) The inmate will be given a copy of the Health Care Grievance form and the written response. The inmate will sign and date the Health Care Grievance form, acknowledging receipt.

f) In the event that an inmate feels that the Health Care Grievance has not been satisfactorily resolved by Proactive, an appeal may be submitted to the Health Services Administrator within five (5) calendar days following the inmate’s receipt of the response to his/her Health Care Grievance.

g) The inmate shall utilize the Health Care Grievance Appeal form when filing his/her appeal.

h) Should the inmate fail to timely file his/her appeal within the allotted time frame, said appeal shall be denied.

i) The Health Services Administrator, and/or his/her designee, shall provide a timely response to the inmate’s appeal within ten (10) calendar days following the inmate’s appeal.

j) Each inmate shall be entitled to one appeal per Health Care Grievance.

Related Forms

Education Log

Grievance Procedure

Health Care Complaint

Health Care Grievance

Health Care Grievance Appeal

References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-01 Healthy Lifestyle Promotion

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Healthy Lifestyle Promotion (J-B-01)

NCCHC Opioid Standard: Healthy Lifestyle Promotion (O-F-01); Use of Tobacco (O-F-02)

NCCHC MH Standard: Mental Health Education and Self-Care (MH-F-01); Healthy Lifestyle Education and Promotion (MH-F-02)

ACA Standard: Health Education (4-ALDF-4C-21); Dietary Allowances (4-ALDF-4A-07); Smoking Prohibited (4-ALDF-1A-21)

Purpose

To ensure that patients receive health education and training in health maintenance and self-care skills, inmates are provided with a nutritionally adequate diet, and to establish guidelines whereas patients, staff, and visitors are not exposed to the detrimental effects of tobacco products.

Policy

General education resources shall be available to all patients, and specific health education shall be provided to patients with serious health conditions. The facility is encouraged to maintain a nutritionally adequate diet for the general population. Proactive supports a smoke free environment, along with providing information on the health hazard of tobacco use.

Procedure

LIFESTYLE EDUCATION

1) Health education and self-care instructions will be provided during sick call encounters. Verbal instructions as well as written instructions may be provided.

2) Instruction sheets for minor, commonly occurring ailments, to include smoking abatement and dental hygiene will be readily available, as well as education sheets provided on assessment protocols, Education may be provided in handouts or pamphlets on a variety of health topics and kept in easily accessible areas for patients. Language translation will be arranged if needed.

3) Health education and self-care instructions will be included in chronic care treatment plans.

4) Health staff promote and provide education on exercise and physical activity options in the facility.

5) Information on exposure prevention, screening, and treatment of sexually transmitted infections, including HIV and Hepatitis C is available to all patients.
a) Patients associated with OTP/MAT services will be provided this education upon starting services.

b) Substance abuse counseling is provided to OTP/MAT patients as clinically indicated in a group or individually.

FACILITY DIETS

1) A registered or licensed dietician/nutritionist of the institution or an independent contractor for the institution will review regular and medical diets annually, or whenever a substantial change in the menu is made. Written documentation of the review will include any changes or recommendations, date, signature, and title of the consulting dietician.

2) The dietician is notified whenever the regular diet menu is changed.

TOBACCO USE

1) Smoking is prohibited indoors. If the facility allows smoking outside, specific areas are designated for smoking.

2) At a minimum, a prevention and abatement program will include the provisions on written materials on prevention, abatement, and health hazards of tobacco use. The materials are available in areas accessible to all inmates (e.g., clinic, library, housing areas).

Relevant Forms
No relevant forms for this policy.

References

Healthy Lifestyle Promotion (O-F-01); Use of Tobacco (O-F-02). National Commission on Correctional Health Care: Standards for Opioid Treatment Programs in Correctional Facilities, 2016.


Health Education (4-ALDF-4C-21); Dietary Allowances (4-ALDF-4A-07); Smoking Prohibited (4-ALDF-1A-21). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section B: Health Promotion, Safety, and Disease Prevention

J-B-02 Infectious Disease, Prevention and Control

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Infectious Disease, Prevention and Control (J-B-02)

NCCHC Opioid Standard: Infection Prevention and Control Program (O-B-01)

NCCHC MH Standard: Infection Prevention and Control Program (MH-B-01)

ACA Standard: Communicable Disease and Infection Control (4-ALDF-4C-14, 15, 16, 17, 18)

Purpose

To provide guidelines for the management of, and to reduce unnecessary exposure to, infectious and communicable diseases for patients, institution, and health care staff, as well as to enact protection for health of patients, staff, and visitors through maintenance of a clean and orderly health unit.

Policy

A comprehensive infection control program will be implemented at the facility that includes surveillance, prevention, and treatment of infectious diseases within the correctional environment. This program will minimize the risk of infection and transmission of communicable diseases for patients and employees and provide a system for the reporting of diseases as required by local, state, and federal law. The infection control program will be based on guidelines established by the Center for Disease Control and Prevention, the Occupational Safety and Health Administration (OSHA), the Association for Professionals in Infection Control and epidemiology, and other nationally recognized infection control organization.

Procedure

1) Proactive’s corporate office will develop and review annual infection control policies and an infection control manual to be approved by the facility’s responsible physician.

2) Corporate Chief Medical Officers may make recommendations regarding the infection control monitoring and practices.

3) Corporate clinical leadership and the institutional Infection Control Committee may also make recommendations regarding infection control monitoring and practices.

   a) Institutional ICC:

   i) Every institution in which Proactive provides medical services will establish an ICC, which will be a sub-committee of the institutional CQI committee;
ii) Meetings are to be held at least quarterly or whenever an infection control issue requires immediate or continuing attention;

iii) Membership is to include the Medical Director or physician, the dentist or representative, if applicable, an Infection Control Coordinator, and Institutional Authority representative, and any other representatives depending on issues for discussion as designated in conjunction with the HSA or Proactive’s corporate office;

iv) Each institution will designate a licensed health staff member to serve as the Infection Control Coordinator. The responsibilities of the Infection Control Coordinator will include:
   1. Coordinating the collection of data on communicable diseases or conditions through review of appropriate services;
   2. Reporting data to the institutional authority;
   3. Reporting communicable diseases and test results required by local, state, and/or federal laws and maintaining those records for at least two (2) years;
   4. Monitoring infection control practices of health staff and identifying areas for improvement;
   5. Working with designated staff to maintain institution sanitation reports and inspections;
   6. Coordinating and monitoring employee health programs required by OSHA and recommended by the Center for Disease Control;
   7. Monitoring sharp injuries of staff and recording information on the Staff Injury Log, as appropriate;
   8. Ensuring and maintaining confidentiality of employee health records as required by OSHA;
   9. Ensuring communicable disease education to health care and correctional staff and maintaining the Education Log which must be kept for three (3) years; and
   10. Keeping of committee minutes for the institutional ICC meetings.

v) The responsibilities of the committee include:
   1. Reviewing infection control submitted by the Infection Control Coordinator;
   2. Reviewing deficiencies in infection control practices and institutional sanitation reports with recommendations for corrective action;
   3. Reviewing tuberculosis (TB) prevention and control programs, including adequacy of skin testing programs, rate of medication compliance and completion of treatment, skin test conversions, and outbreak investigations;
4. Reviewing vaccinations and vaccine education;
5. Identifying and recommending CQI studies related to infection control activities;
6. Monitoring compliance with employee health programs required by OSHA;
7. Monitoring outbreaks of communicable diseases or other infection control issues; and
8. Providing oversight to ensure staff receives appropriate education for handling and disposal of biohazard materials including blood and body fluid spills.

4) The HSA or designee will monitor and ensure the following activities and components of the safety program as performed:
   a) Medical, dental, and laboratory equipment and instruments are decontaminated and inventoried on the Contraband Perpetual Inventory form daily;
   b) Sharps and biohazardous wastes are handled, stored, and disposed of in a safe and sanitary manner consistent with local, state, and federal regulations;
   c) Patients with possible communicable diseases are examined promptly and appropriately and all measures are taken to detect serious infections or communicable diseases;
   d) Infected patients receive medically indicated care; and
   e) Patients with contagious diseases are medically isolated if appropriate.

5) Standard precautions will be followed with all patient contacts. Proactive’s exposure control plan defines the approach to eliminating or minimizing employee exposure to bloodborne and airborne pathogens as required by OSHA guidelines. The exposure control plan is as follows:
   a) Handwashing and use of gloves:
      i) Frequent and thorough hand washing is the most effective way to reduce the spread of communicable disease. It is the responsibility of the staff to wash their hands using soap and water, even if gloves are used. If no water is available, alcohol or hand cleaning germicide can be used as a temporary means;
      ii) It is the responsibility of the staff to wear gloves when there may be contact with any body fluids, when handling items or equipment contaminated or potentially contaminated with body fluids, or when the employee has an open wound or abrasion (which should always be covered);
      iii) Cotton gloves worn when working with evidence from a crime scene can be worn over protective disposable gloves when exposure to blood may occur. Such a situation shall only apply to providing care at a crime scene, and no solely part of a forensic investigator;
iv) Gloves contaminated with body fluids are to be disposed of as biohazard waste;
v) Re-wash and re-glove hands after each procedure.

b) Clothing:
i) Health care staff may wear scrub uniforms pursuant to their respective positions.

ii) Proactive strongly recommends that clothing which has become contaminated be changed immediately and placed in an individual biohazard bag to be disposed of as biohazard waste. Disposable scrub uniforms will be provided to each institution in the event of clothing contamination. If contaminated items are taken from the facility, it is done at the individual’s own risk.

iii) Protective clothing, such as overalls, disposable scrubs, aprons, boots, or protective shoe covers may be worn over clothing where large amounts of blood is present. These items must be disposed in biohazard bags, if disposable, in a manner consistent with OSHA’s bloodborne pathogen standard. Items that need laundering will be handled in the same manner as uniforms. Non-absorbent boots, etc. should be cleaned in the same manner as equipment with bleach solution or disinfectant.

c) Facial

i) Face masks, eye protection, or face shields are required for everyone whose job entails potential exposure to blood via splash to the face, nose, or eyes;

ii) Eyewash stations will be provided within the health service area and be capable of delivering 1.5 gallons of clean water per inmate for at least 15 minutes.

d) Equipment:

i) Ambu-bags will be used for resuscitation. The equipment will be located on each crash cart or in each emergency response bag.

e) Dressing changes:

i) All contaminated dressings are to be disposed of in appropriate biohazard containers. If patients are given dressing material, they will be instructed on proper technique and disposal and will be given appropriate supplies.

f) Disinfection/Sterilization:

i) Eyewash station nozzle covers should be present to prevent contamination by airborne contaminants. The flow valve must allow the flow to maintain on with the use of the operator’s hand.

ii) All eyewash stations will be tested quarterly, or per local requirements, and results reported on the Safety and Sanitation Inspection form.

iii) Any non-disposable item must be washed and dried prior to disinfection or sterilization to remove any organic material.
iv) All environmental surfaces are to be cleaned with a bleach solution (changed every 24 hours or mixed at the time of use). Alcohol-based disinfectants will be used for areas not suitable to contact with a bleach solution.

1. Low-level disinfectant using 1:100 bleach solution, alcohol, or other EPA-approved germicide can be used on items that do not come into contact with non-intact skin or mucous membranes, including, but not limited to, furniture, blood pressure cuffs, and crutches.

2. Medium-level disinfectant using alcohol or other EPA-approved can be used for thermometers, hydrotherapy tanks, etc.

3. High-level disinfectant using a 1:10 bleach solution or other EPA-approved germicide is used for objects that come in contact with non-intact skin or mucous membranes, including, but not limited to, laryngoscopes, ambu-bags, and respiratory therapy equipment.

v) Sterilization is essential for critical items (items which enter tissue of the vascular system) including, but not limited to, scalpels, needles, and some dental equipment. Steam sterilization will be used according to manufacturer’s recommendation. Documentation of sterilization must be turned in weekly to the HSA on the Sterilization Record Dental autoclaves shall be maintained according to the manufacturer’s instructions.

vi) Laboratory:

i) Standard precautions and gloves will be used in collecting and handling specimens, contaminated equipment, cleaning equipment, counters, or spills.

ii) Laboratory equipment will be cleaned and disinfectant in accordance with the manufacturer’s recommendations. All sharps are to be disposed of in a leak-proof puncture resistant container and emptied when 2/3 full.

iii) Specimens must be transported in a container that is closed and will prevent leakage whether color-coded (red) or labeled with the approved biohazard label.

iv) Specimens stored in a refrigerator should be monitored and documented daily on a Refrigerator Temperature Log. The refrigerator and/or freezer should have a biohazard label and will not be used to store food or medication. The refrigerator is to be kept in a locked room.

v) Centrifuges will have a cover to be used whenever in operations.

vi) Eating, drinking, or storing any food or drinks is prohibited in the laboratory area.

h) Radiology:

i) Standard precautions will be used for all patients brought to radiology;
ii) Any incidents of exposure to blood borne or airborne pathogens will be managed according to established procedure;

iii) Cleaning and disinfecting of equipment will be performed between patients and at the end of each day.

i) Isolation rooms:
   i) Each Isolation room must have medium and large gloves, disposable gowns, N95 particulate filter respirator and regular masks, goggles or face shields, small and medium biohazard plastic bags, and disposable surgical caps.
   ii) As these items are used, it is the responsibility of the charge nurse to have them replaced.

j) Intravenous therapy:
   i) Aseptic technique will be utilized for the implementation and administration of intravenous therapy in accordance with established guidelines.

k) Disposal of sharps:
   i) All sharp objects such as needles and razors will be considered contaminated after use and disposed of in approved sharps disposal containers and removed from the institution as biohazard waste;
   ii) Contaminated needles and other contaminated sharps will not be bent, recapped, or removed. Shearing or breaking of contaminated needles is prohibited;
   iii) Sharps disposal containers will not be emptied, Sharps disposal containers and other biohazard materials will be stored in a secure area and in a secondary container that will be provided by the contracted biohazard waste disposal company;
   iv) Sharps disposal containers will be functional, accessible, and visible.

l) Post Mortem:
   i) A human body is not considered regulated waste under the blood borne pathogen protocol;
   ii) A human body whose blood or body fluids may be a source of occupational exposure provides a similar risk of exposure to that from a living human being;
   iii) Personal protective equipment will be selected as with any other task that has a risk of occupational exposure based upon the anticipated type of exposure to blood or other body fluids during the task/procedure;
   iv) Standard precautions are to be used as with all patient contact;
   v) If the deceased has been diagnosed with hepatitis, TB, a sexually transmitted disease, or HIV, the provider will prepare a written notification of this to accompany the body, with the original to be placed in the patient’s health record, and the copy to accompany the remains;
vi) Documentation of the transfer of the remains is made in the progress notes in the patient’s health record, which is to remain confidential and privileged.

m) In addition to standard precautions, airborne precautions for patients suspected of having a disease spread through droplet nuclei (e.g., TB, measles, and varicella) should be used;

n) In addition to standard precautions, droplet precautions for patients suspected of having a disease spread through large particle droplets that do not remain suspended in the air (e.g., flu, meningitis, mumps, rubella, group A Streptococcus) should be used;

o) In addition to standard precautions, contact precautions for patients suspected of having a disease spread through direct or indirect contact (e.g., respiratory skin or wound infection(s), including MRSA, E. coli, hepatitis A, scabies, etc.) should be used;

p) Flammable, toxic, and caustic materials will be controlled and used safely. The HSA will provide instruction to all staff regarding the handling of these materials on site and will maintain documentation of all staff instruction and any incidents involving such materials;

q) Details of all precautions can be found in the Infection Control Manual.

6) All health and correctional staff with potential for occupational exposure to blood and airborne pathogens will be provided education by the Infection Control Coordinator on communicable diseases, personal protective equipment, work control practices, and disinfection/sterilization procedures at the time of hire and annually thereafter. Confidentiality of health care information will also be addressed and only those persons with a medical need to know may be informed of health diagnoses and critical information.

7) Active TB patients, patients suspected of having active disease, or any patient requiring airborne infection isolation are to be housed in a designated negative pressure room which is monitored regularly for negative air status via the Airborne Infection Isolation Room Checklist form. Negative airflow shall be verified:
   a) Immediately prior to placing a patient requiring negative air isolation into the room;
   b) Daily when occupied by a patient requiring a negative air isolation; and
   c) Monthly when unoccupied.

8) Isolation cells are to be used to separate any potentially infectious patients from the rest of the population. Appropriate medical care and treatment, to include scheduling of follow-up visits, shall be provided to any isolated patient that is appropriate to the condition and following state and local health requirements. A patient will only be returned to general population under the direction of an advanced clinical provider and only when there is no longer a clinical risk to the patient or others identified.

9) Health care staff will make referrals or arrangements for community referrals for patients released from the facility with communicable or infectious diseases.
10) Each institution will abide by local, state, and federal regulations regarding the reporting of infectious disease as follows:

11) Patients entering any institution in which Proactive provides health care will be examined and treated, if indicated, for ectoparasites in order to prevent possible institutional infestation.

12) The HSA or designee will ensure that a monthly environmental inspection of the medical area within the facility is conducted with documentation of any Corrective Action Plan. This inspection is to be documented on the Safety and Sanitation Report and should include:

13) Testing and treatment:
   a) Employee testing and treatment:
      i) Proactive employees will be provided a pre-hire tuberculin skin test (TST) with repeat testing at least annually. Potential employees that test positive on their pre-hire TST must be medically cleared by an outside clinician prior to beginning work. They should provide documentation, which states they have no evidence of active TB disease. Established employees that convert to a positive TST as part of their annual TB skin testing require the same outside medical clearance but should be referred as a Workmen’s Compensation case by the local health department; please check with your local HD to see if referral from your employer is appropriate.
      ii) Employees with a previously positive TB skin test should be screened for symptoms of active disease upon hire and again annually. Those displaying symptoms for active disease should be referred to an outside provider to be evaluated. They should be cleared of active disease prior to returning to work.
      iii) Hepatitis B vaccination and post-exposure follow-up will be offered in compliance with CDC guidelines and OSHA requirements.
      iv) If a staff member sustains significant exposure to blood or body fluids, HIV, Hepatitis C, and Hepatitis B, testing and treatment will be offered per the Infection Control Manual section on Bloodborne Pathogens.
      v) All employee post-exposure follow-up, vaccinations, or tests regarding TB, HIV, Hepatitis C, and Hepatitis B, will be documented on the Proactive Employee Vaccinations & Tests form and maintained by the HSA.
   b) Patient testing and treatment:
      i) All patients will be assessed for possible infectious disease or processes upon admission to the institution and appropriate precautions taken.
         a. Patients will be assessed for TB risk at intake using the TB screening form. The TB Screening form has two components.
         b. The first component is to identify those patients with possible active disease in need of isolation. Patients who screen positive on the first
component will need to be placed in isolation/masked and a chest x-ray will be ordered for clearance.

c. The second component is to identify those patients at high risk of having TB exposure and possible inactive disease. Patients who screen positive on the second component will need a TB test placed immediately at intake.

d. Those screening negative for both components will have a TB skin test placed per facility protocol.
   i. At times of national shortage of TB skin test solution, the Chief Medical Officer(s) may decide to suspend routine screening of the general population both initially within 7-14 days of booking and annual placements. This does not apply to those screened positive on the TB Screening form for either component.

   ii) Patients reporting or who are observed as having signs and/or symptoms of an infectious disease will be referred to an advanced clinical provider to initiate appropriate testing and treatment. Patients identifies as having significant exposure as part of a contact investigation will be offered appropriate testing and/or treatment regardless of demonstrating signs or symptoms of active infection.

   iii) Procedure for TB Skin test placement:
      a. Place Mantoux skin test 0.1ml intra-dermally in forearm upon admission and annually thereafter.
      b. Read and record result in TechCare between 48-74 hours after implant. The result is measured in millimeters of induration not redness.
      c. ≥ 5mm induration is positive if the patient has been in close contact with someone who is infected with active TB, or is immunosuppressed (e.g., HIV/AIDS, organ transplant, cancer). Refer this patient to the infection control nurse and the advanced clinical provider for follow-up.
      d. ≥ 10 mm is positive for all other patients.
      e. Patients who are reactors (have a newly positive tuberculin skin test) or are converters (now reactive after previous negative tests or have an increase in measured induration to qualify as a positive reactor) should receive an order for a chest x-ray to rule out active disease. Patients who have a previous positive tuberculin skin test do not require a CXR unless symptomatic per symptom screening. Decisions to proceed or not proceed with a CXR outside of these
guidelines shall be based on the clinical decision of a licensed provider.

f. Receipt of BCG vaccination is not a contraindication to TST skin testing. Active disease must be ruled out in patients with newly positive TST skin testing regardless of BCG vaccination history. Evaluation of TST reactions in BCG vaccinated patients is interpreted using the same criteria for those not vaccinated. Patients who have received BCG vaccination and have previously had a positive TST do not require repeat TST placement.

iv) Assess patient for signs and symptoms of active disease (night sweats, fever, weight loss, persistent cough, bloody sputum) at intake and annually. If TB is suspected, the patient will be given a mask to wear and arrangements made for transfer to a negative pressure area (isolation). A NIOSH-approved mask will be provided to the staff transporting the patient.

v) Obtain documentation of any past exposure or treatment for TB.

vi) Obtain order for a chest x-ray when patient has an observed newly positive TST and/or has signs/symptoms of active TB disease. If chest x-ray results are abnormal, patient must stay in isolation and have a provider follow-up scheduled. Obtain orders and complete sputum testing x 3. Isolation may be discontinued with negative sputum test with provider order.

vii) Obtain order for baseline chest x-ray for all HIV inmates regardless of TST results or negative symptom screening. The CXR does not need to be repeated if the patient was released from custody within the previous 6 months and has a documented CXR result within the health care record.

viii) When a patient refuses TB skin testing, the HSA or designee will interview and counsel the patient regarding purpose of testing and facts regarding the test (i.e., skin testing does not cause tuberculosis, a positive skin test does not determine active disease). If the patient continues to refuse the testing, the patient will receive a complete TB symptom screening, if symptomatic, then follow procedures for isolation and CXR. If asymptomatic, patient may be housed in populated areas. There should be clear documentation that screening was completed and patient was asymptomatic as well as education documented that patient should immediately report any signs/symptoms of TB disease. An appropriate refusal form shall be completed for all patients refusing tuberculin skin testing.

ix) Provide patient education to all inmates on the prevention and control of TB and community referral to the health department if released prior to TST reading.

x) Latent TB infection treatment including initial and follow-up labs, may be provided for those positive patients without a verified history of completed
treatment. Therapy should generally be reserved for those patients with a relative certainty of completing the full course of treatment and should be provided under the direction of the advanced clinical provider as part of the chronic care management process.

xi) Communicate with local health department any time a patient is released into the community with suspected or confirmed active TB disease and any receiving prophylactic treatment for latent TB infection. When possible, begin discharge planning for these patients prior to release to better coordinate continuity of care.

xii) Patients who have HIV, Hepatitis C, or other infectious disease testing must be informed of the results without unreasonable delay. If the results are found to be positive, the provider or nursing staff may inform the patient of the results. Every patient who tests positive for HIV, Hepatitis C, or other infectious disease will have counseling done at the time the results are given. The patient will then be referred to the provider for medical review within one week of being informed of the positive result.

xiii) Medical test results shall be confidential except for those who have a need to know such information. No person to whom the results of a test have been disclosed under the section may disclose the test results to another person not authorized to receive such information.

xiv) Testing for sexually transmitted diseases will be performed in accordance with the Infection Control Manual with responding to follow local, state, and federal regulations.

xv) All treatment provided for sexually transmitted diseases (i.e., gonorrhea, chlamydia, and syphilis) will be determined by the advanced clinical provider.

xvi) Treatment for individuals with suspected food poisoning will vary with the causative agent and is prescribed by the advanced clinical provider. Enteric isolation precautions will be instituted with outbreaks.

xvii) Victims of animal bites should immediately report the incident to the health care staff, who in turn will notify the institutional authority or designee. The animal should then be immediately quarantined or turned over to the county animal control officer. Any sacrificed animals, such as bats, mice, rats, etc. should be sent in a sealed plastic bag as soon as possible to the appropriate laboratory for testing.

xviii) All treatment for rabies will be consistent with CDC recommendations.

Relevant Forms

Contraband and Perpetual Inventory
Corrective Action Plan

Education Log

Employee Fit Test Respirator Issuance Document

Employee Vaccination and Test Log

Monthly Eye Wash Station Check

Airborne Infection Control Room Checklist

Needle and Syringe End of Shift Count Sheet

Refrigerator Temperature Log

Safety and Sanitation Inspection Form

Staff Injury Log

Sterilization Monitoring Log

Sterilization Record

References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-02 Management of Bloodborne Pathogen Exposures

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Infectious Disease Prevention and Control (J-B-02)
NCCHC Opioid Standard: Infection Prevention and Control Program (O-B-01)
ACA Standard: Communicable Disease and Infectious Control Plan (4-ALDF-4D-14)

Purpose
To provide specific guidelines for the prevention of exposure to blood and body fluids and provide specific recommendations for medically managing patients who have experienced significant exposures to blood or other potentially infectious materials (OPIM).

Policy
To ensure proper prevention and treatment for all patient exposures to blood, body fluids, and OPIM

Procedure

TRAINING
1) All workers will be trained in proper methods of handling and disposing of biohazardous materials and spills prior to being assigned to any duties, which may involve exposure to blood or OPIM.
2) The Health Services Administrator (HSA) will maintain documentation of training of inmate workers utilizing the Inmate Worker Biohazard Training form.
3) Training should include a clear explanation of any duties that are not permitted for inmate workers based on local requirements. For example, at some locations inmate workers are prohibited from handling red biohazard bags or sharps containers.

PERSONAL PROTECTIVE EQUIPMENT
1) Gloves will be worn when:
   a) There may be contact with blood or potentially infectious body fluids;
   b) Handling items, equipment or objects contaminated or potentially contaminated with blood or infectious body fluids;
   c) Cleaning areas or equipment contaminated or potentially contaminated with blood or other body fluids (e.g., blood spills); or
   d) Handling biomedical waste containers and filled red or yellow plastic bags utilized for biomedical waste and contaminated linen.
2) Gloves will be removed when:
   a) When they are torn or punctured;
   b) As soon as the activity that required them is complete; and,
   c) Before leaving an area.

3) Workers will:
   a) Dispose of gloves into a trash container. If grossly soiled they will be disposed of into a marked biohazardous waste container.
   b) Wash hands with soap and water as soon as gloves are removed. If no water is available, alcohol or hand cleaning germicide can be used as a temporary means.
   c) Wear fluid-resistant gowns or protective aprons whenever splashes or spills are anticipated such as blood spill clean-up. These will be available in medical units and in locations where exposures may be anticipated.
   d) Remove protective equipment before leaving the work area and as soon as possible after it becomes contaminated.
   e) Place used protective equipment in areas or containers designated for this purpose when being stored, washed, decontaminated or discarded.
      i) Utility gloves may be decontaminated for reuse if they are intact and will be discarded when they show signs of cracking, peeling, tearing, puncturing or deterioration.

4) Inmates will not clean and sanitize multi-use personal protective equipment utilized by staff (e.g., goggles, face shields).

5) Disposable latex gloves will never be washed for reuse or before disposal.

HEPATITIS B (HBV) VACCINATION

1) Health care staff will review the patient’s HBV vaccination status and vaccine response status.

2) Those who perform job functions that put them at risk of exposure to blood or OPIM will be offered the HBV vaccination series when indicated. Vaccinations should be offered only when there is an indication that the worker has been permanently assigned to the medical unit and there is a reasonable likelihood that assignment will continue long enough to complete the vaccination series.

3) Health care staff will document in the patient’s medical record:
   a) Consent for vaccination;
   b) Refusal of vaccination including a signed ROR;
   c) Administration of HBV vaccine.

POST EXPOSURE MANAGEMENT

1) General instructions for treating the exposure site include:
   a) The injured skin or wound should be emergently cleaned with soap and running water for two (2) minutes.
b) Mild bleeding should be allowed to continue freely for thirty (30) seconds. Pressure should then be applied to stop bleeding and bandage as necessary. Aspiration, forced bleeding or wound incision is not recommended.

c) Antiseptics, bleach, or other cleansing agents should not be used.

d) Mucous membranes should be rinsed with water for at least two (2) minutes.

e) Exposed eyes should be flushed with water or saline for at least two (2) minutes.

f) Remove clothing splashed with blood or other body fluids and put on clean clothing.

g) When an injury is so severe that immediate transport is needed, health care staff will notify the receiving institution that a bloodborne pathogens exposure is part of the injury.

2) Exposure evaluation:

a) Contact of intact skin with blood is not associated with infection and the patient should be counseled that no further follow-up is needed.

b) Patients who are evaluated to have exposure to bloodborne pathogens should be provided with emergent care, evaluation and, if indicated, treatment with post-exposure medications.

c) The evaluating health care staff should interview the injured person to obtain details about the exposure incident and to assess risk of exposure to HIV, HBV, and HCV. Information to obtain will include, but is not limited to:

   i) Exposure site and initial care provided;

   ii) Details on the incident including location and circumstances;

   iii) Type of body fluid involved:

      a. Potentially infectious body fluids including blood, tissue or fluids containing visible blood;

      b. Non-infectious body fluids including feces, nasal secretions, saliva, sweat, tears, urine, and vomitus. Exposure to these body fluids is not considered an exposure unless they contain blood and no further evaluation is required.

iv) Exposure type:

   a. Percutaneous (injuries that occur when the skin is penetrated by a contaminated sharp object).

   b. Mucous membrane exposure (inside the eyes, nose, or mouth) or exposure to non-intact skin (e.g., chapped, dermatitis, abrasion, or open wound).

   c. Human bite:

      i. Rarely result in transmission of HIV or HBV infection;

      ii. Clinical evaluation must include the possibility that the person bitten and the person who inflicted the bite both may have been exposed to a bloodborne pathogen;
iii. Identify whether the person was bitten (potential percutaneous exposure) or was the biter (potential mucous membrane exposure)

d. Sexual:
   i. Indicate the type of exposure. For the purposes of these guidelines only receptive anal or vaginal intercourse are generally considered exposures. If the behavior is recurrent or occurred more than 72 hours ago, treatment is not indicated;
   ii. Any allegations made by a patient of recent sexual assault should be treated per PREA guidelines.

e. Shared injection drug use equipment:
   i. Assess the nature of the exposure and whether or not the behavior is likely to recur. If the behavior is recurrent or occurred more than 72 hours ago, treatment is not indicated.
   ii. Intact skin exposure, without signs of abrasion, to blood or other infectious body fluid does not constitute an exposure and does not require follow-up.

d) Evaluate source case:
   i) Utilize all available information about the source case including chart review, interviewing the source and interviewing the source person’s clinician. Record previous and current laboratory results (HIV, EIA, HBsAG and anti-HCV).

e) HIV status:
   i) If HIV infected, obtain results of the most recent HIV viral load and CD4+T-cell count, history of antiretroviral therapy, results of resistance testing, and clinical status.
   ii) If HIV status is unknown:
      a. Obtain HIV test.

f) If HBsAg positive, obtain HBeAg

3) Evaluate the health status of the exposed person:
   a) Obtain the following baseline labs on the exposed person (preferable within 72 hours):
      i) HIV EIA;
      ii) Anti-HBs (if previously completed HBV vaccination series or vaccination status is uncertain and post vaccination anti-HBs test results are unavailable);
      iii) Total Anti-HBc (if post-vaccination anti-HBs <10 mIU/ml or if not vaccinated or incompletely vaccinated); and
      iv) Anti-HCV
b) Assess vaccination status for tetanus and Hepatitis B.

TRANSMISSION RISK
1) HIV – risk of viral transmission following an exposure incident depends on the type and extent of exposure and is higher with:
   a) Exposure to a larger quantity of blood or other infectious fluid;
   b) Exposure to the blood of a patient with a higher viral load;
   c) A deep percutaneous injury;
   d) Injury with a hollow-bore, blood filled needle;
   e) Exposure to a source with concomitant hepatitis C (HCV) viral infection;
   f) Sexual assault (due to mucosal trauma, multiple assailants or traumatic intercourse);
   g) The presence of a sexually transmitted infection in either the source or the exposed individual;
   h) Risk for acquisition of HIV by exposure route is as follows:

<table>
<thead>
<tr>
<th>Exposure Route</th>
<th>Risk</th>
</tr>
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<tbody>
<tr>
<td>Needleshares (injection drug use)</td>
<td>0.67%</td>
</tr>
<tr>
<td>Receptive anal intercourse</td>
<td>0.5%</td>
</tr>
<tr>
<td>Percutaneous needle stick</td>
<td>0.3%</td>
</tr>
<tr>
<td>Receptive penile-vaginal intercourse</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

   i) Risk for other common infections.

HIV POST-EXPOSURE PROPHYLAXIS (pep) – Non-occupational injury
1) Prompt assessment and follow-up is essential. Ideally, HIV PEP is initiated with 72 hours of the exposure.
2) Consultation on post-exposure management for HIV, HBV, and HCV is required when available.
   a) Call PEP line, the National Clinicians’ Post-exposure Prophylaxis Hotline, at 1-888-448-4911 (every day, 9am – 8pm EST).
   b) Occupational exposures should be referred to employee health.
3) Individuals exposed to a known or suspected HIV-infected source should be counseled about the need for the PEP regimen to be initiated promptly and carried out for 28 days.
4) Recommendations for PEP are based on the HIV status of the source case and the type and conditions of the exposure.

5) Preferred regimens for HIV PEP:
   a) CDC guidelines now recommend 3-drug HIV PEP for all exposures to HIV regardless of the severity of the exposures. PEP can still be associated with severe side effects and is not justified for exposures that pose a negligible risk for transmission. The CDC now recommends emtricitabine plus tenofovir (may be dispensed as Truvada, a fixed-dose combination tablet) once daily plus raltegravir (RAL/FTC/TDF) 400 mg twice daily as HIV PEP for exposures to HIV. This regimen is tolerable, potent, conveniently administered, and associated with minimal drug interactions.
   b) Monitoring and management of PEP toxicity:
      i) Exposed individuals who are prescribed PEP should be monitored for drug toxicity by testing at baseline and again at 4-6 weeks after starting PEP and should include a complete blood count, complete metabolic panel, and a pregnancy test.
      ii) Diabetic patients should be monitored for hyperglycemia if a protease inhibitor is utilized.
      iii) Modification of the regimen should be considered after expert consultation if toxicities are identified.
      iv) Baseline screening/treatment for other STIs should strongly be considered.
      v) Patients should be advised that evaluation of certain symptoms (e.g., fever, rash, back or abdominal pain, pain on urination, blood in the urine, dark urine, yellowing of the skin or whites of the eyes, or symptoms of hyperglycemia) should not be delayed.
   c) Post exposure follow-up:
      i) Individuals with exposure to HIV should receive follow-up counseling, post-exposure testing, and medical evaluation regardless of whether they receive PEP.
      ii) Follow-up HIV-antibody testing should be performed at the following intervals after the exposure date: 6 weeks, 12 weeks, and 6 months.
      iii) If the exposed person becomes HCV infected after exposure to an HIV/HCV co-infected source, and HIV-antibody test should also be obtained at 12 months.
   d) Special considerations for HIV PEP – expert consultation regarding provision of HIV PEP is considered essential in the following special situations:
      i) Delayed initiation of HIV PEP;
      ii) Unknown source (e.g., needle in a sharps container/tattoo needles);
      iii) Known or suspected pregnancy in the exposed person;
      iv) Source case has evidence of antiretroviral resistance;
v) PEP side effects;
vi) Expanded regimens.

**HEPATITIS B POST-EXPOSURE TREATMENT**

1) Prompt assessment and follow-up is essential in the evaluation and decision making regarding HBV post-exposure management. The management of exposures is dependent upon the source case and test results and the vaccination status of the exposed person. The corporate Chief Medical Officer will be consulted on cases where HBV prophylaxis is being considered for a patient.

2) The source case should be tested for HBsAG; those that are HBsAg positive should be tested for HBeAg.
3) The exposed person should be assessed for HBV vaccination status and vaccine response status (previous anti-HBs result).
   a) Those that were tested post-vaccination do not need further testing to assess anti-HBs levels.
   b) Previously vaccinated persons who were not tested for anti-HBs post-vaccination should be tested for anti-HBs using a quantitative method that allows detection of the protective concentration of anti-HBs.
   c) Testing the source patient and the exposed person should occur simultaneously.

4) For exposed persons who are potentially susceptible:
   a) HBV immune globulin and HBV vaccine should be administered as soon as possible after an exposure.
   b) The effectiveness of HBV immune globulin when administered >7 days after exposures is unknown.

5) If a person is currently in the middle of a HBV vaccine series when exposed, then vaccine should be given according to the usual schedule.

6) Incompletely vaccinated persons should receive additional dose(s) to complete the 3-dose vaccine series.

7) Recommendations for post-exposure management of persons who sustain an exposure to an HBsAg positive or unknown source is summarized by the CDC and can be found clicking here. https://www.cdc.gov/hepatitis/hbv/pep/htm

HEPATITIS C POST EXPOSURE TREATMENT
1) There is no known effective prophylaxis for persons exposed to an HCV-positive source.
2) Standard immune globulin is not effective for post exposure prophylaxis of Hepatitis C and will not be given.
3) The corporate Chief Medical Officer or designee will order the following for the exposed patient:
   a) Baseline testing (at time of exposure) for anti-HCV and ALT.
   b) Four months post exposure – anti-HCV and ALT.
   c) Six months post exposure – anti-HCV is negative, then obtain an anti-HCV and ALT. if anti-HCV continues to be negative, then stop further follow-up. If anti-HCV is positive, then obtain HCV RNA. If HCV RNA is positive, then evaluate for treatment.

TETANUS VACCINE
1) For “clean” wounds, a tetanus booster is not indicated.
2) For wounds that are neither minor nor clean (potentially contaminated with dirt or saliva) the exposed person should be evaluated as follows:
   a) For those with an unknown history of tetanus vaccine of less than three doses, administration of immune globulin and the 3-dose vaccine series is indicated.
b) For those with a history of a complete tetanus series, who had a booster more than 5 years ago, administration of Td or Tdap is indicated.

c) For those with a history of three or more doses of Td vaccine and whose last booster was less than 5 years ago, no tetanus booster is required.

**HUMAN BITES ONLY**

1) Individuals with human bite wounds have a high risk of serious bacterial infections and close monitoring of the wound is necessary.

2) Prophylactic antibiotic treatment should be considered for bites to the hands, feet, face, or skin overlying cartilaginous structures of bites that penetrate deeper than the epidural layer.

   a) As soon as possible (prior to signs of infection) treat with amoxicillin-clavulanate 875/125 mg by mouth, twice daily for 5 days.

   b) For penicillin allergies treat with clindamycin (450 mg by mouth three time daily) together with either ciprofloxacin (500 mg twice daily) or sulfamethoxazole/trimethoprim (800/160 mg twice daily) for 5 days.

**SEXUAL EXPOSURES ONLY**

1) Any allegation made by an individual of recent sexual assault should receive prompt forensic evaluation by a health care professional trained in collecting sexual assault forensic evidence.

2) Health care staff will follow all protocols for reporting to the designated institutional authorities and will comply with the Prison Rape Elimination Act (PREA).

3) Evaluation and treatment for sexually transmitted diseases should be considered on a case-by-case basis. Specimen collection for STDs should not be performed until necessary forensic evidence collection has been completed.

4) Refer to Proactive policy Sexual Abuse and Assault for additional guidance.

**PROVIDE COUNSELING, EDUCATION, AND REFERRAL**

1) Individuals with exposures to bloodborne pathogens should be counseled to avoid behaviors by which they could transmit the organisms to another person.

   a) HIV exposure should prompt avoidance of unprotected sex, pregnancy, breastfeeding, and donating blood, organs, tissue, or semen.

   b) HBV or HCV exposure should prompt avoidance of donating blood, organs, or semen.

2) A plan should be made for appropriate follow-up care, preferable with an experienced clinician.

3) When indicated a referral for counseling should be made to help the exposed person cope with the stress associated with a significant exposure.

**COMPLETE REPORTING AND DOCUMENTATION**
1) Reporting and documentation of exposure incidents should include the following:
   a) Report the exposure incident to the appropriate facility supervisor;
   b) Complete an incident report;
   c) Maintain documentation of incident for infection control purposes;
   d) Document exposure follow-up in the individual’s medical record. Do not record the identity of the source case in the exposed person’s medical record;
   e) Utilize appropriate forms in conjunction with HIV testing, administering vaccines, etc.

2) Analyzing the exposure incident:
   a) After providing initial post-exposure management, analyze the incident to determine how similar incidents could be prevented in the future.
   b) Identify contributing factors and insights as to how the incident could have been prevented.
   c) Develop an action plan with interventions to reduce blood exposure.

Relevant Forms

Inmate Food Service Worker Clearance

Inmate Worker Biohazard Training

References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-02 Pandemic Response

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Infectious Disease Prevention and Control (J-B-02)

NCCHC Opioid Standard: Infection Prevention and Control Program (O-B-01)

ACA Standard: Communicable Disease and Infection Control Program (4-ALDF-4C-14, 15, 16, 17, 18)

Purpose

To prepare health care staff to implement the aspects of Proactive’s response to an infectious disease pandemic and to ensure the health, safety and welfare of patients, staff, and visitors.

Policy

Proactive staff will work in conjunction with the institution to ensure the health, safety and welfare of patients, staff and visitors is not jeopardized within the confines of the correctional institution during a pandemic of infectious disease. The Pandemic Response Plan will be based on guidelines established by the Center for Disease Control and Prevention.

Procedure

1) Health aspects of the Pandemic Response Plan will be approved by the institutional authority as well as Proactive’s corporate Chief Medical Officer, and will include:
   a) Responsibilities of health care;
   b) Procedures for triage;
   c) Predetermination of the site for care;
   d) Telephone numbers and procedures for calling health staff and the community emergency response system;
   e) Procedures for evacuating patients; and
   f) Alternate backups for each of the plan’s elements.

2) Health care staff will be trained in the implementation of the Pandemic Response Plan in the facility so that each shift has participated. Training provided to health care staff will be documented in the Education Log.

3) Critiques of the Pandemic Response Plan and tabletop exercise will be conducted, reviewed, documented, and shared with all health care staff.

4) Standard precautions will be followed with all patient contacts. Health care staff will implement Proactive’s exposure control plan as defined in the Infection Control Program Policy and Procedure to eliminate and minimize exposure to infectious disease.
5) All patients will be assessed for possible infectious disease upon admission to the institution and appropriate precautions taken.

6) Should a pandemic episode occur or be suspected within the facility, health care staff should immediately implement the Pandemic Checklist.

7) The Health Service Administrator/Responsible Health Authority and any appropriate Proactive staff along with the institution staff, as appropriate, will conduct annual meetings to review the Pandemic Committee Plan.

8) Annual meetings will include any recommendations or suggestions made by Proactive’s Corporate Chief Medical Officer, Regional Nursing Directors, Corporate Pharmacy, Facility Medical Director, Health Service Administrator, Director of Nursing, Food Vendor, Public Health Department, and appropriate correctional staff.

9) The annual meetings will address, at a minimum, the following issues:
   a) Communication;
   b) Quarantine and Isolation;
   c) Vaccine Supply;
   d) Annual Vaccines;
   e) Staffing; and,
   f) Education and Training.

10) The institution will abide by local and federal regulations regarding the reporting of infectious diseases as detailed in Proactive’s Infection Control Policy and Procedure.

Relevant Forms

Education Log

Pandemic Checklist

Pandemic Committee Plan

Pandemic Team Organization Chart

References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-03 Clinical Preventive Services

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Clinical Preventive Services (J-B-03)

NCCHC Opioid Standard: Health Assessments (O-E-02); Healthy Lifestyle Promotion (O-F-01)

ACA Standard: Preventive Services (4-ALDF-4C-26)

Purpose
To ensure patients are provided with clinical preventive services as medically indicated.

Policy
The site responsible physician and dentist, where applicable, will determine the frequency and content of periodic screening assessments and other preventive services. The physician will determine the medical necessity and timing of screening for communicable diseases as well as immunizations.

Procedure
1) The responsible physician determines the medical necessity and/or timing of screenings and other preventive services (e.g., mammograms, colorectal screening, prostate screening, Pap smears) appropriate to the facility population. However, Proactive corporate minimum standard is to offer access to age appropriate preventative screening education at annual health assessments. (see #2a below).

2) Health assessments will be offered annually. The content of the annual health assessment can be adjusted by the responsible physician as appropriate to the facility population.
   a) At the annual Health Assessment, the RN will offer the patient an appointment with a provider to discuss individualized preventative care screenings and treatment options.
   b) If the patient consents, the patient is to be scheduled for a routine provider appointment. Any facility co-pays would be applicable.
   c) Providers should access Up-to-date, the CDC, and the United States Preventative Services Task Force to determine the most appropriate screenings. Links to these sites are located in TechCare.

3) Dental evaluations by the dentist are offered annually. The dentist determines the frequency and content of these dental evaluations as appropriate to the facility population.

4) The responsible physician determines the medical necessity and/or timing of screening for communicable diseases (e.g., HIV, syphilis, gonorrhea, chlamydia), to include laboratory
confirmation, treatment, and follow-up as clinically indicated appropriate to the facility population.

a. Facilities are encouraged to coordinate with their local public health department for recommendations on testing and treatment of communicable diseases.

5) Influenza vaccine is offered annually to high-risk populations. Tdap is offered to all pregnant females as clinically appropriate. Tdap booster is offered to patients with exposure risks as determined by the treating provider. Other immunizations are administered to patients as clinically indicated by provider order.

Relevant Forms
N/A

References

Health Assessments (O-E-02); Healthy Lifestyle Promotion (O-F-01). National Commission on Correctional Health Care: Standards for Opioid Treatment Programs in Correctional Facilities, 2016.


Section B: Health Promotion, Safety, and Disease Prevention

J-B-04 Medical Surveillance of Inmate Workers

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medical Surveillance of Inmate Workers (J-B-03)

ACA Standard: Injury Prevention (4-ALDF-1A-08); Inmate Assistants (4-ALDF-4D-11)

Other Applicable Standard: N/A

Purpose
To ensure that the health and safety of the inmate worker population is protected.

Policy
Proactive and the responsible physician develop program to prevent illness and injury among the inmate worker population that is an integrated approach to identify and reduce hazards whether they are occupational, environmental, infectious, or other sources.

Procedure
1) An institutional committee identifies and oversees inmate occupational-associated risks through a medical surveillance program. This will be incorporated into the facility CQI and Infection Control Programs.

2) An initial medical screening of an inmate to evaluate for contraindications will be completed prior to enrollment in the work programs. At some facilities, this clearance can be added to the initial health assessment. Enrollment to the work program will be based on job risk factors and patient condition at the time the medical screening is completed.

3) Ongoing medical screening of inmates in work programs will be conducted in a way that affords the same health protections as medical screening of employee workers in equivalent jobs. The institutional committee reviews all job types yearly for proper training material for inmate workers and ongoing clearance guidelines by health staff for all job types.

4) The responsible physician reviews and approves the health aspects of the medical surveillance program.

5) Inmate illness or injury potentially related to occupational exposure or with occupational implications is identified and the information provided to the quality improvement committee for review.

Relevant Forms
No relevant forms for this policy.
References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-05 Suicide Prevention and Intervention

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Suicide Prevention and Intervention (J-B-05)

NCCHC Opioid Treatment Standard: Suicide Prevention Program (O-G-01)

NCCHC MH Standard: Suicide prevention Program (MH-G-04)

ACA Standard: Suicide Prevention and Intervention (4-ALDF-4C-32)

Purpose

To establish procedures for the identification and management of acutely and non-acutely suicidal patients, to reduce the potential for suicide by detainees, to minimize the harm when suicide attempts occur, and to minimize the overall number of suicide completions with the goal of eliminating completed suicides.

Policy

Proactive will maintain a program for the prevention of suicides and to identify and implement appropriate corrective action when suicides do occur.

Procedure

1) Proactive will maintain a program for suicide prevention in all facilities. In jails where Proactive provides medical care but is not contracted to provide mental health, Proactive will work in close association with the mental health provider to prevent suicides.

2) A receiving screen is conducted on all detainees entering an institution as soon as possible after arrival. Qualified health care professionals or health trained correctional officers complete the receiving screen.

3) The receiving screen includes questions regarding past or current mental illness, including hospitalizations; any history of suicidal ideations or attempts; any current suicidal ideation; legal or illegal drug use, drug withdrawal symptoms, and other pertinent medical questions. Reception personnel record on the receiving screen observations of the detainee’s appearance, behavior, state of consciousness, ease of movement, breathing, etc.

4) Upon admission to the correctional system, a qualified health care professional with appropriate training will conduct an initial mental health screening on all detainees. In facilities where the Receiving Screen is conducted by trained correctional officers, the mental health screen will be completed within 14 days by qualified health care professionals with appropriate training.
5) The mental health screen includes inquiries regarding: prior psychiatric hospitalizations, past suicidal ideation and/or attempts; current suicidal ideations; suicidal threats or plans; prior violent behavior; prior victimization; special education placement; prior cerebral trauma or seizures; prior sex offenses; current and past use of psychotropic medications; current and past drug or alcohol use; substance use hospitalization; detoxification and outpatient treatment; and, behavior observations regarding the inmate’s orientation to person, place and time. Additionally, questions regarding significant losses, family mental health and suicide history, suicidal behaviors during prior incarcerations will be recorded. Any observations from transporting officers or other staff that may contribute to a suspicion of suicidal ideation will also be noted in the record.

6) All patients with a positive mental health screen will be referred for a mental health evaluation.

7) Any patient who screens positive for suicidal ideation will be placed on a suicide watch and be kept under close observation based on level of suicide risk.
   a) Acutely suicidal patients are those that are actively engaging in self-injurious behavior and/or threaten suicide with a specific plan. Proactive staff will order placement under constant observation monitored by an assigned staff member on a continuous, uninterrupted basis. Documentation of monitoring will occur per custody staff protocols. Proactive will encourage the use of camera or inmate workers only as an adjunct to staff supervision.
   b) Non-acutely suicidal patients are those that express current suicidal ideation by expressing a wish to die without a specific plan, have a recent history of self-destructive behavior, or demonstrate other concerning behavior indicating the potential for self-injury. Proactive will order that these patients are monitored by facility staff at unpredictable intervals with no more than 15 minutes between documented checks.

8) Any staff who hears a patient verbalizing a desire or intent to commit suicide, observes a patient making an attempt or gesture, or otherwise feels a patient is at risk for suicide, will take immediate steps to ensure the patient is continuously observed and prevented from harm until appropriate medical, mental health, and/or supervisory assistance is obtained.

9) A qualified health care professional will respond as soon as possible upon notification and conduct a face-to-face evaluation of the patient, document appropriately, and report findings during consultation with the site psychiatrist or qualified mental health professional. Health staff will recommend that a potentially suicidal patient be housed in a safe cell, or other secure housing, and placed on a suicide watch until evaluated by a qualified mental health professional.

10) Suicide watch:
    a) Patients placed on a suicide watch may be strip searched prior to being placed in a safe cell according to the correctional facility’s policies and procedures.
b) All clinical decisions regarding the removal of a patient’s clothing, bedding, possessions (books, slippers/sandals, eyeglasses, etc.) and privileges shall be commensurate with the level of suicide risk as determined on a case-by-case basis by a qualified mental health professional and documented in TechCare. This does not apply to custody-ordered restrictions, only clinically ordered restrictions.

c) If a qualified mental health professional determines that a patient’s clothing needs to be removed for reasons of safety, health staff will not restrict the use of a safety smock and safety blanket.

d) Clinically ordered physical restraints may only be utilized as a last resort for periods in which the patient is physically engaging in self-destructive behavior. The decision to utilize physical restraints for suicidal patients are only to be made by qualified mental health professionals in conjunction with the appropriate corrections staff, according to the facility’s policies and procedures. See Proactive’s Restraint and Seclusion policy.

e) All patients placed on suicide watch will receive a face-to-face evaluation by a qualified mental health professional in a timely manner. Referral for follow-up with a mental health provider is to be made as clinically indicated.

f) The patient who is on suicide watch will be assessed at least once every 24 hours by a qualified mental health professional or appropriately trained qualified health care professional on days where no qualified mental health professional is onsite. These assessments will be recorded in TechCare using the Suicide Note form.

g) Only a qualified mental health professional has the ability to remove a patient from suicide watch.

h) The patient will be reassessed within 24 hours of being discharged from suicide watch by a qualified mental health professional or appropriately trained qualified health care professional on days where no qualified mental health professional is onsite. Periodic follow-up assessments will continue as deemed clinically appropriate.

i) Where appropriate, interdisciplinary team meetings, to include correctional, mental health, and medical staff will be conducted to discuss patients on suicide watch that require close supervision and planning.

j) Treatment plans for the suicidal patients are developed with follow-up as clinically indicated.

11) Training:

a) Staff responsible for patient assessment, treatment, or supervision will receive suicide prevention training as part of their orientation. Staff will also receive a training update on an annual basis.

b) Training will include:

i) General information regarding suicides and suicidal behaviors;
ii) Recognition of the signs and symptoms of suicidal behavior, particularly as they pertain to the correctional environment;
iii) Factors that increase the risk for suicide for patients;
iv) A review of Proactive’s Suicide Prevention policy.
c) Proactive qualified mental health professionals, in collaboration with the institutional training officers, may assist with suicide training of correctional staff as well as orient all institutional staff with responsibility for detainee supervision to the Proactive Suicide Prevention policy. Proactive qualified mental health professionals may also be asked by institutional training officers to be involved in annual suicide prevention training for officers.
d) All health staff will be trained in standard first aid and cardiopulmonary resuscitation (CPR).
e) Standard first aid and CPR are to be initiated on anyone found to be unconscious and not breathing.
   i) The staff is trained not to presume that an inmate is deceased.
   ii) Standard first aid and CPR are to be continued until relieved by appropriate medical personnel.
12) Reporting and reviews – serious suicide attempt:
a) A serious suicide attempt is defined as those incidents requiring outside treatment or hospitalization.
b) The Health Services Administrator (HSA) or designee will immediately notify the on-site Medical Director and institutional authority of any serious suicide attempt.
c) A Medical Emergency Code Report is to be completed by staff members responding to the emergency and forwarded to the corporate office via email at notification@naphcare.com by the HSA within twenty-four (24) hours.
d) An administrative review will be conducted by the HSA within thirty (30) calendar days of the event. This review will assess the response actions and procedures used by the correctional and emergency staff involved. Upon completion the report should be forwarded to the corporate office via email at notification@naphcare.com.
e) The Mental Health Director, primary psychiatric provider, or mental health professional will complete the Proactive Suicide and Self-Harm Behavior Case Report. This report should be done within three (3) days of the event. This report will provide information on patient characteristics, and precipitating factors. This report will assist in identifying trends and opportunities for improvement as well as ascertain compliance with Proactive’s standard of care. Upon completion, it should be forwarded to the corporate office via email to notification@naphcare.com.
f) If the suicide was successfully completed then a Psychological Autopsy Case Report should be completed by the primary psychiatric provider or mental health director. This report will provide detailed, comprehensive documentation of
information and circumstances that led to the event. This will be used to assist in identifying trends and opportunities for improvement, as well as ascertain compliance with Proactive’s standard of care. Upon completion, it should be forwarded to the corporate office via email at notification@naphcare.com.

g) The incident report form, and Medical Emergency Code Report, should be forwarded to the corporate office along with the above noted forms. These forms should be sent via email to notification@naphcare.com.

h) Upon completion, the conclusions of all of the above information should be shared with the treating staff in the form of a Morbidity and Mortality meeting. Minutes of this meeting should be forwarded to the corporate M and M coordinator. See Proactive’s policy Procedure in the Event of an Inmate Death, if the event resulted in death.

i) The corporate Morbidity and Mortality (M&M) Review Committee will review all documentation and will report results to the on-site health care team.

j) At all times during the M&M review process, attention should be paid to any indications that the patient may have an undiagnosed and/or untreated communicable disease. This finding must immediately be discussed with the responsible physician and Corporate Chief Medical Officer, as these are matters of public health and may indicate a need for rapid action, such as appropriate communication with public health authorities.

k) Reviews should include the following:
   i) A critical review of the circumstances surrounding the incident;
   ii) A critical review of Proactive procedures relevant to the incident with copies of documentation confirming procedural implementation;
   iii) A synopsis of all relevant training received by involved staff;
   iv) Pertinent physical and mental health care services reports, including a summary of the patient’s involvement prior to death; and Recommendations, if any, for change in policy, procedure, training, and physical or mental health care services in the form of a corrective action plan

13) Corrective action plan:
   a) Corrective action identified through the review process may require the implementation of a Corrective Action Plan (CAP).
   b) CAPs will be developed by the HSA in coordination with the site’s psychiatric provider or mental health director.
   c) CAPs should be submitted to the Corporate Chief Medical Officer for approval and forwarded to the Corporate M&M coordinator.
   d) CAPs are to be implemented and monitored through the facility’s continuous quality improvement program.
e) The ultimate goal is to identify, evaluate, and improve the quality and efficiency of health care rendered at all institutions with the aim to reduce morbidity and mortality.

14) Critical incident debriefing:
   a) A critical incident debriefing provides affected staff and offenders an opportunity to process their feelings about the incident.
   b) Critical incident debriefings are available to all staff and detainees who may have been affected by a serious suicide attempt or a completed suicide.

Relevant Forms

Proactive Suicide and Self-Harm Behavior Case Report
Corrective Action Plan
Incident Report
Medical Emergency Code Sheet
Site Psychological Autopsy Case Report
Suicide Watch Observation Log

References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-06 Contraception

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Contraception (J-B-06)

ACA Standard: Pregnancy Management (4-ALDF-4C-13)

Purpose

To ensure that women receive appropriate contraceptive services as clinically indicated.

Policy

Proactive will provide emergency contraception as clinically indicated. Contraception will be made available upon request to females upon release.

Procedure

1) Emergency contraception will be made available to females at intake and following sexual assault.
2) Female patients will be provided the opportunity to continue contraception at the time of intake, if appropriate.
3) For planned releases to the community, arrangements are made to initiate contraception for women, upon request.
4) Written educational materials regarding contraception and community resources will be made available.

Relevant Forms

N/A

References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-07 Communication on Patient’ Health Needs

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Communication on Patients’ Health Needs (J-B-07)

NCCHC Opioid Standard: Communication on Patients’ Health Needs (O-A-08)

NCCHC MH Standard: Communication on Patients’ Mental Health Needs (MH-A-08)

ACA Standard: Special Needs Inmates (4-ALDF-4C-40); Confidentiality (4-ALDF-4D-14); Transfers (4-ALDF-4D-27)

Purpose

To ensure communication occurs between the facility administration and treating health staff regarding patients significant health needs that must be considered in classification decisions in order to preserve the health and safety of that patient, other patients, medical staff, correctional staff, volunteers, and visitors.

Policy

Proactive will identify patient with special needs, develop and periodically review an appropriate treatment plan, and communicate any pertinent concerns to designated staff.

Procedure

1) Health care staff should communicate with correctional staff regarding any patient special needs that may affect:
   a) Housing
   b) Work assignments
   c) Program assignments or selection
   d) Disciplinary measures
   e) Transport to and from outside appointments
   f) Admissions to and transfers from facilities
   g) Clothing or appearance;
   h) Chronic mental illness
   i) Suicidal intent/behavior;
   j) Developmental disability;
   k) Significant substance use history;
   l) Victim of physical or sexual assault;
   m) Other serious medical/mental health problems;
   n) Activities of daily living.
2) Health staff should try to limit the communication to the minimum amount necessary that the particular correctional staff member has a need to know (e.g., just the needed accommodation to a line officer, but may include the diagnosis and treatment plan if necessary to the jail commander).

3) Communication of health needs is documented per facility policy.

Relevant Forms
N/A

References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-08 Patient Safety

Effective Date:  01/01/2020

Policy Revised:

NCCHC Standard: Patient Safety (J-B-08)

NCCHC Opioid Standard: Patient Safety (O-B-02)

NCCHC MH Standard: Patient Safety (MH-B-02)

ACA Standard: Injury Prevention (4-ALDF-1A-08); Safety and Sanitation (4-ALDF-2A-03); Emergency Plans (4-ALDF-2D-03)

Purpose

To establish a method of protection and safety for patients.

Policy

Proactive is committed to the safety and security of patients for the provision of health care.

Procedure

1) The Health Service Administrator (HSA) or designee will promote patient safety by implementing a patient safety system to prevent adverse and near-miss clinical events by:
   a) Assuring all health care staff has received proper orientation and training;
   b) Encouraging health care staff to identify opportunities to reduce harm or potential harm to patients (e.g., patients with a propensity for seizures being offered a lower bunk);
   c) Educating staff of the process for and non-punitive nature of reporting adverse and near-miss events; and
   d) Ensuring all Proactive policies and procedures are in place within the facility.

2) The HSA or designee will maintain documentation of any adverse or near-miss clinical event with an error reporting system as follows:
   a) Any adverse or near-miss clinical event is to be reported to the corporate jail operations department and corporate legal department immediately;
   b) An Incident Report must be completed and submitted to the corporate jail operations department and corporate legal department within 48 hours of the event;
   c) Should the event be related to a medication variance, all policies and procedures related to medication variances should be followed, including submitting a medication variance report to the corporate jail operation department, pharmacy (if applicable), and corporate legal department immediately.
Relevant Forms

Contraband Perpetual Inventory

Corrective Action Plan

Incident Report

Safety and Sanitation Inspection Form

Medication Variance Form

References


Section B: Health Promotion, Safety, and Disease Prevention

J-B-09 Staff Safety

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Staff Safety (J-B-09)

NCCHC Opioid Standard: Staff Safety (O-B-03)

NCCHC MH Standard: Staff Safety (MH-B-03)

ACA Standard: Injury Prevention (4-ALDF-1A-08); Safety and Sanitation (4-ALDF-2A-03); Emergency Plans (4-ALDF-2D-03)

Purpose
To establish a method of protection and safety for all staff, including custody staff and visitors during emergent events.

Policy
Proactive is committed to the safety and security of health care and institutional staff for the provision of health care services.

Procedure
1) The Health Service Administrator (HSA) or designee will monitor and ensure the following activities and components of the safety program are performed:
    a) Liquid, solid, and hazardous materials are handled, stored, and disposed of in a safe and sanitary manner consistent with local, state, and federal regulations;
    b) Personal protective equipment (i.e., gloves, lab coats, face shields) is available to all staff and patients who may potentially be exposed to infectious, parasitic, or hazardous materials or objects;
    c) Medical and dental instruments, equipment, and supplies, if applicable, are controlled and inventoried on the Contraband Perpetual Inventory form daily;
    d) Regular equipment inspections and servicing, consistent with manufacturer specifications and state regulations, are undertaken for all heavy equipment (i.e., x-ray equipment), to assure that all continue to function properly;
    e) Negative pressure areas for the control of infectious disease are monitored regularly for air quality;
    f) Monthly environmental inspections of the facility are conducted by the institutional authority with documentation of corrective action;
g) All staff sharps injuries are monitored and logged appropriately on the Staff Injury Log. All staff will be required to complete in-service training regarding the proper handling of sharps after two (2) injuries within a six (6) month period;

h) Documentation of inspections, servicing, and monitoring is maintained on the Safety and Sanitation Inspection Report to be included in the MAC and Continuous Quality Improvement meetings;

i) Flammable, toxic, and caustic materials are controlled and used safely;

j) A Material Safety Data Sheet (MSDS) will be maintained on each chemical and a manual of all MSDS information will be kept on site for reference;

k) Emergency communication procedures are identified and established and involve on-site health care staff in conjunction with institution procedures;

l) When a safety concern arises, custody staff are requested and readily available to health staff;

m) Health care staff receive instructions on this safety component and documentation is maintained; and

n) A Corrective Action Plan is documented and instituted regarding any deficiencies.

2) TB screening tests are conducted annually on all healthcare staff.

   a) See Tuberculin Status Assessment for PPD Reactors form for those with past positive skin test.

3) Vaccinations of health staff (e.g., Influenza vaccine) are provided and approved at the discretion of the corporate pharmacy, COO, and CMOs.

4) In the case of accident, trauma, altercation, or any other emergency event necessitating evaluation and/or treatment by staff, emergency stabilization of all employees, jail staff, and visitors will be provided by on-site healthcare staff.

   a) Health staff should use established protocols for patient care to assist in providing this emergency stabilization.

   b) Any stock medications that are used should be documented and reported to the HSA for proper accounting of these medications.

   c) HSA should email a summary of the event using the Incident Report Form and/or Staff Injury Log to notification@naphcare.com.

Relevant Forms

Contraband Perpetual Inventory

Corrective Action Plan

Incident Report

Safety and Sanitation Inspection Form

Needle and Syringe End of Shift Count Sheet
Sterilization Monitoring Log

Sterilization Record

References


Section C: Personnel and Training

J-C-01 Credentials

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Credentials (J-C-01)
NCCHC Opioid Standard: Credentials (O-C-01)
NCCHC MH Standard: Credentials (MH-C-01)

ACA Standard: Personnel Qualifications (4-ALDF-4D-03); Credentials 94-ALDF-4D-05

Purpose

To provide a mechanism to ensure that all health care staff employed or contracted by Proactive hold a valid license or verification to practice within their professions in correctional facilities.

Policy

Proactive will ensure that all professional health care staff comply with applicable state and federal licensure, certification, or registration requirements. Verification of current credentials and job descriptions will be kept electronically on Proactive’s internal website.

Procedure

1) Proactive’s Corporate Office will maintain responsibility for verification of credentials for all employees with a license, certification, or registration that is governed by state or federal laws or regulations. All documents will be obtained by site management:
   a) All candidates must complete a credentialing packet provided by the Proactive corporate office, which will provide the employee with professional liability coverage.
   b) Prospective professional health care staff will present only original documents for verification purposes. The original license will be photocopied and filed with proof of license verification.
   c) It is the responsibility of the Health Services Administrator (HSA) or designee to obtain a current license, registration, or certification; visually inspect it; and send a copy to the corporate office.
   d) Verification and status of licensure for employees is made by contact to the applicable state board prior to making a contract agreement or offer of employment. Documentation of this verification for all non-independent contractors is maintained in their personnel files.
e) The corporate office will conduct a monthly review of staff credentials due to expire, the results of which will be reviewed by the HSA who will then visually inspect and copy the updated license, registration, or certification. Copies of the updated credentials are to be maintained in a file at the corporate office.

f) Credentialing review for professional health care staff will include, but is not limited to, local privileges, if applicable; copying of current professional license, registration, or certification; Drug Enforcement Administration certification, if applicable; curriculum vitae or resume; and application for employment.

2) Verification of credentials will include inquiry regarding sanctions or disciplinary actions of state boards, and the National Practitioner Data Bank (NPDB), and may include inquiries to past employers. Primary source verification by electronic means may also be employed.

3) Health care staff may not perform tasks beyond those permitted by their credentials. Only qualified health care staff will provide clinical treatment to patients.

4) The corporate office will maintain verification of credentials for Proactive contract, full-time, part-time, and per diem professional health care staff. Thereafter, health care staff governed by state professional regulatory boards will be responsible for keeping credentials current for either the duration of their contract or the duration of employment. This includes any continuing education credits that may be mandated.

5) A license specifically restricting practice to correctional institutions is not in compliance with Proactive’s policies and procedures:
   a) All professional health care staff is responsible for notifying the HSA immediately if their license to practice has been revoked, restricted, or is under investigation for any reason. The HSA will then notify both the President and Corporate Chief Medical Officer of Proactive as soon as possible;
   b) If any employee cannot or does not provide a renewed license by the expiration date of their current license, the following actions must be taken:
      i) The employee must cease the performance of all duties requiring licensure; and
      ii) The HSA must make immediate notification to both the corporate Jail Operations Department and corporate Human Resource Department.

6) Specialists providing on-site or tele-health care services have appropriate licenses and certification on file.

7) All health care staff will practice within the confines of their job description, which includes qualifications and specific duties and responsibilities.

Relevant Forms
No relevant forms for this policy.

References


Section B: Personnel and Training

J-C-02 Clinical Performance Enhancement

Effective Date: 01/01/2020

Policy Revised:
NCCHC Standard: Clinical Performance Enhancement (J-C-02)
NCCHC Opioid Standard: Professional Development (O-C-03)
NCCHC MH Standard: Clinical Performance Enhancement (MH-C-02)
ACA Standard: Peer Review (4-ALDF-4D-25)

Purpose
To ensure individuals delivering patient care are reviewed through a clinical performance enhancement program.

Policy
Proactive will conduct an annual peer review on all patient care clinicians.

Procedure
1) The clinical performance enhancement process will evaluate the appropriateness of the services provided by the facility’s direct patient care clinicians:
   a) Providers
   b) RNs
   c) LPN/LVN
   d) Psychologists
   e) Licensed Clinical Social Workers
   f) Dentists
2) The clinical performance reviews (peer reviews) will be performed on the required staff at least annually. Initial peer reviews on new staff will occur within one year of their start date and will occur no sooner than six (6) months from their date of hire.
3) Clinical performance enhancement reviews are performed in the form of peer reviews and should include the name and credentials of the staff member being reviewed, the name and credentials of the reviewer, date of the review, confirmation that the review was shared with the reviewed staff member, and a summary of the findings and corrective action, if necessary.
   a) All documentation regarding peer review activities are confidential and are to be stamped “Peer Review” and filed in a secure place;
b) Provider documentation will meet or exceed a 90% threshold of compliance for each discipline reviewed;

c) Peer review documents are not to be distributed to anyone except the person being reviewed. The Health Services Administrator may need the help of non-physicians, such as nurses, administrators, etc. to investigate certain deficiencies. It is permissible to transcribe some of the information to convey the essence of issues in question, but clinicians must not forward to or copy anyone with Peer Review materials or documents;

d) A peer review log will be maintained by the Health Services Administrator and will include the name of the individual being reviewed with credentials; the date of the last peer review; the initials and credentials of the person performing the review; and if a CAP is required, the date that the CAP was done and when the CAP was completed.

4) Reviews will be documented on appropriate peer review forms, copies of which will be held at the corporate office. The reviews will determine compliance in areas such as:
   a) Completeness of necessary documentation;
   b) Appropriateness and thoroughness in addressing the health complaint;
   c) Documentation and appropriateness of the physical findings;
   d) Laboratory and diagnostic data and thoroughness of the care plan which should address all abnormal findings; and
   e) Documentation of the need for consultations or other referrals to a higher level of care where applicable.

5) The responsible health authority will conduct an independent review should any serious concern arise regarding any alleged variations from the community standard of care.

6) The responsible health authority will implement procedures to improve the health care clinician’s competence when necessary.

7) A corrective action plan (CAP) will be developed utilizing the CAP form as a means to document the intention of change and indicate the plan of action to implement the desired change. The CAP can be proactive or reactive in regard to issues relevant to compliance with Proactive’s policies and procedures.

8) The Health Services Administrator will notify the involved health care staff, meet with the involved health staff individually and develop an individual CAP with each staff member within seven (7) days of any inquiry generated from the corporate office regarding a perceived clinical problem.

9) The CAP must be submitted to the Corporate CQI Committee chairman within ten (10) days of the inquiry of identification of problematic on-site issues.

10) If the Health Services Administrator agrees with the corporate office’s determination that an error, omission or commission occurred, it should be so stated in the CAP and an institutional staff meeting of all staff involved will occur and be documented to prevent or
minimize the occurrence of such errors in the future. The Health Services Administrator’s response should include:

a) Acknowledgement that a problem occurs;

b) A review of its causes;

c) A CAP with its remedies;

d) A date for the staff meeting with a roster of who attended; and

e) Minutes of what was discussed.

11) In the event the on-site staff identifies an issue of non-compliance with any Proactive policy or procedure, a CAP will be initiated for resolution and a copy will be forwarded to the Corporate CQI Committee chairman.

12) A CAP will be documented and may take the form of oral or written counseling, staff education and/or retraining, reduction in privileges, suspension or separation. All applicable laws and regulations regarding reporting of sanctions or privilege reductions will be followed with communications to appropriate Boards and Authorities and the Proactive Chief Executive Officer.

13) CAPs involving measureable criteria will be considered on going until a compliance rate of 90% is achieved. If an indicator fails to achieve 90% compliance after two review periods then the corporate CQI Committee Chairman will be consulted. A minimum of 10 samples will be utilized to determine compliance rates.

14) The CAP process is educational and aimed to document that the corporate office and/or institutional Health Services Administrator did look into the matters of non-compliance with any and all Proactive policies and procedures.

15) Upon request, Proactive shall provide to accrediting organizations a statement that such confidential review occurred and was part of the CQI process.

Relevant Forms

Corrective Action Plan

MH Professional Peer Review

Peer Review Dental

Peer Review Mid-Level

Peer Review Physician

Peer Review Psychiatrist

References


Section B: Personnel and Training

J-C-03 Professional Development

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Professional Development (J-C-03)

NCCHC Opioid Standard: Professional Development (O-C-03)

NCCHC MH Standard: Training for Mental Health Staff (MH-C-03)

ACA Standard: N/A

Purpose
To encourage qualified health care staff to continue education and professional development to ensure the provision of quality health care.

Policy
Proactive supports ongoing staff training pertaining to the provision of services within the correctional environment. Ongoing on-site and national in-service training on specific clinical issues, professional ethical standards, and topics relevant to corrections will be provided in order to enhance the quality of care to patients and to meet standards and recommendations of regulatory agencies (e.g., NCCHC, ACA, OSHA, and JCAHO).

Procedure
1) Full-time health staff will participate in a continuing education program that is appropriate to their position, at a minimum of twelve (12) hours annually.
   a) For facilities with OTP services, OTP health staff shall include 4 hours specific to Opioid Treatment.
2) Part-time health care staff will have education hours pro-rated on full-time equivalency.
3) To maintain compliance:
   a) For states in which twelve (12) hours of continuing education are required annually to maintain a clinical license, a current license will suffice as evidence of completing such continuing education.
   b) The RHA will maintain a list of the state’s continuing education requirements for each category of licensure for all qualified health care professionals.
   c) A valid certification will suffice for Certified Correctional Health Professionals (CCHP).
   d) Documentation is on file for all completed courses, including dates and number of hours per course.
4) All qualified health professionals who have patient contact are required to be current in cardiopulmonary resuscitation technique.

5) Proactive will provide continuing education and ongoing training pertaining to specific issues relevant to programs, interventions, ethics, etc. in order to maximize therapeutic impact and enhance professional skills when interacting with patients.

6) Training will address medical and other needs of the incarcerated population (specific to gender, age, etc. of population served in the facility) and administrative issues necessary to work in the correctional environment.

7) Continuing education and training will be documented and maintained in the employee file and is managed by Proactive University. Sites will be responsible for addressing any education not completed within Proactive University.

8) All qualified health care staff are responsible for earning the appropriate number of hours annually to maintain licensure certification or registration and for providing documentation of continuing education.

Relevant Forms

Education Log

Employee Orientation Competency Checklist

Nursing Skills Competency-Health Assessments

References


Section B: Personnel and Training

J-C-04 Health Training for Correctional Officers

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Health Training for Correctional Officers (J-C-04)

NCCHC Opioid Standard: Professional Development (O-C-03)

NCCHC MH Standard: Mental Health Training for Correctional Officers (MH-C-04)

ACA Standard: Training and Staff Development (4-ALDF-7B-05); (4-ALDF-7B-08); (4-ALDF-7B-10)

Purpose

To establish a systematic method for training correctional staff regarding health-related issues.

Policy

Proactive will encourage training of all correctional staff that interact with inmates on topics relating to health care, as appropriate to their duties.

Procedure

1) The training program will be established and approved by the responsible health authority.

2) A health-related training program may be developed and provided, in collaboration with the institutional training officer, to non-medical institutional staff at least every two (2) years. This training will include, but is not limited to, the following, if applicable:
   a) Administration of first aid, including Naloxone administration for those officers working within a facility with an OTP;
   b) Cardiopulmonary Resuscitation including the use of an automated external defibrillator;
   c) Recognizing the need for emergency care and interventions in life threatening situation (e.g., heart attack, withdrawal);
   d) Recognizing acute manifestations of chronic illnesses (e.g., seizure, asthma, diabetes, schizophrenia);
   e) Intoxication and withdrawal;
   f) Adverse reactions to medications;
   g) Recognizing and communicating with patients with signs and symptoms of mental illness, intellectual and developmental disabilities, and substance abuse;
   h) Suicide Prevention;
i) Procedures for the appropriate referral of patients with health complaints (physical, mental, or dental) to health care staff;

j) Precautions and procedures with respect to infectious and communicable diseases (e.g., tuberculosis, Hepatitis B, HIV);

k) Dental emergencies;

l) Confidentiality of health records and health information;

m) Methods for obtaining assistance and procedures for transfers to appropriate medical providers or medical facilities;

n) Medication administration and documentation; and

o) Conducting a receiving screening.

3) The institutional training officer will be responsible for coordinating health-related training or continuing education for non-health care staff at the institution. Proactive staff may serve as instructors for selected topics. All health-related training should be verified by an outline of the course content and the length of the course. The outline of the course will be kept on file for easy review.

4) Documentation of all training and continuing education will be maintained by the Training Officer and the Health Services Administrator.

5) Compliance with this policy requires that at least 75% of the correctional staff present of each shift is current in health-related training.

6) Trainings for correctional staff permanently assigned special housing for mental health; performing receiving screenings; medication administration; or working as the health care liaison should include additional training and routine refresher training in the recognition and management of inmates with mental illness.

7) Officers assigned to receiving screening and mental health areas, including mental health programs, residential units, or segregated housing areas, receive additional training from mental health staff in order to fulfill their specific roles.

8) Training curriculum for correctional officers assigned to mental health should include, but is not limited to:

   a) Recognition of signs and symptoms of mental illness and suicide risks;

   b) Signs of relapse following treatment;

   c) Communication skills for managing inmates with mental disorders;

   d) Suicide prevention procedures;

   e) Common stress reactions following a suicide attempt;

   f) Actions to minimize the negative effects of suicide on involved parties;

   g) Training in conflict resolution skills;

   h) Dynamics of sexual abuse and sexual harassment in confinement;

   i) Common psychological reactions for sexual abuse/harassment in confinement; and

   j) How to detect and respond to psychological signs of threatened and actual sexual abuse.
Relevant Forms

Annual Education Calendar

Education Log

References


Training and Staff Development (4-ALDF-7B-05); (4-ALDF-7B-05); (4-ALDF-7B-05). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section B: Personnel and Training

J-C-05 Medication Administration Training

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Administration Training (J-C-05)
NCCHC Opioid Standard: Medication Administration Training (O-C-04)
NCCHC MH Standard: Medication Administration Training (MH-C-05)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose
To establish guidelines ensuring the appropriate administration of medication to inmates.

Policy
Proactive will administer all ordered medications to patients in a timely manner, and document appropriately. Health care staff will receive training during orientation regarding limited access to the medication room and controlled substances, and procedures for access.

Procedure
1) Qualified health care staff will receive medication administration training during orientation prior to administering any medications. Staff and trained officers will receive orientation and training related to medication administration, documentation, accountability, common side effects, and medication security matters. Training will be repeated and documented on an annual basis for licensed staff. In-service education on medication administration will be provided as needed for review and to update staff regarding changed in standard operating procedure.

2) Medication administration training of the health care staff will be the responsibility of the Director of Nursing or the Health Services Administrator and should be approved by the responsible physician and facility administrator or designee.

3) All training is to be documented in each employee’s training record, which will be kept on file in the medical unit by the facility trainer.

4) Qualified mental health staff should be involved in any training of staff who administer psychotropic medications, including direct in-service training, as well as assisting in the development of presentation material regarding security, side effects, etc.

5) Topics for medication administration training for health care staff should include diversion of medication, hoarding medications, selling drugs, overdosing, adherence to therapeutic regimens, non-compliance, potential phototoxic effects, narcotic count logs, common side
effects of medications, documentation of medication on the eMAR in TechCare, sharp count logs, and inmate refusals. All topics for medication administration training require approval of the Corporate Nurse Manager.

6) Health care staff may not administer medication unless they have received appropriate medication administration training and will receive, at a minimum, an annual in-service.

Relevant Forms

Education Log

References


Section B: Personnel and Training

J-C-06 Inmate Workers

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Inmate Workers (J-C-06)
NCCHC Opioid Standard: Inmate Workers (O-C-05)
NCCHC MH Standard: Inmate Workers (MH-C-06)
ACA Standard: Inmate Assistants (4-ALDF-4D-11)

Purpose
To ensure health care services are provided by health staff and not inmate workers or inmate assistants.

Policy
Proactive staff may be involved in the clearance of inmates for work programs. However, Proactive will not use inmate workers or assistants for the actual delivery of health care to the correctional population.

Procedure
INMATE WORKER CLEARANCE

1) For sites participating in inmate worker medical clearance, the patient’s medical history in TechCare should be reviewed for any conditions or events that would disqualify the patient from working. This includes, but is not limited to, uncontrolled chronic disease, active infection, and current medically supervised withdrawal.

2) When assessing an inmate for work clearance, the following should be completed:
   a) Review of medications, treatments, and medical history with the inmate. Accuracy should be verified with the inmate. Inmate should also be asked if he or she would like to add any additional health information;
   b) Range of motion assessment and ability to lift, move, bend, and squat without pain;
   c) For kitchen workers, assessment of hygiene and open areas or rash on hands, arms, face, and neck; and
   d) Other relevant evaluation.

3) If an inmate worker’s clearance is questionable, all concerns must be presented to the advanced clinical provider for review, final determination, and recommendations.
4) Proactive’s policy on Inmate Bloodborne Pathogen Exposure should be referenced for information on training inmate workers who may be exposed to biohazardous materials and spills.

![TechCare worker clearance form](image)

Figure: Screen shot of TechCare worker clearance form, showing the location to document any reason for Denying clearance.

**INMATE ASSISTANTS**

1) Inmate Assistants are not to be used under any circumstances by Proactive for the provision of health care services.

2) Inmate Assistants may not:
   a) Distribute or collect sick call slips;
   b) Schedule appointments;
   c) Transport or view health records;
   d) Handle or administer medications;
   e) Score or handle psychological test results; and/or
   f) Handle surgical instruments or sharps.

3) Inmate workers may provide janitorial services within the health care unit, with proper supervision by security staff. They will receive appropriate training if they are involved in cleaning up biohazard spills.

4) Inmates may participate in appropriate peer health-related programs, but not as substitutes for regular program staff.

5) Eligible peer review programs:
   a) Assist patients in activities of daily living (except for infirmary level care patients);
   b) Participate in a buddy system for non-acutely suicidal patients after documented training; and
   c) Participate in hospice programs after documented training.

References


Section C: Personnel and Training

J-C-07 Staffing

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Staffing (J-C-07)
NCCHC Opioid Standard: Staffing (O-C-02)
NCCHC MH Standard: Mental Health Staffing (MH-C-07)
ACA Standard: Personnel Qualifications (4-ALDF-4D-03)

Purpose
To ensure there is a sufficient numbers and types of health staff to care for the facility population.

Policy
Proactive will ensure that sufficient staff will be present to provide health care services to the facility detainee population. Health care staff will act in accordance with the highest standards of professional conduct. Health care staff will function in accordance with their licensure/registration/certification and to the full extent of their knowledge and expertise.

Procedure
STAFFING
1) The HSA will be responsible for approval of the staffing plan.
2) The staffing plan will provide for a sufficient number of health care staff to assure adequate and timely evaluation and treatment of patients.
3) The number of qualified health professionals required shall depend on the size of the facility and the needs of the population.
4) Responsible physician time must be sufficient to fulfill administrative responsibilities.
5) Licensing and/or registration requirements are included in job descriptions or contracts.
6) For facilities without 24 hour health staff coverage, a documented plan is on place for custody staff to follow when a health situation arises.

PROFESSIONAL CONDUCT
1) The primary role of the health care staff is to provide health care. While a certain awareness concerning security is inherent in all positions, the role of the health care staff will not be that of security.
2) Patients will be required to address all health care staff formally and will not be allowed to address Proactive staff by first name under any circumstances.
3) Health care staff will not transport patients unless their presence is required as a medical necessity.
4) The dress and appearance of health care staff will reflect health care professionalism. All health care providers will wear uniforms, white coats, or other appropriate attire.
5) Health care staff, including advanced clinical providers, will be identified while on duty by wearing identification badges.
6) Proactive staff will not participate in the dissemination of confidential information to the media (print, electronic, radio, television) as per the employee handbook. All requests for information from media resources will be directed to the corporate Legal Department.
7) Proactive employees will behave in a respectful manner to everyone at all times. Patients need to be respectful to Proactive staff. If a Proactive staff member feels threatened by a patient’s statements and/or behavior, the staff member must report the statements and/or behavior both to security and to a Proactive supervisor.

Relevant Forms
No relevant forms for this policy

References


Section C: Personnel and Training

J-C-08 Health Care Liaison

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Health Care Liaison (J-C-08)

NCCHC MH Standard: Mental Health Liaison (MH-C-08)

ACA Standard: Personnel Qualifications (4-ALDF-4D-04)

Purpose

To ensure a designated, trained health care liaison coordinates the health services delivery in the facility on days in which no qualified health care professionals are available for 24 hours.

Policy

Proactive will identify and train designated correctional staff, if indicated, to fill the role of health care liaison.

Procedure

1) A designated, trained health care liaison coordinates health care services delivery in the facility and satellite(s) on days when no qualified health care professional is on-site for a continuous 24-hour period.

2) The health care liaison is instructed in the role and responsibilities by the responsible physician or designee.

3) The health care liaison should have a plan that includes contact information for the on-call health staff, ambulance, and other community contacts.

4) The health care liaison receives instruction in reviewing patient information.

5) The health care liaison maintains confidentiality of patient information.

6) Duties assigned of the health care liaison post are appropriately carried out.

Relevant Forms

No relevant forms for this policy.

References


Section B: Personnel and Training

J-C-09 Orientation for Health Staff

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Orientation for Health Staff (J-C-09)

NCCHC Opioid Standard: Professional Development (O-C-03)

NCCHC Mental Health Standard: Training for Mental Health Staff (MH-C-03)

ACA Standard: Training and Staff Development (4-ALDF-7B-03); (4-ALDF-7B-09)

Purpose

To establish a systematic method for orientation of Proactive health care staff to ensure the provision of quality health care.

Policy

Proactive will provide new employee orientation to all Proactive staff to ensure the quality operation of health care services. Initial health care training on specific clinical issues, professional ethical standards, and topics relevant to corrections will be provided in order to enhance the quality of care to patients and to meet standards and recommendations of regulatory agencies (e.g., NCCHC, ACA, OSHA, and JCAHO).

Procedure

HEALTH STAFF ORIENTATION

1) The health care staff orientation program is approved by the responsible health authority and the facility administrator.

2) The orientation plan is reviewed annually or more frequently, as needed.

3) Orientation for the mental health staff is approved by the mental health authority.

4) All full-time health care staff will receive a basic orientation by the Health Services Administrator or designee during the first day of reporting for duty. All part-time or contract health care staff will complete orientation on the days they are contracted to be at the facility.

5) Within ninety (90) days of employment, the health care staff member will receive an in-depth orientation by the Health Services Administrator or designee.

6) Completion of the orientation programs will be documented electronically.

HEALTH SERVICES ADMINISTRATOR ORIENTATION

1) Health Services Administrator orientation and training will be provided by a Corporate Nurse Manager and will include basic and in-depth orientation.
2) The Health Services Administrator who will be providing orientation to new employees will be offered an extensive curriculum with instruction on health care staff orientation.

3) Completion of the orientation program will be maintained electronically.

Relevant Forms

- Education Log
- Employee Orientation Curriculums
- Employee Orientation-Competency Checklist
- Nursing Skills Competency-Health Assessments
- Phlebotomy Manual
- Suture Removal Competency
- Venous Blood Draw Competency

References

- Training for Mental Health Staff (MH-C-03). National Commission on Correctional Health Care: Standards for Mental Health Services in Correctional Facilities.
- Staff Development and Training (4-ALDF-7B-03); (4-ALDF-7B-09). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.
Section D: Ancillary Health Care Services

J-D-01 Pharmaceutical Operations

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Pharmaceutical Operations (J-D-01)
NCCHC Opioid Standard: Pharmaceutical Operations (O-D-01); Emergency Services (O-E-07)
NCCHC MH Standard: Mental Health Pharmaceutical Operations (MH-D-01)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose

To establish standard procedural guidelines for the management of pharmaceuticals and the provision of pharmacy services within the correctional institution.

Policy

Proactive will provide for the proper management (prescribing, dispensing, administering, procuring, accounting, disposal, and distribution) of pharmaceuticals in compliance with states and federal law to meet the needs of patients under the supervision of the correctional institution.

Procedure

1) Proactive will comply with all applicable state and federal regulations regarding prescribing, dispensing, administering, procuring and disposing of pharmaceuticals.
2) Proactive will maintain a Drug Formulary for use by clinicians which is a compendium of drugs selected for the corrections community based on clinical research and the drugs available through state Medicaid programs and health maintenance organizations.
3) The corporate Pharmacy and Therapeutics Committee, under the direction of the Director of Pharmacy and Chief Medical Officers, will establish and maintain a Pharmacy Policy and Procedure Manual, which will establish a standard and uniform method of delivery of appropriate pharmaceutical services. This manual will be reviewed annually, updated as necessary, and distributed to all facilities. The manual will include, but is not limited to, procedures for the following:
   a) Summaries of applicable laws and administrative rules relevant to pharmaceutical services;
   b) Pharmacy service protocols, including a medication formulary and acceptable prescription practices;
   c) Medication procurement, receipt, storage, and dispensing;
d) Medication administration, including accountability for administration and
distribution of medication in a timely manner;
e) Disposal of unused or expired medications;
f) Transcription of medical and telephone orders;
g) Medication Administration Record (MAR);
h) Medication errors;
i) Documentation for use of and procedure for maximum security storage of Drug
   Enforcement Agency (DEA)-Controlled Substances;
j) Contraband, inventory, and useable tool/security control;
k) Pharmacy inspection;
l) Patients on medication prior to incarcerations;
m) Basic program requirements;
n) Duties of the “responsible pharmacist;”
o) Key-control – pharmacy security;
p) Pharmacy technicians;
q) Accountability records/count of syringes;
r) After hours drug cabinet;
s) Medication management;
t) Shift count;
u) Theft or unacceptable loss of medication or syringes;
v) Patient’s drug profile;
w) Automatic stop orders, as defined by protocol;
x) Pharmacy & Therapeutics (P&T) Committee on site;
y) Experimental and investigational drugs; and, Requirements for the staff availability
   of antidotes and other emergency medications and related information (including
   posting of poison control number in areas in which overdoses or toxicological
   emergencies are likely).

4) Documentation such as shipping records, medication administration records, etc. are
   maintained at the facility to ensure adequate control and accountability for all medications.

5) All medication areas will be cleaned and locked, if applicable, at the conclusion of
   medication administration. Medication storage areas will be kept locked when not in use,
   All medications will be kept under control of appropriate health care staff and prepared
   medication will not be left unattended.

6) All DEA-controlled substances will be kept in a double locked container/cart and each dose
   signed out as it is administered to the patient in the facility Narcotics Log designated for
   the particular medication that is being given.

7) A diversion control plan contains measures to reduce the possibility of diversion of
   controlled substances.
8) Medications received from the pharmacy will be compared with the Medication Order/Reorder Request Log to crosscheck and/or identify any discrepancies prior to administering medication.

9) Medications maintained at the facility and properly trained persons administering medications are under the direct supervision of the Medical Director and the Health Services Administrator.

10) Patients will not prepare or administer medication to other patients. Patients are, however, eligible for participation in self-medication or keep-on-person program as stated in Medication Administration/SAM/KOP policy.

11) If ordered by the clinician, patients may be allowed to carry medication necessary for the emergency management of a condition. Those patients must also carry proper documentation to alert security that this medication has been approved by the medical department to be kept with the patient at all times.

12) Medication storage areas are devoid of outdated, discontinued, or recalled medications.

13) Proactive will perform inspections, at least quarterly, to ensure adequate control of and accountability for all medications. Pharmacy Inspections reports will be maintained by Proactive’s Corporate Pharmacy Director as well as the Health Services Administrator. Where there is no on-site staff pharmacist, a consulting pharmacist will be used for documented inspections and consultation on a regular basis.

14) All medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications for external use and disinfectants are stored separately from internal and injectable medications. Medications requiring special storage (e.g., medications that need refrigeration) are stored appropriately.
   a) Drugs and non-prescription medications requiring refrigeration shall be stored in a refrigerator. If stored in a general use refrigerator, medications will be stored in separate, covered, waterproof, labeled receptacles.
   b) Refrigerators used for medication storage will be equipped with a thermometer with the temperature within the refrigerator maintained between 36 degrees and 46 degrees Fahrenheit.
   c) Medication refrigerators will be cleaned and inspected at least monthly by medical staff.
   d) A log will be maintained for each medication refrigerator that documents daily temperature checks as well as monthly cleaning and inspection. Daily temperature checks are not required for days without medical personnel on site.

15) Staff will have access to an adequate supply of antidotes and emergency medication, including naloxone, along with the local poison control number for use in an emergency situation.

Relevant Forms
Medication Order/Reorder Request Log

Stored Patient Medication Record

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – Controlled Substances

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)
NCCHC Opioid Standard: Medication Services (O-D-02)
NCCHC MH Standard: Medication Services (MH-D-02)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose

To maintain guidelines and procedures for the use of controlled substances in the correctional facility.

Policy

All controlled substance medication that is administered to patients by nursing staff shall be done consistent with proper nursing practice and in accordance with applicable federal, state, and local requirements.

Procedure

DOCUMENTATION OF CONTROLLED SUBSTANCES

1) Controlled substance medication will be kept under a double-lock system both in the medication room as well as the medication carts and counted each shift with the signature of the on-coming and off-going nurse.

2) Controlled substances will be entered into the site perpetual inventory receiving log upon receipt of the medication from the pharmacy. The medication will remain accounted for in the perpetual inventory until assigned to a specific medication cart.

3) Upon receipt of a controlled substance for the medication cart, the medication will be entered into the control substance record book. Each medication will have an individual page in the book. When the page is full, the remaining balance of the medication will be carried as a balance forward with a notation denoting the number of the new page.

4) Documentation of each dose of the controlled substance in the record book will contain the following information: Patient name and ID number, name of the drug, amount used or wasted, amount of medication left, and signature of medical personnel administering the medication. Wasted controlled substances require signatures from two staff members.

5) Documentation of administration of the medication will be completed in the patient record on the eMAR in TechCare.
DISCREPANCY IN CONTROLLED SUBSTANCE COUNT

1) When a potential discrepancy has been identified while completing a controlled medication count, the count should be completed in its entirety before taking any action or attempting to reconcile, as completing the entire count may reveal the discrepancy is due to documenting usage on the wrong record.

2) Once the entire count has been completed and the cause of the discrepancy has not been identified, the following actions must be taken:
   a) The Health Services Administrator and/or Director of Nursing must be notified;
   b) Shift personnel are to remain in the unit until released by the Health Services Administrator and/or Director of Nursing;
   c) The health care personnel relinquishing responsibility and the health care personnel assuming responsibility will note on the applicable usage sheet “Count Not Reconciled.” The “amount remaining” on the applicable usage sheet will be corrected with a notation that it is a “corrected count.” The date and time of the correction must be entered on the usage sheet.
   d) Both health care staff member will sign the count record indicating the count was completed with a notation that the count was “corrected.”
   e) The health care personnel relinquishing responsibility will complete an Incident report with a written account of issues regarding the discrepancy in the count. The Incident Report will then be submitted to the Health Services Administrator and/or Director of Nursing or designee. The form will then be scanned and emailed to the corporate office.
   f) Other site personnel present during the off-going shift may also be required to complete an Incident Report at the request of the Health Services Administrator and/or Director of Nursing.
   g) The Health Services Administrator and/or Director of Nursing will direct any further action that must be taken, including security notification.
   h) The Health Services Administrator will notify the consulting pharmacist regarding any further action needed. The consultant pharmacist and/or security personnel may be involved in any subsequent investigation.
   i) The Health Services Administrator will report the findings to the site’s Vice President of Operation and Regional Nursing Director.

Relevant Form

Incident Report

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – General Guidelines & Distribution

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)

NCCHC Opioid Standard: Medication Services (J-D-02)

ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose

To establish guidelines ensuring the appropriate administration of medications to all patients.

Policy

Proactive will administer all ordered medications to patients in a timely manner and document appropriately. Proactive staff administering medication will receive orientation and training related to medication administration, documentation and medication security matters.

Procedure

GENERAL MEDICATION SERVICES

1) All medications, other than those not legally requiring a prescription, are to be administered or delivered to a patient only on the order and directions of a physician, dentist, PA, ARNP, or other legally authorized professional.
   a) Opioid substance use disorder treatment medications are prescribed by providers with appropriate training and licensure to prescribe them.
   b) Opioid substances use disorder treatment medications are dispensed and/or administered only by a pharmacist, RN, LPN, or other authorized by federal and state law to administer them.

2) Prescriptive practices of the facility are under the direct supervision of the Medical Director of the facility.
   a) Justification for any significant deviation by a provider from the approved prescriptive practices are documented in the patient record.

3) Medications are prescribed only when clinically indicated.

4) Patients entering the facility on prescription medication continue to receive the medication in a timely fashion as prescribed, or acceptable alternative medications are provided as medically indicated unless contraindicated by their medical condition.
   a) Proactive health staff will have the patient sign an Authorization for Release of Health Information Pursuant to HIPAA upon initial intake or in a timely fashion when need for medication verification is identified. The authorization will be faxed
to the previous provider(s) in a timely fashion, preferably by the end of the current shift.
b) Confirmation of the current prescribed medication(s) should be validated upon intake prior to the prescribing of reported medication(s) unless a clinically acceptable treatment plan is established by the clinical provider. This confirmation may be accomplished by facsimile, email, prescription database query, or a documented telephone call.

PRESCRIBING MEDICATION
1) The advanced clinical provider initially prescribing and/or continuing to prescribe medication must review the patient’s condition and response to the medication at frequent intervals to document said response and side effects and to adjust the medication when appropriate.
2) The treating advanced clinical provider will instruct the patient of the risks and benefits of the proposed medication, possible side effects, and alternative treatments at the time such medication is ordered or initiated.
3) In the event a patient has had a significant break in the continuum of care regarding a compliance-crucial medication regimen, a new medication regimen may be initiated by a clinical provider. This new medication regimen will adhere to the Proactive formulary using medication designed to treat the identified symptomology.

ORDERS FOR PRESCRIPTION AND OVER THE COUNTER MEDICATIONS
1) Prescription medication will be ordered only by practitioners authorized by state law to prescribe or order medications.
2) Nurses may implement written, verbal, or telephone orders, but may not initiate an order for a prescription medication. Verbal or telephone orders may only be implemented after direct contact with the advanced clinical provider. The nurse will then document the name of the provider and the date and time, the order was received in either a quick note or a SOAP note in TechCare. Medications will then be entered into TechCare on the electronic medication administration record (eMAR) using the ordering provider’s name. The clinical provider will sign off the medication order via electronic signature in TechCare.
3) Over the counter (OTC) medications do not require a physician’s order. OTCs may be ordered and administered by licensed health care staff per physician-approved nursing protocols.
4) Orders for all medications will be documented in TechCare. Medications will then be entered in the patient’s eMAR in TechCare.
5) Medications will be placed on the eMAR by the clinical provider unless a verbal or telephone order is given. At that time, the nurse receiving the order will enter the medication.
6) Medication requested by the facility will be delivered the next business day unless ordered after order cut-off time. If ordered past the order cut-off time, medication will be processed with the next available shipment. Medication deliveries are available six days a week. The facility may obtain medications that might be needed sooner from the back-up pharmacy.
Details regarding the back-up pharmacy are available in the pharmacy policy and procedure manual.

CRUSHING AND FLOATING OF MEDICATIONS PRIOR TO ADMINISTRATION

1) Crushing and floating solid medications is done at the risk of changing the pharmacokinetics of the formulation. Medications may only be crushed and/or floated if they do not fall into the categories listed below. The Advanced Clinical Provider must write a specific order of limited duration, for a specific patient for each medication that is to be crushed and/or floated. The medications must be prepared individually and administered individually to each patient.
   a) Medications designed to be administered as sublingual, buccal, or enteric coated or that are designed as extended/slow release formulas should not be crushed or floated without the approval of the chief medical officer and/or pharmacist.
   b) Some medications are inherently corrosive to the oral mucosa and/or upper gastrointestinal tract, may be markedly bitter, or may be capable of staining the oral mucosa and teeth.

2) Custody staff may request across the board crush orders for certain medications of high abuse. When and if this occurs, the charts are reviewed of each patient individually to identify any contraindication to this crush order.

ADMINISTRATION OF MEDICATION AND DIRECTLY OBSERVED THERAPY (DOT)
1) Staff have primary responsibility in ensuring that medications are administered safely and understood by the patient. Nurses must take full responsibility for their actions when administering medications.

2) Staff are responsible for building and maintaining current medication knowledge comprised of the following:
   a) The generic and proprietary names for medications;
   b) Drug classification;
   c) Normal drug dosages or dosage ranges;
   d) Appropriate route(s);
   e) Desired actions of medications;
   f) Common side effects of medications;
   g) Toxic and undesired effects of medications;
   h) Contraindications in the uses of medication:
      i) Drug incompatibilities with other medications; and
   j) Nursing implications of the administration of medications.

3) When an unfamiliar drug is ordered, a resource should be consulted for review prior to administering medication.

4) Accurate documentation is a major responsibility of medication administration. All medication administration should be clearly documented on the eMAR at the time of administration.

5) Medication(s) should be administered within 48 hours of the provider’s ordered start date.

6) Nurses should always question an incorrect, incomplete, or unclear medication order. The nurse should refuse to accept an order that is considered unsafe and should immediately report the order to the site Medical Director and/or the Health Services Administrator or designed for action.

7) Administering of medication will not be documented until the medication is actually administered to the patient.

8) Documentation of a medication will only be done by the person who actually prepared and administered the medication.

9) The computers used for electronic medication administration are to remain on the docking station until the medication administration procedures begin and should be returned to the docking station for syncing immediately following the administration of the medication, thus allowing the information to download into TechCare.

10) The advanced clinical provider is to be notified immediately of any impending expiration of a drug order to determine whether the order should be continued, altered, or discontinued.

11) Trained health care staff, through directly observed therapy or self-administration, if applicable, will accomplish administration of medication.

12) If a health care staff member, while administering medications, observes or receives a report of a potential serious health problem, a referral should be made to an advanced clinical provider.

13) Medication is to be administered from designated areas that are clean, secure, and free from excessive noise and distraction.
14) Health care staff may ask the patient to provide identification prior to receiving the medication.

15) Security should perform oral cavity checks of each patient administered medications orally. If this is not a policy of the facility then the health care staff administering the medications shall be vigilant to attempts at checking or diverting medications.

16) Medication schedules are to be developed in coordination with facility routines, and will permit dosing of medications in accordance with commonly used dosing patterns. Correctional staff may announce medication administration times. If the patients are called by housing unit, efforts will be made to ensure that they are seen in a timely manner.

17) Critical and/or essential medication must be administered to patients who present after regular pill pass hours:
   a) Should the incident be an isolated event, the inmate will be counseled about the importance of reporting on time and any obstacles to attending pill pass are to be identified and resolved.
   b) Should the patient be chronically late for pill pass with no known obstacles, the health care staff may file an incident report with security staff.

18) No medication will be preset, including insulin, which might adhere to the plastic in the syringe.

19) Thorough hand washing will be performed prior to preparing and administering medication.

20) Staff administering medication will compare the eMAR and medication label for consistency with the order. If discrepancies are noted, staff will immediately check the order in the health record.

21) If a patient doubts or questions the medication being administered, the staff will double-check the order to reduce medication errors.

22) If a necessary prescription is unavailable for a patient at the time of administration, it will be obtained from floor stock per the Pharmacy Policy and Procedure Manual. Only one dose of medication will be signed out of floor stock for the patient at each pill call. Medication will never be borrowed from one inmate’s prescription to give another. If there is no floor stock at the facility, then urgent doses are to be obtained from the local pharmacy.

23) At the conclusion of medication administration, the staff will run a missed medication report on all eMARs to determine which medications were not administered because the patient did not come to pill call. Attempts will be made to determine why a patient did not receive any life sustaining medications and to administer them at a later time if at all possible. All medications administered should be documented on the eMAR.

24) Health care staff will review the eMARs for stop dates to determine if orders for any chronically administered medication will expire in the next seven (7) days, and seek a timely renewal if clinically indicated.

25) If a prescription has expired and not been discontinued, the nurse will notify an advanced clinical provider for evaluation and reorder. Chronic medication should ideally be reordered during chronic care visits.
26) All unused or expired medication(s) are to be disposed of in accordance with local requirements.

Relevant Forms

Common Measurement Conversions

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – Medication Administration Record

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)
NCCHC Opioid Standard: Medication Services (O-D-02)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose

To establish guidelines ensuring the appropriate administration of medication to patients.

Policy

An electronic medication administration record (eMAR) will be maintained for each patient to document all medication that has been administered.

Procedure

1) When an order is written for a medication, it is the responsibility of the person writing the order to enter the medication onto the eMAR in TechCare.
2) All known medication allergies, along with important non-medication allergies (e.g., bee stings), should be included on the eMAR or No Known Drug Allergies should be documented.
3) The order being entered into the eMAR must include the name of the medication, strength, route, frequency, and start and stop date.
4) The eMAR will contain the following information:
   a) Dates started and stopped;
   b) Medication strength, directions, route, and dose;
   c) Times administered; and
   d) The electronic signature of the staff member administering the medication.
5) The appropriate time to give the medication should be included in the hour blocks. Times are automatically entered per TechCare but can be changed as needed.
6) Auto start and stop dates populate based on the date that the medication is entered and the number of days the medication is ordered for.
7) It is the responsibility of the person administering the medication to document the administration of the medication accordingly on the eMAR. Documentation and administration of medication will be completed by trained staff only.
8) Patients who do not report for medication administration will be identified by using the missed med report in TechCare. A missed med report should be run at the end of the pill
pass to ensure that all necessary medications have been administered. Correctional staff should locate all patients who failed to receive medications and have them report to the medical unit for their medication. If the patient is in segregation or out of the facility for an appointment or court, health care staff should be notified immediately.

9) If the patient refuses medication, attempts will be made to have the patient sign a refusal. If unable to obtain a written refusal from the patient, the health care staff member will sign a refusal and obtain a signature from the correctional officer or another nurse as a witness. If the inmate continues to refuse medication, the policy for non-adherence/refusal will be followed. Health care staff will also document the refusal on the eMAR.

10) PRN or as needed medication entered on the eMAR will include the dates started and stopped, medication strength, directions, route, dose, times given, and the electronic signature of the staff member administering the medication.

11) STAT medications entered on the eMAR should include the date, time, medication, route, and electronic signature of appropriate staff members. STAT doses will also be documented in the progress notes of the electronic health record.

12) One-time only medications entered on the eMAR should include the date, time, medication, route, and electronic signature of appropriate staff members.

13) All discontinued medications should be documented in TechCare.

14) When a medication order is changed, the clinical provider/nurse must discontinue the previous order, re-enter the order with the new start, and stop dates. The medication is to be left on the medication cart until the replacement medication is available.

15) If a medication has been clearly discontinued, the nurse noting the change on the eMAR is to remove the medication from the cart and return it to the drug room.

16) Clinical providers will monitor eMARs for expiring medications and renew as needed. Nursing staff will notify providers of any expired medication orders in need of timely renewal.

17) When a patient is transferred to another correctional facility, the eMAR or a discharge summary with a list of medications will be sent with the patient to the receiving facility per federal, state or local correctional policy and procedure.

18) When an OTC medication is administered as a part of a nursing protocol, the prescriptive authority may be noted as “per nursing protocol.”
Relevant Forms

No relevant forms for this policy.

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – Medication Misuse and Diversion

Effective Date:  01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)
NCCHC Opioid Standard: Medication Services (O-D-02)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose

To establish guidelines to assist in the prevention or mitigation of the misuse or diversion of medications.

Policy

The diversion or misuse of prescribed medication can cause harm to the intended patient by causing a deterioration of the condition being treated and could expose other patients to adverse reaction or injury when they take a medication that was not prescribed to them. Diversion is not only a clinical concern but a custodial concern as well as these medications tend to have a high trade value among incarcerated individuals. Patients receiving these medications are often bullied or coerced into providing them to others. Proactive staff will follow a clear guideline to prevent the misuse or diversion of medications in the correctional environment.

Procedure

1) In an effort to prevent or mitigate medication diversion the following Diversion Control Plan practices are to be followed by site personnel:
   a) Prescribing – providers are encouraged to avoid or minimize the use of medications that are known to have abuse potential. Medications in this category should be utilized only when there is a clear clinical indication and when acceptable alternatives are not available. When the use of these medications is necessary, providers are encouraged to limit the use to shorter duration with re-evaluation of clinical need prior to renewing the drug order.
      i) Providers should be observant for behaviors that may indicate a patient seeking a medication for misuse or diversion. These behaviors include, but are not limited to: requesting the medication by name prior to describing symptoms requiring treatment; comments such as “only this medication works for me” or “I am always prescribed this medication”; reporting allergies to alternative treatments; refusals or non-compliance to alternative treatments; threats or attempts at manipulation when requested medication
is not prescribed; inappropriate signs of distress when a requested medication is not provided;

ii) Medications that are frequently diverted or misused include: Antipsychotics such as risperidone (Risperdal), quetiapine (Seroquel), and Olanzapine (Zyprexa); Opioids such as oxycodone (OxyContin), tramadol (Ultram), and codeine (Tylenol #3); Diphenhydramine (Benadryl); Muscle relaxants such as cyclobenzaprine (Flexeril), tizanidine (Zanaflex) or methocarbamol (Robaxin); Gabapentin (Neurontin; Benzodiazepines such as chlordiazepoxide (Librium), lorazepam (Ativan), or clonazepam (Klonipin); Antidepressants such as buproprion (Wellbutrin), or mirtazapine (Remeron); Amphetamines/stimulants such as methylphenidate (Ritalin, Concerta) or levoamphetamine/dextroamphetamine (Adderall); and Clonidine (Catapress). Medication Assisted Treatment medications used for substance use disorder, such as buprenorphine (Subutex, Suboxone), and Methadone.

b) Preparation and administration – when possible, administer the medication in a formulation that limits the possibility of diversion. Choices include ordering the medication as a liquid, aerosol, or injectable; or as a tablet that could be “crushed and floated”. Consideration should be given to the challenges associated with these formulations such as cost or personnel time to administer. Medications should be “crushed and floated” only if in agreement with manufacturer recommendations and with approval of prescribing provider or CMO. Health care staff shall observe for patient behaviors such as ‘Cheeking’ or “cupping” medications when administered. Checking a patient’s mouth prior to leaving the medication cart or area is encouraged. At some facilities, this is a function of security personnel but should be supported by Proactive staff.

c) Multi-disciplinary Communication – communication between providers, health care staff, and custody staff should be ongoing regarding the risk for medication diversion and misuse, including methods to minimize drug diversion, situations of known diversion, and plans to address individual cases of diversion. Often correctional facilities have their own policies and procedures that address the issue of drug diversion so it is important to be aware of the expectation of the custody client and ensure their processes are in agreement with local Proactive practice. Health care staff should be observant for signs that could indicate medication diversion is occurring and report to appropriate staff.

d) Patient communication – patients should be carefully educated when medications that are at higher risk for diversion or misuse are prescribed. Educational topics include a clear explanation why the treatment is indicated, the importance of medication/treatment compliance, policies and procedures that will be enforced if
diversion is discovered or suspected, and the importance of reporting attempts of coercion by other patients to obtain medication.

2) Proactive providers retain the ability to modify or discontinue medication if patients are found to be misusing or diverting these medications, or if there is a reasonable suspicion that medication misuse or diversion is occurring.

3) If medication misuse or diversion is identified or reasonably suspected the site medical director or provider designee will be notified via chart review, face-to-face consultation, and/or telephone notification. The provider will then make a determination whether to discontinue, modify, taper, or prescribe alternate medication(s) based on determination of medical necessity of the medication, risk(s) associated with the misuse or diversion, availability and reasonable substitution of alternate formulation(s), and availability of alternate medications with less likelihood of misuse or diversion.

4) Patients will be notified of medication discontinuation or modification by a health services staff member along with any necessary education regarding any new medications or modifications to formulation.

5) Patients who are found to be, or reasonably suspected of, medication misuse or diversion will not be denied care as a result of these actions but may be subject to closer monitoring to prevent or discourage any future misuse or diversion of their prescribed medications. This will apply to all prescribed medications without limit to any particular medical or psychiatric condition.

Relevant Forms

No relevant forms for this policy

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – Medication Variances

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)
NCCHC Opioid Standard: Medication Services (O-D-02)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose
To establish guidelines ensuring the appropriate administration of medication to patients.

Policy
All ordered medication variances will be documented, thoroughly investigated, and will stimulate appropriate corrective action.

Procedure
CATEGORIES OF MEDICATION VARIANCES
1) Omission – the failure to administer an ordered medication.
2) Unauthorized Drug – Administration to a patient of medication dose not authorized for the patient such as a dose given to the wrong patient, duplicate doses, administration of an unordered drug or a dose given outside of a stated set of clinical parameters.
3) Wrong Patient – any medication given to anyone other than the intended prescribed person.
4) Wrong Dose – any dose that is the wrong number of prescribed units or any dose above or below the ordered dose by a predetermined amount.
5) Wrong Route – administration of a drug by a route other than that ordered by the prescriber. Doses given via the correct route but the wrong site (e.g., left eye instead of right eye) are also included.
6) Wrong Rate – administration of a drug at the wrong rate, the correct rate being that given in the prescriber’s order or established by protocol.
7) Wrong Dosage Form – administration of a drug by the correct route but in a different dosage form that that specified by the provider.
8) Wrong Time – administration of a drug outside of the ordered administration time or med pass.
9) Wrong Preparation of a Dose – incorrect preparation of the medication dose, such as incorrect dilution or reconstitution, not shaking a suspension, using an expired drug, not keeping a light-sensitive treatment protected, or mixing drugs that are physically/chemically incompatible.
10) Incorrect Administration Technique – situations when the drug is given via the correct route, site and so forth, but improper technique is used.

MEDICATION VARIANCE PROCEDURES
1) When a medication variance is discovered, an advanced clinical provider will be notified and provided information regarding the type of variance and any adverse effects experienced by the patient. The provider will then determine what treatment, if any, is appropriate. Any and all patient treatments will be documented in TechCare.
2) A Medication Variance Report will be completed for all medication variances and sent to the Health Services Administrator, Director of Nursing, or designee, who will ensure that the form is completed, a site review is performed, and it is forwarded to the corporate office per “Notification: email.
3) The Medication Variance Report will be documented, investigated, the category of variance identified, and recommendations for corrective action, if any, will be made by the Regional Nursing Director.
4) A copy of the investigative review with recommendations will be returned to the Health Services Administrator, The Health Services Administrator is responsible for ensuring that any recommendations for corrective action will be completed at the site.
5) The Medication Variance Report will be placed in a confidential file in the Health Services Administrator’s office and scanned into the electronic NCCHC folder in SharePoint. The report will not be placed in the patient record and there will be no reference to the report made in the progress note.

Relevant Forms

Medication Variance Report

References


**Section D: Ancillary Health Care Services**

**J-D-02 Medication Services – Non-Formulary Medications**

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)

NCCHC Opioid Standard: Medication Services (J-D-02)

ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

**Purpose**

To establish guidelines ensuring the appropriate dispensation of non-formulary prescribed medication to patients.

**Policy**

Proactive advanced clinical providers will receive orientation and training relating to non-formulary medication ordering, dispensation and documentation.

**Procedure**

1) The advanced clinical provider will receive non-formulary training during orientation prior to prescribing any medications.

2) The Health Services Administrator is responsible for all non-formulary medication training and must document all training on the Employee Orientation-Competency Checklist kept on file at the health care unit.

3) All advanced clinical providers prescribing non-formulary medication must use the following procedures:
   a) Complete a non-formulary medication request that also includes documentation, if any, of the current, non-formulary medication prescription from the patient’s community provider;
   b) Non-formulary medication requests should be completed in TechCare;
   c) Answer any question(s) posed by the corporate office pertaining to the non-formulary medication request as soon as possible including why a formulary medication is not an appropriate alternative; and
   d) Prescribe a formulary substitution to continue treatment until the non-formulary medication request is resolved or, if deemed appropriate and if verified on intake, the non-formulary medication may be continued until the non-formulary medication request has been resolved.

4) Upon receipt of the non-formulary medication request, the corporate pharmacy will acknowledge receipt to the Health Services Administrator, give preliminary approval or
denial, and/or relay the medication request to the Corporate Chief Medical Officer for further review. Corporate pharmacy staff will provide a timely response to the advanced clinical provider or Health Services Administrator, including substitution recommendations, if applicable.

5) Non-formulary medication prescription requests may be denied under the following circumstances:

   a) If the drug has not been approved by the US Food and Drug Administration for the indication for which it is being prescribed;
   b) If the patient has not taken the previously prescribed non-formulary medication as prescribed with the last four (4) days;
   c) If proper procedures pertaining to the prescribing of the medication(s), including psychotropics, have not been followed;
   d) If a clinically reasonable substitution of a formulary medication can be made; or
   e) If a patient has recently ingested alcohol or illicit drugs which may alter the intended therapeutic action of the non-formulary medication.
Figure: TechCare’s non-formulary request form, which must be completed in order to prescribe a non-formulary medication.

<table>
<thead>
<tr>
<th>DIAGNOSIS:</th>
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<table>
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<tr>
<th>REQUESTING PROVIDER:</th>
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<table>
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<tr>
<th>REASON FOR REQUEST:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient has own medication supply</td>
</tr>
<tr>
<td>2. The inmate has been verified through appropriate Naphcare pathways to have been actively on this medication in the community and there has not been a gap of more than 4 days since they last took it. (Must be documented in TechCare under reconciliation tab or in a)</td>
</tr>
<tr>
<td>3. The Non-Formulary Medication was ordered by an off-site provider and I feel there is no appropriate alternative medication on the Formulary. (Off-site providers recommendations must be documented in TechCare.)</td>
</tr>
<tr>
<td>4. This medication is a court ordered medication or patient returned from competency restoration on this medication.</td>
</tr>
<tr>
<td>5. The inmate has a special medical condition that requires this medication (HIV, Cancer, Hepatitis, Dialysis, Transplant, or Post Surgery).</td>
</tr>
<tr>
<td>6. The inmate has not responded to equivalent formulary medications.</td>
</tr>
<tr>
<td>7. This is a follow-up Non-Formulary request for a previously approved Non-Formulary medication.</td>
</tr>
<tr>
<td>8. This is a change in dosage of a previously approved Non-Formulary medication.</td>
</tr>
</tbody>
</table>

Note to Provider:

This Non-Formulary Medication request will be sent to the Corporate Medication Review Panel consisting of pharmacy team members and corporate medical administrators for further review. If approved, the medication will be ordered and placed on the eMAR. If an alternative plan is recommended instead, this will be communicated to you, your site HSA, and DON. The medication requested in this form will not be ordered until approved through this process. Once approved, the order will expire in 6 months and must be renewed through option 1 of this form.

Relevant Forms

Employee Orientation-Competency Checklist

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – Pre-Pouring of Medication

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)

NCCHC Opioid Standard: Medication Services (O-D-02)

ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose
To establish guidelines ensuring the appropriate administration of medication to patients.

Policy
All medication that is administered to patients by nursing staff shall be done consistent with proper nursing practice.

Procedure
1) Only a licensed health care staff member will prepare medication for immediate administration.
2) The licensed health care staff member will have direct and constant control over the medication.
3) Medication prepared for administration by the licensed health care staff member should be administered only within that staff member’s shift.
4) Prescribed medication shall be handled in a manner that allows the licensed health care staff to maintain the ability to determine the right patient/medication/route/dose/time for all medication administration.

Relevant Forms

No relevant forms for this policy,

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – Refusal or Non-Adherence

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)
NCCHC Opioid Standard: Medication Services (O-D-02)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose

To establish guidelines for patient medication compliance, documentation of refusal, and reporting of non-adherence.

Policy

All ordered medications will be administered to patients in a timely manner and appropriately documented. Proactive staff administering medication will receive orientation and training related to medication administration, documentation, and medication security matters.

Procedure

REFUSAL OF MEDICATIONS

1) Generally, patients have the right to refuse medication. Patients may be required to take medication only under the following circumstances:
   a) If the inmate has been mandated by court order to receive medication;
   b) If the inmate’s behavior is acutely dangerous to self, others, or to the security of the institution; or
   c) In cases in which treatment is medically necessary and the inmate has been found to be incompetent by a judge in a civil court.

2) Involuntary psychotropic medication may be administered according to mental health policy and procedure.

NON-ADHERENCE WITH MEDICATIONS

1) Non-adherence with medication will be monitored by the on-site health care staff. This does not include medications offered as PRN (as needed).

2) Medications administered by individual dose will be monitored primarily using the eMAR as a guide. Medication compliance will be assessed by the advanced clinical provider and discussed with the patient during patient care encounters.
3) Staff administering medications will report non-adherence of critical medications such as insulin to the Health Services Administrator after pill call is complete. The Health Services Administrator or designee will periodically review the eMAR for non-adherence.

4) Patients on SAM/KOP should bring their medication with them to chronic care clinic visits for compliance checks by the health care staff as an effort to determine compliance. Consult local custody requirements regarding patient ability to transport medications.

5) Correctional staff may check for contraband medication during periodic searches and report findings to the health care staff. Any medication that is confiscated should be returned to the health care staff.

6) When it is determined that a patient is non-adherent, a counseling session will be scheduled with a medical staff member who will identify and address reasons for non-adherence and this session will be documented in TechCare.

7) Counseling should include rationale for the medication and the possible risks of not adhering with the medication therapy as ordered.

8) If the patient refuses or is routinely non-compliant with psychotropic medication, a referral to the mental health department will be provided for additional counseling regarding non-compliance.

9) If reasons for non-compliance are related to side effects, are related to lack of agreement with the plan of care, or continue after the initial counseling session the patient will be referred to the provider via “Medical Chart Review” as a sick call type. The Advanced Clinical Provider will review the patient’s information and make a determination if changes to treatment, if any, are required. This may include adjustments to the medication, discontinuation of the medication, or scheduling the patient for additional education.

10) Patients with serious medical conditions, who are persistently non-adherent despite counseling sessions, may be evaluated for discontinuation of medication. The advanced clinical provider will consider the risks of discontinuing the medication given the patient’s pattern of non-adherence.

11) If the consequences of refusing the medication are serious or life threatening, a Release of Responsibility form will be obtained. The advanced clinical provider is to be notified and will provide direct counseling to the patient regarding risks of continued non-compliance. The encounter must be thoroughly documented in the health record.

12) Should the patient choose to resume a prescribed medication it can be continued regardless of a previously completed Release of Responsibility unless there are clinical contraindications per an Advanced Clinical Provider. Contraindications to continuing this medication should be documented in the record and the medication discontinued.

13) If a health care staff member, while administering medications, observes or receives a report of a potential serious health problem, a referral should be made to an advanced clinical provider.

Relevant Forms
Informed Consent-Specific Procedure

Informed Consent-Specific Procedure-Spanish

Release of Responsibility

Release of Responsibility-Spanish

Written Counseling for Medication Non-Compliance

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – Self-Administration and Keep-on-Person

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)
NCCHC Opioid Standard: Medication Services (O-D-02)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose

To establish guidelines for self-administration or keep-on-person programs.

Policy

All ordered medications will be administered to patients in a timely manner and appropriately documented. Proactive staff administering medication will receive orientation and training related to medication administration, documentation, and medication security matters including those taking part in self-administration or keep-on-person programs.

Procedure

1) If a self-administration program is authorized by the correctional facility, all patients are eligible for participation, except the following:
   a) Any patient identified as ineligible by the health care staff for reasons including, but not limited to, non-adherence despite counseling; hoarding medication; exchanging medications with another patient; possession of an expired medication; possession of another patient’s medication; abuse of self-administration guidelines; or any other reason which would interfere with the self-administration of medication or compliance with treatment plans;
   b) Patients who have chronic or episodic symptoms of psychosis, significant and/or ongoing behavior patterns of self-injury, serious mood disorders, or impulse disorders affecting judgment;
   c) Infirmary level care patients; and
   d) Patients in segregation who are assessed to be at risk for self-injury.

2) Stable patients receiving mental health treatment may self-administer non-psychotropic medication only with the documented order/consent of the treating mental health provider and approval of the Medical Director if the mental health provider is not a Proactive employee.
a) Documentation of the mental health provider’s consent should be listed on the patient problem list, along with the rationale explained in a progress note or mental health chart form.

b) If applicable to the facility, the appropriate flag should be assigned allowing or disallowing participation. If no flag is available, then a treatment order should be placed on the eMAR.

c) The decision will immediately be reversed should the patient become self-injurious. If the decision is reversed, “not Eligible for SAM/KOP program” will be entered on the problem list. Appropriate flag and/or treatment order should be added/removed.

3) Medications excluded from the self-administration program include, but are not limited to, the following:
   a) Psychotropic medications (regardless of whether prescribed for mental or physical health reason(s);
   b) Controlled substances;
   c) Liquid an injectable medications;
   d) Anti-retroviral medications;
   e) INH and other tuberculosis medications;
   f) Any situation where the Medical Director or public health authority believes that directly observed therapy (DOT) is warranted; and
   g) Any other medication identified as causing potential harm or abuse within the individual facility as determined by the Medical Director.

4) All patients who are given self-administered medication must be asked to read and sign the Informed Consent-KOP Form found in TechCare and on NaphCare online under Informed Consent-KOP. All paper signed consents will be scanned into the health record. A copy of the consent will be given to the patient to keep with the medication to show security if the need arises.

5) All medications for self-administration will be blister packaged with the exception of some medications, such as nitroglycerin and medication received from a local approved source (i.e., health department). Efforts will be made to have these medications blister packed if at all possible.

6) All inhalers, ophthalmic or otic preparations, topical creams, ointments, soaps, etc. will be dispensed in their original container with proper labeling for self-administration.

7) Patients may request a refill of medication when current package is within five days of completion. The patient may possess up to a thirty-day supply of each medication in addition to the remaining five days’ supply in the previous packages. After the patient receives the refill, and the remaining five-day supply is finished, the empty package will be returned. If the remaining medication is for greater than five days, the patient will be instructed to complete the medication and then exchange the package for the refill.
a) Nursing staff will review medication refill requests and determine whether the medication is a chronically administered medication (i.e., Hypertension) and will consult with an advanced clinical provider regarding the renewal order.

b) If the medication refill request is clearly not one to be renewed, the request will be returned to the patient with instruction to return to sick call to discuss medication renewal.

8) Patients will be responsible for reordering SAM/KOPs by completing a Sick Call Request form via kiosk if available or paper and placing it in the appropriate area for pick-up by a nurse. These forms will be picked up/checked at a minimum of daily, but reordering will only occur on business days. Refills should be requested when the blister pack is within five days of completion.

9) A designated time will be established for pick-up of medication for self-administration. When the medication is ordered for self-administration, the patient will be informed as to when to pick up the medication. Both the staff member and the patient will sign the eMAR indicating that the medication has been picked up.

10) If the patient does not pick up the medication within twenty-four hours, the staff will determine whether the patient is segregated or has been released or transferred. Any medication not picked up within three days will be returned to the pharmacy.

Relevant Forms

Informed Consent-KOP

Informed Consent-KOP Spanish

References


Section D: Ancillary Health Care Services

J-D-02 Medication Services – Special Populations

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medication Services (J-D-02)
NCCHC Opioid Standard: Medication Services (O-D-02)
ACA Standard: Pharmaceuticals (4-ALDF-4C-38)

Purpose
To establish guidelines ensuring the appropriate administration of medication to patients in special populations or categories.

Policy
All ordered medications will be administered to patients in a timely manner and appropriately documented. Proactive staff administering medication will receive orientation and training related to medication administration, documentation, and medication security matters, including those pertaining to special populations.

Procedure
DIABETIC PATIENTS
1) All diabetic patients, if not contraindicated by security, will receive instruction in the self-administration of insulin. The patient education will be documented in TechCare.
2) If self-administering insulin, the patient will be supervised by trained staff and directly observed while disposing of the syringe in a puncture resistant container.
3) The administering of insulin should be documented on the eMAR at the time observed by the staff member.

INFIRMARY LEVEL CARE PATIENTS
1) Patients ordered into infirmary level care are to be removed from the SAM/KOP program.
2) Upon discharge from Infirmary level care, the medical staff will reassess whether the patient will be placed back on the SAM/KOP program.
3) The advanced clinical provider should coordinate the stop dates of chronic medication in the discharge orders along with follow-up appointment to prevent any lapse in therapy.

SEGREGATED PATIENTS
1) Patients in segregation who do not present any behavior suggesting self-injury, may be permitted to remain on the SAMKOP program if allowed by the facility.
2) If it is the judgement of the medical, mental health, or correctional staff that the patient may be self-injurious or violent in any way, the patient may not remain on the SAMKOP program.

PATIENTS LEAVING THE FACILITY FOR COURT HEARINGS
1) Patient medication orders will be reviewed to determine whether the patient needs medication while out of the facility for court hearings, etc.
2) Logistics of off-site medication administration will be determined by the Health Services Administrator.

OVER THE COUNTER MEDICATIONS
1) A licensed health care provider may give self-administered OTC medications to the patient during a clinical encounter. The OTC medication is to be blister packed or placed in an appropriate container and properly labeled.
2) Documentation of all OTC medication given to the patient must be placed in the progress note.
3) OTC medications made available in the housing unit for administration by correctional staff may include Acetaminophen or Mylanta. Any other requests for medications to be placed in the housing units will be submitted to the Medical Director for approval.
4) Correctional staff should maintain a separate logbook for the purpose of documenting any OTC medication issued to a patient. The logbook should include date, time, patient’s name and identification number, medications issued and quantity.
5) Selected OTC medications may be made available in the commissary for purchase.

STAT MEDICATIONS
1) STAT doses will be administered immediately according to physician’s order.
2) STAT medications will be documented on the eMAR and progress note at the time of administration.

INJECTABLE MEDICATIONS
1) All injectable medications will be administered by licensed health staff, except insulin, if the facility allows insulin to be self-administered.
2) Syringes will be disposed of in puncture-resistant containers immediately after each injection. If an injection is given outside of the medical unit, an appropriate container must be available to dispose of the syringe at the time of the injection.
3) Needles will not be recapped by health care staff or patients prior to disposal in the appropriate container.

PSYCHOTROPIC MEDICATIONS
1) All new psychotropic medications must have a patient and/or guardian consent on record.
   a) A new consent is not needed at follow up visits for routine medication renewals and titrated doses of the same medication, as long as there is already an initial consent on file for that medication.
   b) A new consent is also not needed for medication started at initial intake after verification of medication and doses with the community provider.
2) If patient consent is not on record, the medication nurse should notify the treating psychiatric provider of the need of consent prior to administration.

Relevant Forms

No relevant forms for this policy

References


Section D: Ancillary Health Care Services

J-D-03 Clinic Space, Equipment, and Supplies

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Clinic Space, Equipment, and Supplies (J-D-03)
NCCHC Opioid Standard: Clinic Space, Equipment, and Supplies (O-D-03)
NCCHC MH Standard: Clinic Space, Equipment, and Supplies (MH-D-03)
ACA Standard: Clinical Services (4-ALDF-4G-03)

Purpose
To ensure that supplies, equipment and space allocations are sufficient to deliver all health care.

Policy
The health services unit will be equipped and maintained to allow adequate private examination of patients and appropriate space for patients waiting for health care services.

Procedure
1) Examination and treatment rooms used for all health care encounters will have sufficient space to allow for necessary equipment, supplies, and privacy.
2) Pharmaceuticals, supplies, and emergency equipment will be maintained and monitored at least monthly to establish inventory levels and working order of equipment.
3) The health care unit will have sufficient office space, equipment and storage space for health records and supplies, and secure storage of pharmaceuticals.
4) A designated area for equipment and records will be established for all laboratory, radiologic, or other ancillary equipment maintained on site.
5) Proactive will work with facility staff to ensure drinking water and toilets, along with sufficient seats, are available to patients staged in a waiting area for more than a brief period of time.
6) Sharps and tools will be kept under a double lock system and will be accounted for at the end of each shift. A major inventory list will be maintained and audited at a minimum of weekly. All sharps counts must be reconciled prior to any staff leaving the facility. It is the responsibility of the Health Services Administrator or designee to maintain control of all keys.
   a) Medical sharps and tools will be counted at the end of each shift between the oncoming shift and the off-going shift using the Needle & Syringe End of Shift Count Sheet;
b) Documentation of medical sharps and tool counts will be kept in a sharps book/binder and transferred to the NCCHC electronic folders at the end of each month;
c) Keys for medical sharps will be restricted to the charge nurse or other designee to maintain security of sharps;
d) Dental sharps and tools will be counted each time the dental staff is onsite;
e) Documentation of dental sharps and tools will be documented in the sharps book for the dental area and maintained for the month. Sharps logs will be scanned into the NCCHC electronic folders at the end of the month;
f) Two signatures for dental sharps must be present; and
g) Keys for dental sharps should be restricted to the dentist, dental assistant or designee to maintain security of dental sharps.

7) The following equipment and supplies will be available in each treatment area (at a minimum):
   a) Hand-washing facilities or an alternative means of hand sanitizer;
   b) Examination tables, including the ability and supplies to perform a pelvic exam if females are housed on-site;
   c) Examination light (goose neck);
   d) Scales;
   e) Thermometer (manual and/or electronic);
   f) Sphygmomanometer;
   g) Stethoscope;
   h) Ophthalmoscope;
   i) Otoscope;
   j) Wheelchair, cane, walker, crutches, stretcher, etc.;
   k) Oxygen;
   l) Automated external defibrillator;
   m) Pulse oximeter;
   n) Transportation equipment (e.g., wheelchair, stretcher);
   o) Biohazard and non-biohazard trash containers; and,
   p) Personal protective equipment.

8) The following equipment and supplies will be available in each on-site dental treatment area:
   a) Hand-washing facilities;
   b) Dental examination chair;
   c) Examination light;
   d) Sterilizer;
   e) Instruments;
   f) Biohazard and non-hazard trash containers;
   g) Personal protective equipment and,
9) A dental operatory will require, at a minimum:
   a) A x-ray unit with developing capability;
   b) Blood pressure monitoring equipment; and,
   c) Oxygen.
10) The Health Services Administrator or designee will be responsible for establishing supply and equipment inventories, reordering supplies as necessary, arranging equipment repair, monthly checks of health care areas, and conducting weekly monitoring of the major inventory of sharps and tools.
11) Medical and nursing manuals will be available at each facility to all staff.

Relevant Forms

Dental Needle Count Sheet

Needle and Syringe End of Shift Count Sheet

References


Section D: Ancillary Health Care Services

J-D-04 On-Site Diagnostic Services

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: On-Site Diagnostic Services (J-D-04)
NCCHC Opioid Standard: Diagnostic Services (O-D-04)
NCCHC MH Standard: Diagnostic Services (MH-D-04)
ACA Standard: none

Purpose
To provide on-site laboratory and diagnostic services in a safe and timely manner.

Policy
All laboratory and diagnostic services offered on-site by Proactive will be registered, accredited, or otherwise meet applicable state and federal regulations.

Procedure
1) On-site laboratory services shall be limited to those that are eligible for a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver (COW). The Health Services Administrator shall obtain form CMS-116 from Centers for Medicare and Medicaid Services and submit a completed form to the appropriate local state agency. The Health Services Administrator is also responsible for submitting a renewal application biannually, not less than nine (9) months before the certificate’s expiration date.

2) The Health Services Administrator/Responsible Health Authority maintains documentation that on-site diagnostic services (e.g., laboratory and radiology) are certified or licensed to provide that service.

3) On-site laboratory and diagnostic services which may be available include multiple test dipstick urinalysis, urine drug screen, PT/INR, HgbA1c meters, finger-stick blood glucose testing, peak flow meter (hand-held or other), occult stool cards and developer, electrocardiogram, x-ray, pregnancy test kits, Doppler for fetal heart tones, rapid strep tests, and HIV test kits.

4) A manual will be maintained that includes instructions on the proper collection of specimens, the operation and maintenance of on-site testing equipment and materials, and the procedures for submitting specimens and retrieving results from a reference lab or public health agency.
5) Tests shall be completed either by order of a provider or as part of a provider-approved protocol (e.g., finger-stick glucose testing at intake for patients with diabetes).

6) All sites have access to urine drug screens (UDS) onsite and/or blood/oral fluid drug testing sent to the contracted lab vendor for timely offsite processing.
   a) Patients receiving monitoring for short term medically supervised withdrawal have a UDS performed at intake.
   b) Patients receiving maintenance medication assisted therapy while in custody will receive a random UDS monthly and as clinically indicated.

7) All laboratory tests and/or diagnostic studies not available at the institution will be completed by a contracted vendor.

8) Documented orders by the provider will be present in TechCare for all diagnostic services. Providers will order laboratory tests on the Proactive formulary unless a non-formulary test is necessary for diagnosis or management of a patient’s condition.
   a) Non-formulary tests will require a non-formulary request form to be completed, submitted, and approved prior to testing being conducted. This form is automatically generated for completion upon order entry of a non-formulary lab test.

9) Designated health care staff will immediately document and report all “critical values” to a provider.
   a) Designated health care staff will perform, document, and report results of those tests that are performed on-site.
   b) Critical values processed by the contracted vendor will result in a call to the facility health care staff.

10) Off-site diagnostic testing is processed by the normal utilization management procedure via off-site referral submission in TechCare.

11) Laboratory specimens for transfer will be obtained, labeled, and transported according to requirements of OSHA and the laboratory testing facility contracted with Proactive (i.e., BioReference, LabCorp).

12) X-rays taken on-site will be read and a report sent to the site by the contracted vendor via TechCare interface or paper copy to be scanned into TechCare.

13) Test reports for physician review are available in TechCare in the diagnostics tab in the provider queue. The provider will indicate his review by electronic signature. Test results unavailable in TechCare will be placed in the designated area at each site for provider review. Once the clinical provider has reviewed, dated, and initialed the diagnostic test results, the results will be given to the medical records clerk to scan into the patient’s electronic health record.
   a) Test results should be shared either at the next scheduled visit if abnormal or a Patient Notification of Lab Test or X-Ray Results form is completed and sent to the patient for normal results.
Figure: TechCare screen shot demonstrating the lab test ordering feature.

Relevant Forms

Patient Notification of Lab Test or X-Ray Results

References


Section D: Ancillary Health Care Services

J-D-05 Medical Diets

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medical Diets (J-D-05)
ACA Standard: Dietary Allowances (4-ALDF-4A-07-08); Therapeutic Diets (4-ALDF-4A-09-10)

Purpose
To ensure that patients are ordered therapeutic (special) diets.

Policy
Therapeutic diets will be ordered by staff as clinically indicated.

Procedure
1) Orders for medical diets:
   a) include the type of diet, the duration for which it is to be provided, and any other special instructions;
   b) are communicated in writing to facility dietary staff or via electronic interface; and,
   c) are documented in the health record;
2) Proactive will work with facility staff to ensure a registered dietician nutritionist (RDN), or licensed dietician of the institution or an independent contractor for the institution reviews all medical diets for nutritional adequacy at least annually, and whenever a substantial change in the menu is made. Written documentation of the review will include any changes or recommendations, date, signature, and title of the consulting dietician.
3) Proactive will encourage the facility to have a procedure in place to notify the RDN whenever the medical diet menu is changed.
4) The institutional authority is responsible for supervising workers who prepare medical diets.
5) Follow-up nutritional counseling will be provided to all patients who refuse prescribed diets.
6) Patients will be educated on how to make healthful choices from the standard diet and canteen/commissary.
7) Self-reported “food allergies require independent confirmation (e.g., letter from allergist, verification of Epi-pen prescription, etc.) before requesting a modification to the standard diet.
Figure: TechCare allows the user to easily enter a medical diet for a patient, including diet start and end dates.

Relevant Forms

No relevant forms for this policy.

References


Dietary Allowances (4-ALDF-4A-07-08); Therapeutic Diets (4-ALDF-4A-09-10). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section D: Ancillary Health Care Services

J-D-06 Patient Escort

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Patient Escort (J-D-06)
NCCHC Opioid Standard: Patient Escort (O-E-11)
NCCHC MH Standard: Patient Escort (MH-E-08)
ACA Standard: Transportation (4-ALDF-4C-06)

Purpose

To ensure that patient access to care is maintained through timely movement to all health care encounters.

Policy

Patients are transported safely and in a timely manner for all health care appointments inside and outside of the facility.

Procedure

1) The Health Services Administrator will explore scheduling options with the appropriate institutional staff to determine how to structure acute care clinics, chronic care visits, mental health care visits, dental visits, medication assisted therapy visits, on-site specialty health care appointments, and off-site specialty health care appointments, including accommodations needed in the transport process (i.e., administration of medication, wheelchair transport, etc.). Correctional staff will be notified as soon as possible of any accommodation needed by patients during transportation.

2) Factors to be considered during transport should include:
   a) Security level;
   b) Institutional schedule (e.g., counts, meals, recreation time, visiting times, programs); and
   c) Escort availability.

3) Health care staff and institutional staff will maintain the confidentiality of any patient being transported. Correctional staff transporting patients to offsite appointments are provided with health care information only as it relates to maintaining the security and safety of the patient, officers, and public individuals.

4) The Health Services Administrator will provide correctional staff with timely identification of patients requiring movement related to health care.
5) Health care staff will complete the required institutional documentation for patient movement or transport.

6) Health care staff will attempt to schedule appointments, whether on or off-site, in the manner least disruptive to the institution’s routine.

7) If scheduled activities are cancelled due to security issues, the activities will be rescheduled as soon as possible as clinically indicated and prioritized by health care staff.

8) The mental health authority monitors the number of kept and un-kept appointments. Appointments missed due to the unavailability of an escort staff are noted and referred to the continuous quality improvement program.

Relevant Forms

No relevant forms for this policy.

References


Section D: Ancillary Health Care Services

J-D-07 Emergency Services and Response Plan

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Emergency Services and Response Plan (J-D-07)

NCCHC OTP Standard: Emergency Response Plan (O-A-07); Emergency Services (O-E-07)

NCCHC MH Standard: Emergency Response Plan (MH-A-07); Emergency Services (MH-E-06)

ACA Standard: Emergency Plan (4-ALDF-4C-08); Emergency Response (4-ALDF-4D-08); First Aid (4-ALDF-4D-09)

Purpose

To prepare health care staff to implement the health aspects of the institution’s response to emergencies; Ensure the health, safety, and welfare of patients, staff, and visitors during emergencies; And to provide twenty-four hour emergency health care services per the facility contract with Proactive.

Policy

Proactive staff members are prepared to implement the health aspects of the facility’s emergency response plan. The facility provides 24-hour emergency services.

Procedure

EMERGENCY TRAINING FOR CORRECTIONAL AND HEALTH STAFF

1) Facility staff will provide emergency services until qualified health professionals arrive.

2) Proactive staff will be trained to immediately initiate a response to emergency health-related situations. The training program will be conducted on an annual basis and will include instruction on the following:

a) Recognition of signs/symptoms and knowledge of action that is required in potential emergency situations;

b) Administration of basic first aid;

c) Certification in cardiopulmonary resuscitation (CPR) in accordance with the recommendations of the certifying health organization;

d) Methods of obtaining assistance;

e) Signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal;

f) Procedures for patient transfers to appropriate medical facilities or health care providers; and

g) Suicide intervention.
3) Emergency response training, when provided by Proactive to correctional staff, will be conducted on an annual basis and will be established by Proactive in cooperation with the institution. Training provided by Proactive to correctional staff will be documented on the Education Log.

EMERGENCY RESPONSE PLAN

1) Health aspects of the institution emergency plan will be approved by the responsible health authority and facility administrator and will include the following:
   a) Responsibilities of health staff;
   b) Procedures for triage for multiple casualties;
   c) Predetermination of the site for care;
   d) Emergency transport of the patient(s) from the facility;
   e) Use of an emergency vehicle:
   f) Telephone numbers and procedures for calling health staff and the community emergency response system (e.g., hospitals, ambulances);
   g) Use of one or more designated hospital emergency departments or other appropriate facilities;
   h) Emergency on-call physician, dental, and mental health services when the emergency health care facility is not nearby;
   i) Security procedures for the immediate transfer of patients for emergency care;
   j) Procedures for evacuating patients in a mass disaster;
   k) Alternate back-ups for each of the plans elements;
   l) Time frames for response; and
   m) Notification for the patient that is legally responsible.

2) At least one mass disaster drill is conducted annually in the facility so that over a three (3) year period each shift, to include mental health staff, has participated.

3) The disaster drill is critiqued using the \textit{Emergency Response Critique Form} and shared with staff. Critiques are documented in the staff meeting minutes and scanned into the respective NCCHC electronic folder. Recommendations for health staff are acted upon.

4) A man-down drill is practiced annually per shift where health staff are regularly assigned. All training of Proactive staff for these drills will be documented on the \textit{Education Log}.

5) All man-down drills will be documented using Proactive’s \textit{Medical Emergency Code Report}.

6) All man-down drills are critiqued using the \textit{Man Down Drill Critique Form} and shared with staff. Critiques are documented in the staff meeting minutes and scanned into the respective NCCHC electronic folder. Recommendations for health staff are acted upon.

Relevant Forms

\textit{Emergency Response Critique Form}

\textit{Medical Emergency Code Report}
Education Log

Man-Down Drill Critique

References


Emergency Plan (4-ALDF-4C-08); Emergency Response (4-ALDF-4D-08); First Aid (4-ALDF-4D-09). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section D: Ancillary Health Care Services

J-D-08 Hospital and Specialty Care – Inpatient Psychiatric Care

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Hospital and Specialty Care (J-D-08)

ACA Standard: Continuity of Care (4-ALDF-4C-04); Referrals (4-ALDF-4C-05)

Purpose
To ensure that inpatient psychiatric care is provided to patients as needed.

Policy
Psychiatric inpatient and specialty care services are provided to patients with serious mental health problems specific to their needs.

Procedure
1) Access to inpatient psychiatric services will be arranged as clinically indicated.
2) All off-site facilities with which Proactive contracts for services, will be certified or licensed as required by law.
3) Referral and admission to licensed mental health facilities will be provided pursuant to Proactive’s Utilization Management policy and procedure for patients whose psychiatric needs exceed the treatment offered at the facility.

Relevant Forms
No relevant forms for this policy.

References


Continuity of Care (4-ALDF-4C-04); Referrals (4-ALDF-4C-05). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section D: Ancillary Health Care Services

J-D-08 Hospital and Specialty Care - Utilization Management

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Hospital and Specialty Care (J-D-08)

NCCHC Opioid Standard: Hospital and Specialty Care (O-D-05)

ACA Standard: Continuity of Care (4-ALDF-4C-04); Statistical Reports (4-ALDF-7D-26)

Purpose

To evaluate the appropriateness and medical necessity of services provided to patients. The Utilization Management Program seeks to provide services that are efficient, cost-effective, medically appropriate and within recognized standards of care.

Policy

The program makes determinations of necessity, efficiency and appropriateness of services and treatment plans in accordance with nationally recognized criteria. The program reviews all off-site services using prospective case review, concurrent case management, and retrospective review, in order to effectively monitor and improve the use of health care resources. The program controls the cost of services provided through the establishment of a network of contracted providers, by evaluating medical necessity of services and by determining appropriate payer source.

Procedure

UTILIZATION MANAGEMENT PROGRAM

1) Objectives of program:
   a) Aid in accomplishing Proactive’s mission to provide the most appropriate care for patients that is efficient, consistent, and resourceful;
   b) Ensure that our patients’ rights are recognized and protected;
   c) Provide a system of review to determine the necessity and appropriateness of health care in all settings;
   d) Continually evaluate the metrics that support achievement of these goals and intervene when opportunities to improve are identified;
   e) Assure availability and delivery of medically necessary off-site health care services to patients; and
   f) Identify actual and potential issues to maintain continuous quality improvement.

2) Organization structure:
   a) The program is physically located at the corporate headquarters and clinically supervised by a corporate Chief Medical Officer. Reviews are performed by a team of
credentialed Licensed or Registered Nurses and a UM Manager (UM Staff), in consultation with Clinical Advisors and the corporate Chief Medical Officer who oversees the program.

SCOPE OF REVIEW

1) The Utilization Review and Management Program ensures efficient use of off-site services through prospective, concurrent and retrospective review. The review includes factors such as medical necessity of patients, length of stay, and the appropriate use of diagnostic and therapeutic clinical services. The review and determinations will not be based on cost considerations.

2) There will be no automatic referral of cases to the corporate Chief Medical Officer for review. The corporate Chief Medical Officer will review the cases sent by the UM Staff and will also review a sample of UM determinations on a regular basis for clinical necessity appropriateness/timeliness.

3) Utilization review is performed on all off-site services ordered by the providers. Outpatient services, diagnostic procedures and office visits are reviewed prospectively. Inpatient hospital stays are reviewed concurrently. Emergency room visits are reviewed retrospectively.

4) In conjunction with the details regarding a patient’s clinical condition, UM staff refer to Milliman’s Care Guidelines® for making coverage determinations of medical necessity. UM staff, in conjunction with the scheduling team, will designate the provider who will perform the procedure and the facility in which the procedure will be performed. At the time of scheduling, an authorization number will be generated. Following the patient’s return to the detention facility, the corporate Medical Records Department will request the patient’s medical records from the off-site visit, to include in the patient’s electronic medical record for continuity of care.

5) UM decisions are based solely on the appropriateness of care and health care services. UM nurses, providers, and other staff involved in the UM process are not offered rewards or incentives that would influence decision-making.

PROCESS OF REVIEW

1) Requests for medical services are submitted to UM electronically through the off-site order entry link found on each patient’s homepage in TechCare. The order should include the following:
   a) Type of referral requested;
   b) Recommended time frame for referral request;
   c) Diagnosis and reason for referral request;
   d) Specific recommended course of action; and
   e) Supporting information for referral (e.g., lab test results, diagnostic studies, pertinent progress notes, scanned medical records from other facilities, physical exam findings and medication and treatment history.
2) UM staff then perform the following actions to determine appropriateness and medical necessity:
   a) Review demographics and coverage under the current contract;
   b) Review prior history for trends or previously approved services;
   c) Gather all current and past medical conditions;
   d) Compare the information to Milliman criteria;
   e) Contact the site within twelve hours of the initial request should additional information be needed; and
   f) Update the pending appointment in TechCare with “Approved”, “Corporate MD Pending”, “Awaiting Site Info”, or “Site Provider Pending” status.

3) If the corporate MD approves, the request populates to the scheduling tab. If additional information is needed, the corporate Chief Medical Officer writes a comment to the site staff indicating the type and extent of information needed in order to make a decision about the request, and the request populates to the Awaiting Information tab where the onsite staff is alerted to attach the additional requested clinical documentation. This tab is also used if the corporate Chief Medical Officer would like the onsite provider to consider an alternate plan. In this case, a comment is written with a suggestion or aspects of the case to consider in determining if an alternate plan may be appropriate. If an alternate plan to the original order will be employed, the ordering provider will update the information in TechCare as follows:
   a) Change the order to “Alternate Plan” status;
   b) Document an agreed upon plan of care and approved time frames;
   c) Complete any orders which need to be carried out prior to the consultation; and
   d) Document that the provider discussed the plan of action with the patient.

4) Denial and Appeal:
   a) In the event that a request is not approved and the site provider and corporate Chief Medical Officer are unable to come to an agreement on an Alternate Care Plan, the request can be changed to “Denied” status by the corporate Chief Medical Officer.
   b) The onsite provider who made the off-site request may appeal the denial to the corporate Chief Medical Officer by adding additional information to the request and/or medical record in support of the request and changing the status to “Documentation of Appeal.” The request is then forwarded to an advanced clinical provider – uninvolved in the case up to this point – for review. The individuals who conduct appeal determinations must be clinical peers who hold an active, unrestricted license or certification to practice medicine or a health care profession in a state or territory of the United States and cannot be the individual who made the original decision for denial, nor the subordinate of such an individual. These individuals must be in a state or territory of the United States when conducting the appeal considerations and must be in the same profession and in a similar specialty as typically manages the medical conditions, procedure, or treatment as mutually deemed appropriate.
c) After reviewing the case, the reviewer may either approve or deny the request. All requests entered as Urgent status will receive Expedited Appeal. All requests entered as Routine or Priority status will receive Non-Expedited Appeal. Expedited appeals are completed with verbal notification of determination to the requesting party within 72 hours of the request followed by a written confirmation of the notification within 3 calendar days to the patient and attending physician or other ordering provider or facility rendering service. Non-expedited, or standard appeals, are completed, and written notification of the appeal decision issued, within 30 calendar days of the receipt of the request for appeal to the patient and attending physician or other ordering provider or facility rendering service. The clinical provider reviewing the appeal will have the opportunity to add comments and documents directly into TechCare, and to use the additional information when making an appeal.

d) Once the request for an appointment has been approved and entered appropriately and completely in TechCare, the corporate schedulers will schedule the appointment with an approved off-site provider. The Health Care Administrator or designee will be responsible for reviewing the scheduled appointments daily and providing the institutional authority with the information needed for transport. Corporate schedulers must be informed of all cancelled appointments.

5) Insurance Verification

a) Proactive facilities will follow a process to ascertain whether any patient seeking medical services has public or private insurance coverage and, if the patient seeking medical services has insurance coverage, that insurance plan is billed for services that are provided.

i) Each detainee will be questioned regarding health insurance as part of the initial intake screening. This will include determination of both public and private insurance coverage.

ii) All detainees that are identified as having insurance coverage will be flagged as such in the electronic health record.

iii) In the event that billable health services are provided, the designated Proactive staff will notify the service provider of the coverage information with instructions to seek payment through that insurance.

iv) Claims processing will verify that the provider first seeks payment from the insurance provider prior to any payment being sought from Proactive.

CASE MANAGEMENT

1) Case management for inpatient, outpatient, and ambulatory physical health is based on an evaluation of medical needs, patient acuity, surgical indicators and levels of care. These attributes may individually or in combination be used to objectively make a health care determination.
2) Hospital care is reviewed concurrently during the stay. On a daily basis the UM team requests clinical information from the hospital case manager and reviews the clinical management and proposed discharge planning. The UM staff coordinate the discharge with the hospital case manager and attending physician. The patient is discharged when the receiving facility can provide the level of care needed for continued convalescence.

ONGOING REVIEW
1) A Health Services Report (HSR) will be generated through TechCare monthly. These reports will be used by the UM Manager, corporate Chief Medical Officers, quality representatives, and jail operations representatives to review statistics and trends from each facility for ongoing quality improvement and process review.
2) UM Committee activities will focus on:
   a) Trending of statistical data provided in the HSR;
   b) Hospitalization re-admissions with thirty days;
   c) Monitoring of utilization, resource consumption, and clinical practice patterns;
   d) Reviewing cost-effectiveness;
   e) Implementing discharge planning efforts to streamline hospitalizations;
   f) Identifying high-risk patients;
   g) Providing quality care;
   h) Making recommendations for quality improvement; and
   i) Reviewing this policy at least annually and revising as necessary.

Relevant Forms

No relevant forms for this policy.

References

Hospital and Specialty Care (O-D-05). National Commission on Correctional Health Care: Standards for Opioid Treatment Programs in Correctional Facilities, 2016.

Continuity of Care (4-ALDF-4C-04); Statistical Reports (4-ALDF-7D-26). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section D: Ancillary Health Care Services

J-D-08 Hospital and Specialty Care

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Hospital and Specialty Care (J-D-08)

NCCHC Opioid Standard: Hospital and Specialty Care (O-D-05)

ACA Standard: Continuity of Care (4-ALDF-4C-04); Referrals (4-ALDF-4C-05)

Purpose
To ensure that hospital and specialty care are available to patients who need these services.

Policy
All aspects of care, including hospitalization and specialty care, are available, coordinated and monitored from admission to discharge.

Procedure
1) Proactive will ensure that appropriate access to hospital and specialist care is ordered when medically necessary and within the clinically indicated timeframe. It is required that patients in need of health care beyond facility resources, as determined by the responsible physician, be ordered to be transferred to a facility where such care is available.

2) Any specialty services provided onsite will be in keeping with the legal requirements of the jurisdiction. Only licensed and certified health care staff will be used for on-site specialty services.

3) When a patient is referred for off-site care, requests for specialty care along with pertinent medical information will be entered into TechCare per Proactive’s policy and procedure regarding off-site referrals, refer to policy titled J-D-08 Hospital and Specialty Care-Utilization Management on NaphCare online.

4) Upon notification that a patient will be transferred to another institution, health care staff will review the patient’s health record and complete a Transfer Summary form, which will accompany the patient with a copy to be retained in the patient’s health record. This can also be achieved or augmented by printing a release summary from TechCare.

5) Off-site facilities or health professionals will provide a summary of assessment findings, testing, treatment, and any follow-up recommendations to accompany the patient’s return to the facility and will be included in the patient’s health record.

Relevant Forms
No relevant forms for this policy.

References

Hospital and Specialty Care (O-D-05). National Commission on Correctional Health Care: Standards for Opioid Treatment Programs in Correctional Facilities, 2016.

Continuity of Care (4-ALDF-4C-04); Referrals (4-ALDF-4C-05). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section E: Patient Care and Treatment

J-E-01 Information on Health Services

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Information on Health Services (J-E-01)

NCCHC Opioid Standard: OTP Admission Process (O-E-01)

NCCHC MH Standard: Information on Mental Health Services (MH-E-01)

ACA Standard: Access to Care (4-ALDF-4C-01, 4-ALDF-4C-02)

Purpose
To ensure that all patients are informed of the availability of health care services and how to access them upon arrival at the facility.

Policy
It is the policy of Proactive to provide patients information on health care provided within the facility and the process to access that care.

Procedure

INFORMATION ON HEALTH SERVICES
1) Access to health care services information will be posted in the intake/booking area.

2) Health care staff will instruct patients verbally and in writing within twenty-four (24) hours of their arrival, conveyed in a language that is easily understood by each patient, on how to access health care. Instructions to be made available to the patients will include:
   a) How to access health services, including emergency and routine medical, mental and dental health services.
   b) Fee for services program, if applicable; and
   c) Procedures regarding the health care grievance system.

3) Patients with special needs such as hearing/vision impairment and/or language barriers will be provided assistance through the use of available resources.

INITIAL HEALTH CARE ORIENTATION
1) Patients verify, by signature, the receipt of their initial health care orientation and written orientation materials.

2) Orientation materials should include:
   a) Health Care Services Patient Orientation;
   b) Dental Hygiene Procedure;
c) Sexual Assault Information; and
d) Grievance Procedure.

3) Patients will be instructed as to how to obtain and complete a request for health care services.

Relevant Forms

Health Care Services Patient Orientation
Dental Hygiene Procedure
Sexual Assault Information
Grievance Procedure

References


Section E: Patient Care and Treatment

J-E-02 Receiving Screening

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Receiving Screening (J-E-02)
NCCHC Opioid Standard: Health Assessments (O-E-02)
NCCHC MH Standard: Receiving Screening for Mental Health Needs (MH-E-02)
ACA Standard: Health Screens (4-ALDF-4C-22)

Purpose
To ensure that all patients admitted to the correctional institution are screened to identify those with urgent or emergent health needs.

Policy
Proactive is committed to a proactive care model, which begins at intake with the immediate identification of those patients with acute and/or chronic medical, dental, or mental health problems needing treatment. Each patient admitted to the facility will be screened as soon as possible and the appropriate health care treatment will be enacted.

Procedure

1) A Receiving Screen will be performed on all patients by health trained correctional officers or qualified health care professionals as soon as possible upon intake to ensure that emergent and urgent medical, dental, and mental health needs are identified and met. The screening will consist of a Receiving Screening form, which includes documentation of visual observations of the patient by medical staff.

2) Reception personnel ensure that any patient who is unconscious, semi-conscious, bleeding, mentally unstable, severely intoxicated, in active drug or alcohol withdrawal, or otherwise urgently in need of immediate medical attention is referred for appropriate care and medical clearance into the facility. If referral is made to a contracted hospital emergency room for care, admission to the correctional institution following this referral and treatment is predicated upon written medical clearance from the treating facility.

3) Receiving screening forms are completed in the patient record in TechCare and are time stamped with the completion date and the name of the person completing the form. Any paper screening or medical clearance forms should be scanned into TechCare after their completion.

4) Goals of the screen include:
a) Ensuring that potentially infectious patients are isolated from the general population as medically indicated; and
b) Health needs are identified and addressed by qualified health care professionals.

5) The screening shall include, at a minimum, an inquiry into the patient’s:
   a) Current and past illnesses, health conditions, or special health requirement (e.g., hearing impairment, visual impairment, wheelchair, walker, sleep apnea machine);
   b) Current or history of serious infectious disease;
   c) Recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats);
   d) Past or current mental illness, including hospitalizations;
   e) History of or current suicidal ideation;
   f) Dental problems (decay, gum disease, abscess);
   g) Allergies;
   h) Dietary needs;
   i) Prescription medications (including type, amount, and time of last use);
   j) Alcohol along with legal and illegal drug use (including type, amount, and time of last use);
   k) Current or prior withdrawal symptoms;
   l) Other health problems as specified by the responsible physician; and
   m) Observation of:
      i) Appearance (e.g., sweating, tremors, anxious, disheveled);
      ii) Behavior (e.g., disorderly, appropriate, insensible);
      iii) State of consciousness (e.g., alert, responsive, lethargic);
      iv) Ease of movement (e.g., body deformities, gait);
      v) Breathing (e.g., persistent cough, hyperventilation); and
      vi) Skin (including lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse)

6) The receiving screening form is approved by the responsible health authority.

7) Health care staff must be present for the disposition of the patient and evaluation of any problems identified on receiving screenings performed by health trained correctional officers.

8) All female patients entering the facility of childbearing age (15-55) will receive a urine pregnancy test.

9) All pregnant patients will be assessed for opiate use to avoid opiate withdrawal risks to the fetus. The assessment will include a urine drug screen.

10) The entirety of TechCare’s receiving screening form will be completed. Additional physical or mental health findings and any other pertinent information not explicitly requested by items on the form will be documented in free text areas.
11) The disposition of the patient (e.g., immediate referral to an appropriate health care service, placement in the general population) will be appropriate to the findings of the receiving screening and indicated on the receiving screening form.

12) When health-trained correctional personnel perform the receiving screening, they are trained by the responsible physician or designee in early recognition of medical or mental health conditions requiring clinical attention. Training is based on a curriculum approved by the responsible physician and contains instruction on completing the receiving screening form and when to contact health staff to determine appropriate disposition of patient.

13) Health staff regularly monitors receiving screenings to determine the safety and effectiveness of this process.

14) All patients with verified prescriptions should be presented to a provider for development of a treatment plan with or without the verified medication or with an alternative treatment plan. Nursing and intake staff may not discontinue a prescription without authorization from the appropriate medical provider. It is the duty of the provider to continue or discontinue the medication based on clinical judgement and interpretation of available clinical data. Appropriate documentation in the patient chart must coincide with the clinicians’ findings.

15) A tuberculin screening or skin test may be administered at the time of the receiving screening per facility protocol. The TB screen will be completed in TechCare on the TB Screening form. Implanted skin tests will be documented on the TB Skin Test form with follow-up scheduled for 48 – 72 hours later.

16) When indicated, an authorization for Release of Health Information will be completed and signed upon initial intake to verify reported prescriptions. Confirmation of all current medications prescribed, including psychotropic medication, may be validated by the dispensing pharmacy, clinic, or practitioner or via electronic database searches.

17) Previous health records, which may be useful in evaluating and classifying the patient can be requested. If requested, the name and address of the provider or clinic will be listed and the patient will sign the appropriate completed authorization. The authorization will be emailed to medical.records@naphcare.com prior to the completion of the obtaining staff’s shift and the original authorization, with the fax confirmation report attached, will be scanned or documented in the health record. In an urgent situation, the previous provider should be contacted, if a contact phone number can be identified.

18) Upon completion of the receiving screen, results, diagnostic processes, and associated task completion for the patient will be maintained electronically by TechCare.
Figure: TechCare’s receiving screening form, a portion of which is shown here, addresses all necessary issues to ensure proper care and disposition of the patient.

Related Forms

Authorization for Release of Information

Authorization for Release of Health Information - Spanish

References


Section E: Patient Care and Treatment

J-E-03 Transfer Screening

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Transfer Screening (J-E-03)

NCCHC MH Standard: Transfer Screening (MH-E-03)

ACA Standard: Health Screens (4-ALDF-4C-23)

Purpose

To ensure that patients who are transferred within the same correctional system continue to receive appropriate health services.

Policy

All patients transferred within the correctional system and staying within the care of Proactive will have their health treatments maintained from one facility to the other.

Procedure

1) Qualified health care professionals review each transferred patient’s health record or summary to ensure continuity of care and medications.

2) A Transfer Summary form should be completed if continuity is maintained within TechCare from one facility to the next.

3) Documentation in TechCare demonstrates continuity of health care and medication administration.

Related Forms

Transfer Summary form

References


Section E: Patient Care and Treatment

J-E-04 Initial Health Assessment

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Initial Health Assessment (J-E-04)

NCCHC Opioid Standard: Health Assessment (O-E-02)

ACA Standard: Health Appraisals (4-ALDF-4C-24-25); Periodic Examinations (4-ALDF-4C-23)

Purpose
To ensure each patient admitted into the correctional institution has a comprehensive health assessment.

Policy
Each patient will receive a comprehensive health assessment to identify a patient’s health needs and to establish a plan of care to meet those needs.

Procedure
1) A full health assessment by a qualified health care professional will be completed as soon as possible and no later than fourteen (14) calendar days after the patient’s arrival to the institution. This is documented in TechCare on Physical Assessment form.
2) If the health assessment is deferred because of a documented health assessment within the last 12 months, documentation must confirm that the new receiving screening shows no change in health status.
   a) If the receiving screening shows a change in health status, the initial assessment is repeated;
   b) Proactive encourages a new physical assessment be completed at all bookings regardless if repeated booking within the last 12 months.
3) The health assessment should include, but is not limited to, the following:
   a) Review of current receiving screening;
   b) Review of current mental health screen;
   c) Assessment for any signs of trauma or disease which may have occurred since the last exam;
   d) A qualified health care professional collecting data to complete medical, dental, and mental health histories. This will include any follow-up from positive findings obtained during the receiving screening and subsequent encounters;
   e) A qualified health care professional recording of vital signs to include height, weight, pulse, blood pressure, and temperature;
f) A physical examination (as indicated by the patient’s gender, age, and risk factors) performed by a physician, physician assistant, nurse practitioner, or RN; and
g) A screening test for latent tuberculosis (e.g., PPD, Chest x-ray, laboratory test) unless completed prior to the initial health assessment.

4) Proactive staff will ensure the patient is provided with educational information on pertinent health related issues.

5) Once data collection is complete, the clinician will integrate the clinical information onto a comprehensive problem list and treatment plan, which will be recorded in TechCare.

6) Additional testing, if indicated, will be ordered by the physician or advanced clinical provider. If a significant chronic condition is identified, part of the treatment plan will be entering the patient into an appropriate chronic care program.
   a) Patients started on medication with cardiac risk, such as those causing QT prolongation, may have an EKG ordered as clinically indicated.

7) Treatments and further diagnostic workup are to be initiated as ordered by the provider.

8) Referrals to dental or mental health staff will be initiated based on the findings of the health assessment or subsequent referral or request.

9) Proactive staff will ensure through communication with appropriate facility classification channels that patient needs related to adaptation to the correctional environment are met.

10) All findings (e.g., history and physical, screening, and laboratory) will be reviewed by the treating provider.

11) All Health Assessments upon completion are sent to the provider queue H&P approval tab in TechCare to be signed off by a provider.
Figure: TechCare screen shot demonstrating a portion of the Physical Assessment form.

Related Forms
No relevant forms for this policy.

References


Health Appraisals (4-ALDF-4C-24-25); Periodic Examinations (4-ALDF-4C-23). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.
Section E: Patient Care and Treatment

J-E-05 Mental Health Screening and Evaluation

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Mental Health Screening and Evaluation (J-E-05)

NCCHC Opioid Standard: Mental Health Screening and Evaluation (O-E-03)

NCCHC MH Standard: Mental Health Assessment and Evaluation (MH-E-04)

ACA Standard: Mental Health Screen (4-ALDF-4C-29); Mental Health Appraisal (4-ALDF-4C-30); Mental Health Referrals (4-ALDF-4C-31).

Purpose

To ensure that all patients admitted to the correctional institution are screened in order to identify those patients who may require immediate mental health care or who pose a health or safety risk to themselves or others.

Policy

Proactive is committed to identifying and meeting the acute and chronic mental health needs of patients admitted to the correctional institution. Each patient who is admitted to the institution will be screened and appropriate mental health care treatment will be enacted.

Procedure

1) All patients entering the correctional institution will receive a mental health screen within fourteen days of the patient’s arrival to the institution.
   a) Proactive encourages the Mental Health Screen to be completed at intake with the Receiving Screening and Physical Assessment.

2) The initial mental health screening includes a structured interview performed by qualified mental health professionals or qualified health care professionals using the Mental Health Screening form in TechCare. The form will be completed in its entirety and results will be made a part of the patient’s health record.

3) Qualified health care professionals completing the mental health screen will receive documented training.
   a) Mental health staff should be involved in training staff that perform the mental health screen.
   b) Topics for training should include alcohol and other drug diversion and misuse, substance use disorder, intellectual impairment, and suicide behavior.

4) The initial mental health screening includes:
   a) A history of:
i) Psychiatric hospitalization and outpatient treatment;
ii) Substance use hospitalization;
iii) Withdrawal seizures;
iv) Detoxification and outpatient treatment;
v) Suicidal behavior;
vi) Violent behavior;
vii) Victimization;
viii) Special education placement;
ix) Cerebral trauma;
x) Sexual abuse;
xii) Sex offenses.

b) The status of:
   i) Psychotropic medications;
   ii) Suicidal ideation;
   iii) Drug or alcohol use;
   iv) Drug or alcohol withdrawal or intoxication;
   v) Orientation to person, place, and time.

c) Emotional response
d) Screening for intellectual functioning (i.e., mental retardation, developmental disability, learning disability).

5) Those who identify positive indicators of mental health issues on the mental health screen will be referred for a mental health evaluation following the completion of the screening. Any referrals deemed necessary by the interviewer will be indicated on the mental health screen. Early identification of patients with serious mental illness or in need of immediate mental health services requires an expedited referral.

6) Mental health evaluations of patients with positive screens should be completed within 30 days or sooner if clinically indicated.

7) Patients who require off-site acute mental health services will be transferred to the appropriate facility per Proactive policy regarding off-site referrals.

8) The mental health evaluation is to be conducted in a timely manner as dictated by the nature of the referral.

9) When indicated, an authorization for Release of Health Information will be completed and signed to verify reported prescriptions. Confirmation of all current medications prescribed, including psychotropic medication, may be validated by the dispensing pharmacy, clinic, or practitioner, or via electronic database searches.

10) Previous health records, which may be useful in evaluating and classifying the patient, can be requested. If requested, the name and address of the provider or clinic will be listed and the patient will sign the appropriate completed authorization. The authorization will be emailed to medical.records@naphcare.com prior to the completion of the obtaining staff’s shift and the original authorization, with the fax confirmation report attached, will be
scanned or documented in the inmate’s health record. In an urgent situation, the previous provider should be contacted if a contact phone number can be identified.

Related Forms

Authorization for Release of Health Information

Authorization for Release of Health Information - Spanish

References


Mental Health Screen (4-ALDF-4C-29); Mental Health Appraisal (4-ALDF-4C-30); Mental Health Referral (4-ALDF-4C-31). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section E: Patient Care and Treatment

J-E-06 Oral Care

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Oral Care (J-E-06)

ACA Standard: Oral Care (4-ALDF-4C-20)

Purpose

To ensure that a patient’s serious dental needs are met.

Policy

Proactive will provide dental services to patients in accordance with established guidelines for dental evaluation and treatment.

Procedure

1) Oral care under the direction and supervision of a licensed dentist is provided to each patient.

2) An oral screening is a component of the physical assessment and is performed as soon as possible but no later than 14 calendar days from admission.
   a) Proactive encourages the oral screen to be conducted at intake with the Receiving Screen and Physical Assessment.

3) Oral screening may be done by the dentist or qualified health care professional who has received documented training approved or provided by the dentist. Documentation of the dental training will be maintained on site.

4) Each patient will be provided instruction in oral hygiene and preventative oral education information within 14 days and is documented within the physical assessment.

5) Dental services may be provided on a fee-for-service basis to be paid by the patient. There will be no charge for the initial oral screening. No patient will be denied dental services because of the inability to pay.

6) An oral examination, performed by a dentist, (supported by x-rays as indicated) will be performed within twelve months of admission and further dental exams will be offered as medically indicated but no less than annually.

7) A full range of services necessary to provide a diagnosis or treatment plan will be made available. Radiographs are used in the development of the treatment plan.

8) Prosthetic appliances that are damaged or lost due to circumstances beyond a reasonably diligent patient’s control may be required in accordance with institutionally contracted dental services.
a) Patients waiting for prosthetics who have difficulty masticating their food may be offered a soft diet upon recommendation of the dentist.

9) The dentist rendering treatment will determine the necessary diagnostic services. Diagnostic services necessary to provide adequate information to the dentist will be made available.

10) Arrangements will be made for consultation with specialists in dentistry or oral surgery as needed for emergency or complex dental care.

11) Each patient has access to the preventive benefits of fluoride in a form determined by the dentist to be appropriate for the needs of the individual. The dentist providing dental services in accordance with the established guidelines for dental evaluation and treatment will determine the treatment necessary.

12) For on-site dental services, Proactive’s infection control procedures are followed.

13) Extractions will be performed in a manner consistent with community standards of care and adhering to the American Dental Association’s clinical guidelines and may be subject to a fee-for-service.

14) Dental treatment may be requested by the patient through the facility health care request process:

   a) A request will be submitted using the Sick Call Request form unless the facility has an electronic submission mechanism. Each visit may be subject to a fee-for-service.

   b) The dental or health care staff will screen the patients with unexpected dental problems during normal sick call hours.

   c) In the event the visual observation of the teeth and gums result in notation of any obvious or gross abnormalities, an immediate referral to the dentist will occur.

   d) Patients with dental conditions requiring emergency or urgent treatment will be scheduled accordingly.

   e) The following priority codes are to be sued and entered on the Dental Sick Call:

      i) Priority – when a patient is in moderate pain or has a chronic or acute infection which could compromise the patient’s health, treatment should be received within seven days.

      ii) Routine – generally, this will be in the order in which the request for treatment was received.

15) The dentist will directly supervise and be responsible for all activities involving dental staff. The dentist performing treatment ultimately has the right to defer specific treatment when that treatment cannot be adequately rendered due to non-cooperation of the patient (i.e., poor oral hygiene, failure to follow instructions).

16) All dental records are to be maintained in the health record as follows:

   a) Health record entries will be standardized through the use of the Dental Visit form in TechCare. This form should be completed at every visit with a dental provider.
b) Each time a patient is seen for dental care, a review of the patient’s medical history will be conducted prior to initiating treatment.

c) Orders can be documented on the Dental Visit form in TechCare triggering the most common orders. Orders for other medications and treatments can be ordered in the eMAR via a Drug Order or Treatment Order.

d) If treatment is deferred, the reason and behavior modifications needed prior to re-instituting treatment will be entered into the note.

17) All patients have the right to refuse treatment that has been recommended. While a patient does not have the right to dictate his own treatment, an expressed desire to decline treatment will be honored. Patients who refuse dental treatment that the dentist feels is urgently medically necessary will be required to sign a Release of Responsibility Specific Procedure found on NaphCare online under Release of Responsibility. This form will be scanned into the health record. Routine refusal will be documented as normal in TechCare with a “refused” checkbox.

18) Informed consent shall be obtained before any procedure which carries a significant risk of complications (e.g., extractions) is performed.
Figure: The TechCare dental visit form, a portion of which is shown here, will be used to document dental visits.

Related Forms

Dental Needle Count

Dental Hygiene Procedure

Dental Instrument Inventory

Release of Responsibility
Release of Responsibility - Spanish

References


Section E: Patient Care and Treatment

J-E-07 Nonemergency Health Care Requests and Services

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Nonemergency Health Care Requests and Services (J-E-07)

NCCHC Opioid Standard: Routine Health Care Services (O-E-06)

NCCHC MH Standard: Nonemergency Mental Health Care Requests and Services (MH-E-05)

ACA Standard: Clinical Services (4-ALDF-4C-03)

Purpose

To provide patients with access to a qualified health care professional for non-emergency health care needs.

Policy

Patients will have the opportunity to confidentially request medical assistance or health care services for non-emergent illness or injury on a daily basis. Access to services will occur through the sick call process.

Procedure

HEALTH CARE REQUESTS

1) Upon arrival at the institution, patients will be oriented verbally, in writing, or by electronic means regarding access to health care services, including sick call, which will occur through a confidential written request form. All sick call requests will be triaged by licensed health care staff daily upon receipt of the sick call request.

2) The sick call request forms will be made available to all patients daily, regardless of housing assignment. Patients will submit the sick call request by placing it in a secure box in the housing unit or centralized location such as the dining area, hand the form directly to a nurse during med pass or segregation rounds, or submit the request via a facility kiosk system, if available. Health staff will ensure that adequate numbers of forms are available in designated areas. Patients needing assistance in completing the forms may request assistance from any health staff member.

3) A licensed health care professional will conduct sick call. Nurses conducting sick call will receive training on nursing protocols and the referral routing system.

4) Nursing sick call will be conducted daily:
   a) After initial triage, sick call slip issues deemed emergent will be seen immediately;
b) Sick calls deemed non-emergent containing a clinical symptom will have a face-to-face encounter within 24 hours of receipt by qualified health staff or health care liaison, if applicable; and
c) Routine mental health and dental sick call slips will be referred to the respective departments for follow-up after initial triage by the above process.

5) During sick call, qualified health care professionals will make timely assessments as follows:
   a) Nursing staff trained in the use of nursing protocols will assess and treat minor health complaints. The most appropriate protocol assessment form in TechCare will be completed to document the sick call encounter;
   b) Nursing staff will address all clinical concerns raised by the patient during the encounter. The patient can state as many complaints as reasonable to be addressed in the encounter, with those potentially serious complaints being addressed first;
   c) Patients seen in sick call more than twice for the same complaint without a satisfactory resolution will be referred to an advanced clinical provider.
   d) The nurse may treat, without referral, health problems assessed as minor and amenable to treatment by first aid and/or over the counter medications;
   e) Patients having health complaints beyond the training or experience of the nurse will be referred as follows:
      i) Emergent referral – refer to an advanced clinical provider immediately;
      ii) Urgent referral – refer to an advanced clinical provider the next business day; and
      iii) Routine referral – refer to an advanced clinical provider to be seen within ten (10) calendar days.

6) The duration of sick call will be sufficient to meet the health care needs of the facility’s population.

7) Sick call will be conducted in an adequately equipped room with access to water or hand sanitizer for hand cleansing during and between patient encounters.

8) Encounters will be conducted in a manner that provides privacy and maintain confidentiality for the patient.

EVALUATION OF HEALTH CARE REQUESTS

1) If the patient has indicated on the sick call request form a desire to be evaluated at sick call and the complaint is of a non-urgent nature, the patient’s name will be placed on the sick call log within the appropriate time frame and with the appropriate level health care provider.

2) When a request describes clinical symptoms, the patient must be scheduled for face-to-face sick call.

3) If the patient has indicated on the request form a desire to be evaluated at sick call and the complaint is of a potentially urgent nature (e.g., chest pain), arrangements will be made to evaluate the patient as soon as possible.
4) If the patient does not wish to be evaluated at sick call, but desires a medication refill, laboratory test results, etc., the nursing staff will review the health record and provide a written response to the patient or, if necessary, schedule the patient for an appointment.

5) Requests for medication refills will be forwarded to the pharmacy if there is a valid order for refills in the health record.

SICK CALL DOCUMENTATION PROCEDURES

1) Nursing staff will document the time and date that the sick call request was received and triage decision on the request form.

2) A sick call request resulting in a clinical encounter and/or the administration of over-the-counter medication will have this information documented in a progress note or nursing protocol form. Patients will be encouraged to purchase over-the-counter medications in the commissary for minor self-treatable health problems.

3) The sick call request form will not be used to document the clinical encounter. All encounters are documented directly into TechCare.

4) Written responses to the patient regarding lab test results, etc. will require documentation in the health record. Written responses to patients will be kept confidential.

5) Each health encounter will generate an entry in the health record using a progress note or nursing protocol form. An advanced clinical provider will identify health problems of a serious or chronic nature on the problem list. A registered nurse may add previous or current medical diagnosis to the problem list or ask the advanced clinical provider to do so. Entry of diagnoses that are self-reported by the patient but not verified should be minimized. Self-reported diagnoses that are added to the problem list should be designated as such.
NO SHOWS OR CANCELLATIONS

1) If a patient submits a sick call request indicating a desire to cancel the request for evaluation, the patient will be removed from the sick call schedule.

2) Should the patient not submit a cancellation form in time to have his or her name removed from the schedule, he or she must report to sick call as scheduled to communicate his or her desire to cancel a sick call evaluation.

3) Health care staff will ensure that “no shows” are not permitted for sick call, scheduled appointments, laboratory tests, or consultations. Correctional staff will be contacted to
determine the location of the patient so that the appointment can be completed. If the patient is out of the institution or otherwise unable to come to health services, the reason will be documented in a progress note.

SICK CALL IN SEGREGATED AREAS
1) Sick call will be available to patients in segregation consistent with the provision of sick call for general population.
2) A sick call request form will be utilized to make a non-urgent request known. The patient may also submit a request during medical rounds or during pill call to the licensed health staff.
3) The request form will be collected in a manner that ensures confidentiality. The patient may use an envelope, which can be collected by health staff or may place it directly into a portable lock box.
4) Sick call encounters in segregation will be conducted in an adequately equipped room in the immediate area or in the main clinic.
5) Sick call encounters will be documented for all patient encounters. Documentation of each sick call encounter will be made in the patient’s health record using the most appropriate note template or nursing assessment form.
6) Cancellations of a scheduled sick call for a patient in segregation will be documented the same as a patient in the general population.
7) All inquiries requiring a more in-depth examination shall result in a referral to the appropriate level provider.
8) If the patient’s medical or mental health condition contraindicates continued assignment to segregation, the Health Services Administrator (HSA) will be notified and the HSA will notify the institutional authority to request the patient be placed in the appropriate treatment setting (e.g., infirmary, intake observation area) until the health condition improves.

APPOINTMENT TRACKING AND DATA COLLECTION
1) Use of the sick call system within TechCare is mandatory.
2) The sick call system helps track all visits to completion, along with documenting refused or rescheduled visits.
3) If the patient refuses or cancels a scheduled sick call visit, this is to be documented in the sick call system.
4) Sick call requests will be maintained in the patient’s health record.

Related Forms
Offsite Referral Form
Sick Call Request
References


Section E: Patient Care and Treatment

J-E-08 Nursing Assessment Protocols and Procedures - Evaluation Following Use of Force

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Nursing Assessment Protocols and Procedures (J-E-08)

NCCHC Opioid Standard: Nursing Assessment Protocols (O-E-08)

ACA Standard: Use of Force (4-ALDF-2B-03)

Purpose

To establish health care requirements for evaluation and treatment of patients following use of force events, including those where Tasers and other devices may be deployed.

Policy

A physical evaluation of the patient will be performed and documented following the use of force aside from routine use of restraints during day-to-day activity and transport.

Procedure

EXAMINATION AFTER USE OF FORCE

1) After any use of force, other than the routine use of restraints during day-to-day activity and transport, an examination will be performed at the health care unit.

2) Should the patient be in segregation, the nurse will go to the unit and, at a minimum, will perform a visual inspection of the patient.

3) The nurse will notify mental health staff following the use of force with any patient.
   a) Should the nurse question whether the patient has any mental health issues, which could have contributed to violent or combative behavior, the patient will be referred immediately for a mental health evaluation.
   b) Patients without a history of mental health disorders who exhibit signs and symptoms of a mental health disorder will be referred to mental health staff or to a facility with mental health evaluation capability if mental health services are not provided onsite.

4) If possible, a complete physical exam will be performed, including vital signs.
   a) With the patient’s consent, the patient’s clothing will be removed and a description of any noticeable injury or trauma will be documented on the anatomical person diagram.
   b) Any subjective history voiced by the patient will be documented.
5) Should the patient be uncooperative during the examination, a physical assessment will be made to the extent permitted under the circumstances, and the findings will be documented in the progress note.

DOCUMENTATION OF USE OF FORCE

1) The examination documentation will include:
   a) Date and time of the use of force;
   b) Date and time of examination; and
   c) Name and time stamp of examiner (electronically).

2) All injuries are to be documented on the Post Use of Force form located within the Nursing Protocols tab in the patient record in TechCare.
   a) The form will be filled out in its entirety, including vital signs.
   b) Injuries, if any, will be documented on the anatomical person diagram.

USE OF TASERS AND ELECTRONIC DEVICES

1) After use of electronic devices, including Tasers and electronic security belt systems, nursing and/or mental health staff will be notified immediately by custody staff.

2) Medical and/or mental health staff will examine as soon as possible and treatment will be rendered as deemed necessary by a medical professional.

3) Once the patient is fully under control, and in the judgment of the jail supervisor there is no remaining risk, medical personnel will assess the patient who has been subjected to an electronic device.
   a) Health care staff will evaluate and treat any respiratory or cardiac symptoms prior to the removal of Taser probes.

4) The following steps will be taken for removal of Taser probes:
   a) Remove clothing from the entry site;
   b) Probe will be photographed or documented by custody staff per their procedures prior to removal as requested by custody staff;
   c) Evaluate for any contraindications to the removal of a Taser probe, including location deep within the tissue such that it is not visible or other area of compromise, such as the eye, neck, face, genitalia, female breast; bone; cartilage; or near any blood vessel or area that would cause damage if removed;
   d) Probe will be grasped with fingers or pliers on both sides of the entry site, with tension applied to the surrounding skin, and the probe will be pulled out perpendicular to the skin surface;
   e) The site will be cleaned with alcohol and covered with a bandage; and
   f) Probe will be placed sharp side down into the Taser cartridge and returned to the officer on scene for evidence.

5) Medical staff are required to complete a note in TechCare, including assessment of the patient, removal, and care provided.
6) The medical and/or mental health provider will be contacted when clinically indicated by medical or mental health staff.

7) The use of an electronic device and care provided may be investigated as needed by the Health Services Administrator.

Related Forms
No relevant forms for this policy.

References


Section E: Patient Care and Treatment

J-E-08 Nursing Assessment Protocols and Procedures

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Nursing Assessment Protocols and Procedures (J-E-08)

NCCHC Opioid Standard: Nursing Assessment Protocols (O-E-08)

NCCHC MH Standard: Nonemergency Mental Health Care Requests and Services (MH-E-05)

ACA Standard: Continuity of Care (4-ALDF-4C-04)

Purpose

To ensure that nurses who provide clinical services are trained and do so under specific guidelines.

Policy

Nursing assessment protocols shall be used by nursing staff when providing clinical care, to the extent possible. Nurses shall comply with relevant state practice acts and conduct data gathering and treatments appropriate to the level of competency and preparation of the nurses who will carry them out.

Procedure

1) Proactive has developed Nursing Assessment Protocols that have been approved by and reviewed annually by the Nursing Administrator, and responsible physician based on the level of care provided in the facility.

2) All nursing assessment protocols are accessible to nursing staff in TechCare and limited by role.

3) Documentation of nurses’ training in protocol use exists, including:
   a) Evidence that all new nursing staff are trained and demonstrate knowledge and competency for the protocols and procedures that are applicable to their scope of practice;
   b) Evidence of annual review of skills/competency; and,
   c) Evidence of training when new protocols are introduces or reviewed.

4) Nursing assessment protocols do not include the use of prescription medications, except for those covering emergency, life-threatening situations.
   a) Emergency administration of these medications requires a providers order before or immediately after administration.
   b) Standing orders are not allowed, and all prescription medications require a provider order.
5) If mental health protocols are used onsite, qualified mental health professionals make timely assessments based on these protocols approved by the responsible mental health clinician.

Figure: This TechCare screenshot shows an example of a nursing assessment protocol form.

Related Forms
No relevant forms for this policy.

References


Section E: Patient Care and Treatment

J-E-09 Continuity, Coordination, and Quality of Care during Incarceration

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Continuity, Coordination, and Quality of Care during Incarceration (J-E-09)

NCCHC Opioid Treatment Standard: Continuity and Coordination of Care during Incarceration (O-E-09)

NCCHC MH Standard: Continuity and Coordination of Mental Health Care during Incarceration (MH-E-09)

ACA Standard: Continuity of Care (4-ALDF-4C-04)

Purpose

To ensure that patients receive all necessary health care services ordered by health care staff.

Policy

Patient health care is coordinated and monitored from admission to discharge.

Procedure

1) Orders are evidence-based and should be provided to each patient by health care staff in a timely manner and documented in the patient’s medical record.

2) In the event a patient is sent off-site to an emergency room, the Health Services Administrator and/or designee will submit a notification immediately to ERNotification@naphcare.com.

3) Family members/next of kin of patients with life-threatening illnesses or injuries will be notified per institutional policy.

4) Upon return from an emergency room visit, urgent care visit, or hospitalization, including psychiatric visits, a qualified health professional will see the patient, review the discharge information and treatment recommendations, and notify the advanced clinical provider to obtain treatment orders and follow-up instructions, as indicated. A progress note entry will be documented in the patient record in TechCare, or other appropriate hospital/offsite visit return form completed.

5) In the event a patient returning from an emergency room visit or hospitalization has conditions that cross disciplines (e.g., medical, mental health, substance abuse, dental) coordination should take place between all providers involved in the patient’s care.

6) Diagnostic tests will be reviewed by the clinician in a timely manner.
7) Treatment plans are to be modified as clinically indicated by diagnostic tests and treatment results are shared and discussed with the patient. Recommendations from specialty appointments are reviewed and acted upon by the clinician in a timely manner. Justification for changes in treatment plan recommendations are documented in the health record.

8) If any deviations from standards of practice in treatment are indicated, clinical justification for an alternative course of treatment will be noted in a progress note and is shared with the patient.

Related Forms
No relevant forms for this policy.

References

Continuity and Coordination of Care during Incarceration (O-E-09). National Commission on Correctional Health Care: Standards for Opioid Treatment Programs in Correctional Facilities, 2016.


Section E: Patient Care and Treatment

J-E-10 Discharge Planning

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Discharge Planning (J-E-10)

NCCHC Opioid Standard: Discharge Planning (O-E-10); Pharmaceutical Operations (O-D-01)

NCCHC MH Standard: Discharge Planning (MH-E-10)

ACA Standard: Continuity of Care (4-ALDF-4C-04)

Purpose

To establish a discharge plan for those patients with health problems in order to provide the opportunity for linkage to community service providers.

Policy

Proactive is committed to providing quality services to patients while detained and supplying community links for continued treatment as appropriate.

Procedure

1) Discharge planning by the health care staff should include the following:
   a) As part of the intake/health assessment process, patients should be informed verbally that they may have access to a prescription to continue their prescription medication after they are released from the institution, per the order of the provider. Additionally, resource information on medical, mental health, and substance abuse, along with local social services, housing, and other services will be provided to patients. A local resource information sheet will be provided to inmates when possible.
   b) The maximum duration for a discharge prescription order shall be thirty (30) days. The order will be carried in TechCare as an active order for its duration, starting from the day of release from the facility.
   c) Patients who are aware in advance of their release date may inform health staff. The provider will then review the medications and determine which medications need to be provided and for what duration. Prescriptions as ordered will then be provided to the patient on the day of release.
   d) Patients participating in a MAT program while in the facility will be connected to a community partner for continuation of their medications.
      i) No take home doses are provided upon release from the facility.
e) When a patient on prescription medication is released from the facility without advance notice, the patient can request an order for the prescription within three days after release.

f) Should the health care staff be notified prior to an patient’s discharge, resource information on patient education and community providers will be made available to the patient upon his/her discharge from the facility and appointments made when possible. Arrangements or referrals for follow-up will also be made for all serious medical and mental health needs, if possible.

g) Should the patient be re-incarcerated while the discharge order is still active, nursing staff should confirm that no changes in the health status of the patient have occurred, and in that circumstance may continue to administer the medication until the order expires.

2) Health care staff will collaborate with the correctional staff responsible for release arrangements for an effective discharge plan.

3) Arrangements for follow-up care and treatment are made for those patients with critical mental health needs,

4) All discharge planning, including medical and mental health referrals, is to be documented in the inmate’s health record.

5) A release summary is available in TechCare for assistance in discharge planning, especially in those patient’s discharged to a prison or other correctional entity.
Figure: This TechCare screenshot shows an example of a portion of a release summary.

Related Forms
No relevant forms for this policy.

References

Discharge Planning (O-E-10); Pharmaceutical Operations (O-D-01), National Commission on Correctional Health Care: Standards for Opioid Treatment Programs in Correctional Facilities, 2016.


Section F: Special Needs and Services

J-F-01 Patients with Chronic Disease and Other Special Needs - Care of Patient with Gender Dysphoria

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: J-F-01 Patients with Chronic Disease and Other Special Needs

ACA Standard: None

Purpose

To ensure that patients with gender dysphoria (GD) are appropriately identified, diagnosed, and managed with regard to mental health and medical needs.

Policy

Proactive will provide health care management for patients with GD in order to meet the patient’s physical and mental health needs.

Procedure

Note: This procedure is subordinate to any federal or state regulations requiring higher levels of care or additional services or treatments for certain GD patients (e.g., ICE detainees).

1) GD Diagnosis:
   a) For patients reporting a diagnosis of GD, an advanced clinical provider will attempt to obtain history on the diagnosis using TechCare records from previous incarcerations, outside medical records from prior to intake, and/or personal communication with outside medical providers:
      i) Both medical and mental health records, if available, will be reviewed;
      ii) A Proactive (or other contracted) provider will consult with the outside treating psychiatrist and any other practitioners involved in the management of the patient’s GD prior to incarceration;
      iii) If the diagnosis and current treatment cannot be verified or if there are any concerns regarding a documented or reported diagnosis, the patient will be evaluated by an onsite provider.
   b) For patients without a diagnosis of GD and patients whose GD diagnosis and treatment plan cannot be verified, a diagnosis of GD must be made by a provider in accordance with DSM-V criteria in order for GD treatment to commence.

2) GD Management:
a) Due to the short term and transient nature of the jail setting, the goal of GD management during the period of incarceration will be to maintain the patient at the treatment level existing upon intake to the jail setting.
b) Hormonal therapy:
   i) Informed consent demonstrating that the patient is aware of the risks and benefits of hormone therapy will be signed;
   ii) An advanced clinical provider will perform a medical assessment to ensure there are no contraindications to hormone therapy or medical reasons that would put the patient at risk if therapy were to be initiated;
   iii) A mental health evaluation will be completed to ensure the appropriateness of hormonal therapy;
   iv) Baseline laboratory studies will be obtained, as appropriate;
   v) Requests for hormonal therapy must be entered into TechCare and approved through the non-formulary approval process, if applicable, prior to initiation;
   vi) For patients on hormonal therapy at the time of intake:
      1. Refusal of the consent to release of information will result in delay of discontinuation of treatment;
      2. If hormonal therapy was taken without a prescription or unlawfully, the patient will be referred to a provider for evaluation; and
      3. Upon provider order hormonal therapy will be initially provided at an equivalent dose and frequency taken prior to intake, and may be adjusted in order to maintain the normal range for the appropriate sex, age, and medical comorbidities.
   vii) For patients not on a hormonal therapy regimen at the time of intake:
      1. Hormonal therapy will generally not be initiated during jail incarceration secondary to the acute transient nature of jail stays.
   viii) Routine follow-up by both mental health and a medical provider will be used to monitor and adjust therapy as needed:
      1. Increases or decreases in hormonal dose and changes to frequency or route of administration must be determined to be medically indicated by an advanced clinical provider in consultation with a psychiatric provider.
      2. Hormone therapy may be discontinued due to:
         a. Lab abnormalities;
         b. Interactions with drugs required for other conditions;
         c. Cardiovascular disease;
         d. Liver disease;
         e. Blood clotting event; or
f. Other reasons deemed to be cause for discontinuance by an advanced clinical provider.

c) Surgical management:
   i) Surgical management of GD will be deferred during the time of incarceration at the Proactive served facility due to the medical risks of the surgery and post-operative period, as well as safety, security, and operational concerns.
   ii) In-process surgical interventions will be completed while under Proactive’s care only if delay of the surgery would put the patient at undue risk or result in poor outcomes.

d) Decisions regarding changes in the therapy, management approach, lab results, and decisions to not begin or continue treatment will be communicated with the patient.

e) Patients not actively receiving medication for GD will continue to be seen by medical and mental health staff.

3) With the patient’s consent, mental health staff may communicate with custody staff regarding:
   a) Recommendations that the patient be allowed access to alternative clothing, canteen items, appropriate housing or other permissions as a part of the comprehensive management of GD;
   b) Vulnerabilities to sexual attack;
   c) Findings related to the patient’s GD diagnosis that may compromise the patient’s safety.

Related Forms

No relevant forms for this policy.

References

Section F: Special Needs and Services

J-F-01 Patients with Chronic Disease and Other Special Needs - Dialysis Services

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Patients with Chronic Disease and Other Special Needs (J-F-01)

ACA Standard: Continuity of Care (4-ALDF-4C-04)

Purpose

To provide dialysis treatments in a timely manner to those patients with end stage renal disease (ESRD).

Policy

Patients with ESRD will need renal replacement therapy-either hemodialysis or peritoneal dialysis (PD).

Procedure

PROCEDURES FOR ALL DIALYSIS PATIENTS

1) Obtain a complete metabolic panel and complete blood count. Some laboratory tests for ESRD patients have different normal ranges than those used for patients without ESRD.
   a) Blood urea nitrogen and creatinine will be elevated, and this elevation can be dramatic if it has been days since the patient’s last treatment.
   b) Hemoglobin and hematocrit may be low with an expected hemoglobin between 10 and 13.
   c) Potassium should be 5.5 or less; if it is >6, Kayexalate orders can be obtained.
   d) Carbon dioxide may be low due to metabolic acidosis.

2) Complete a short assessment, asking for symptoms including shortness of breath, chest pain, nausea, vomiting, diarrhea, constipation, appetite, and diet changes. Assess blood pressure (may be elevated if no recent dialysis), temperature (may be low due to uremia), lung sounds, edema, date of last treatment, medications (including erythrocyte stimulating agents, phosphate binders, antihypertensives, stool softeners, and calcimimetics). Document the assessment in TechCare and notify the nephrologist of any signs/symptoms of concern or indications of distress.

HEMODIALYSIS

1) Upon entry to the facility the following steps should be followed:
   a) Obtain release of information and send for records from current dialysis treatment center and provider;
   b) Notify Corporate dialysis nurse of patient admission to facility;
c) Notify corporate Nephrologist of patient admission; and,

d) Obtain information regarding treatment schedule and date of last treatment.

2) If a patient is to receive hemodialysis treatments, coordinate with the community dialysis center for offsite treatment services three times per week, unless services are provided onsite.

PERITONEAL DIALYSIS

1) Additional steps are to be taken for peritoneal dialysis patients:
   a) Gather additional data from the patient, including the name of the current nephrologist, current community dialysis unit or details on home dialysis treatments, whether the patient has a caregiver who assists with treatments, and whether there are supplies at the patient’s home that can be brought to the facility.
   b) Call the current nephrologist and community dialysis center to obtain PD treatment, lab, and medication orders.
   c) Verify with the community dialysis center that the patient has been properly trained to perform treatments. Verification should be in the form of documentation provided by the center.
   d) Ask the community dialysis center to provide supplies, if they cannot be obtained from the patient’s home.

2) Arrange for supplies to be delivered to the correctional facility either from the patient’s home or the community dialysis center, if the patient is mentally stable and can perform the treatments him/herself.

3) If unable to obtain supplies from patient’s home or community dialysis center, notify supplies@naphcare.com so that supplies may be ordered.

4) Utilize a room free from air disturbances and provide face masks for all persons in the room during the exchange, treatment supplies, and a sink for hand washing. The patient should be allowed to perform the exchanges as normal. Provide the patient with treatment sheet documentation forms obtained from the community provider.

5) Should the patient not be mentally stable or deny having adequate knowledge to perform these treatments, arrange for a clinic visit in the community dialysis center. A nurse from the correctional facility should attend the visit for training and repeat demonstration, or arrangements should be made for a PD nurse from the community dialysis center to make a facility visit for training and demonstration.

6) If we are unable to ensure that this dialysis modality can be safely performed, the patient may be transitioned to hemodialysis for the duration of his/her incarceration at the discretion of the attending nephrologist.

7) Monthly consults are to be arranged with the patient’s community Nephrologist.

REFUSAL

1) Patients have the right to refuse health care services. If the event of treatment refusal, the nurse will provide non-adherence counseling to the patient.
2) Specific information regarding the type of treatment being refused, the condition of the patient, and the potential consequences of treatment refusal must be documented in the patient’s health record.
3) The patient will be asked to sign a Release of Responsibility form documenting the refusal.
4) Patients refusing treatment will be monitored and re-counseled regarding their current condition and the consequences of continued refusal.
5) The Health Services Administrator should be notified about any refusal of a dialysis treatment.
6) A mental health referral will be made for patients refusing two or more dialysis treatments.

Related Forms

Release of Responsibility
Release of Responsibility – Spanish
Informed Consent.
Informed Consent – Spanish

References
Patients with Chronic Disease and Other Special Needs (J-F-01). Standards for Health Services in Jails. 2018. National Commission on Correctional Health Care


Section F: Special Needs and Services

J-F-01 Patients with Chronic Disease and Other Special Needs - Hunger Strike

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Patients with Chronic Disease and Other Special Needs (J-F-01)

ACA Standard: Hunger Strike (4-ALDF-2A-52); Informed Consent (4-ALDF-4D-15)

Purpose

To establish a standard procedure to protect patients’ health and well-being by monitoring, counseling, and providing appropriate treatment to any patient who is refusing to consume adequate food and/or liquid.

Policy

Proactive will ensure that patients who report food refusal, or are witnessed to be refusing to eat, receive thorough and proper treatment by health care staff for purposes of assessment and intervention.

Procedure

TRAINING

1) All health care staff shall be initially and annually trained to recognize the signs of a hunger strike or lack of adequate caloric intake, along with the procedures for referral for medical assessment, and the correct procedures for managing a detainee non-compliant with sufficient dietary intake.

INITIAL REFERRAL AND MEDICAL EVALUATION

1) Facility and health staff shall consider any patient observed to have not eaten for 72 hours to be on a hunger strike, and shall refer the patient to the appropriate health care staff for evaluation and management. The patient will also be referred to a mental health professional for an urgent mental health evaluation.

2) Should the mental health professional determine the patient is incapable of making sound decisions regarding his health, the Health Services Administrator and the institutional authority should be notified immediately for possible judicial intervention per custody determination.

3) Health care staff shall recommend the patient be placed in a single occupancy medical observation room or in the infirmary, where applicable, if measuring food and liquid intake/output becomes necessary.

4) Health care staff shall monitor the health of the patient, and attempt to ascertain the reasons for the hunger strike. Should the patient be engaging in a hunger strike due to a
mental condition, or be incapable of giving informed consent due to age or illness, appropriate medical/administrative action shall be taken in the best interest of the patient.

5) Upon the initial evaluation of a patient on hunger strike, health care staff shall:
   a) Admit the patient to the Hunger Strike admission management area in TechCare;
   b) Measure and record height and weight;
   c) Measure and record vital signs;
   d) Refer for mental health evaluation by an advanced mental health provider;
   e) Examine general physical condition;
   f) Proceed with other necessary studies as clinically indicated per provider order; and
   g) Educate the patient on the possible immediate and long-term harms that may result from a continued hunger strike, using the Effects of Starvation form.

6) Vital signs are to be recorded by health care staff at least once every eight hours, or more often as clinically indicated, during the hunger strike. Weight is to be recorded daily at the same time each day, preferably in the morning. As opportunities occur, the patient should continue to be educated on the possible immediate and long-term harms that may result from a continued hunger strike.

7) A consult with an advanced clinical provider will be scheduled to determine any modification or augmentation of procedures, as well as whether the health care staff will be required to measure and record food and water intake and output.

8) All documentation, including examination results and recordings of weight and vital signs are to be maintained in TechCare.

9) All food and water intake and output is to be recorded by health care staff on Proactive’s Hunger Strike Monitoring form and scanned into TechCare.

10) After 72 hours or nine consecutive skipped meals, the patient should be screened with a CBC, CMP, and urine dip.

REFUSAL OF TREATMENT
1) Any health evaluation or treatment refused by a patient must be documented in TechCare.
2) Health care staff will attempt to secure the patient’s signature on the Release of Responsibility form.
3) Patients refusing treatment will be monitored and re-counseled regarding their current condition and the consequences of continued refusal.
4) Should the health care staff feel the hunger strike poses a risk to the patient’s life or permanent health, they are to be immediately referred to the advanced clinical provider.
5) Involuntary treatment shall be administered in accordance with established guidelines and applicable laws and only after the advanced clinical provider determines the patient’s life or health is at risk.
   a) In the event this is found to be necessary, strong consideration should be given to inpatient commitment/treatment at an appropriate medical or psychiatric hospital.
RELEASE FROM TREATMENT

1) Only an advanced clinical provider may order a patient be released from hunger strike evaluation and management. The order shall be documented in the patient’s health record.

2) After release, the health care staff shall provide appropriate medical and mental health follow-up care as ordered by the advanced clinical provider.

Related Forms

The Side Effects Of Starvation

Food Refusal

Hunger Strike Monitoring

Release of Responsibility

Release of Responsibility - Spanish

References


Section F: Special Needs and Services

J-F-01 Patients with Chronic Disease and Other Special Needs

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Patients with Chronic Disease and Other Special Needs (J-F-01)
NCCHC Opioid Standard: Treatment Plans (O-E-04)
NCCHC MH Standard: Treatment Plans (MH-G-03)
ACA Standard: Chronic Care (4-ALDF-4C-19)

Purpose
To ensure that patients with chronic disease, other significant health conditions, and disabilities, receive ongoing multidisciplinary care aligned with evidence-based standards.

Policy
All patients will be screened, identified, and monitored in chronic care in a manner consistent with national clinical guidelines established for the care and treatment of chronic illnesses. Patients with special needs will be identified, have an appropriate treatment plan developed and periodically reviewed.

Procedure

ESTABLISHING CHRONIC CARE CLINICS
1) The responsible physician approves, for facility use, clinical guidelines established by Proactive consistent with national clinical guidelines for the management of chronic diseases.
   a) Guidelines for care of many major disease processes can be found on NaphCare online under Jails: Care Guidelines;
   b) Any condition not specified online will also be treated consistent with national clinical guidelines and community standard.
2) Chronic care flags in TechCare will be associated with the following:
   a) Neurological diseases, including seizure disorder, migraines/chronic headache, stroke, CNS injury, and dementia;
   b) Respiratory diseases, including asthma and COPD/emphysema;
   c) Cardiovascular diseases, including CAD, hypertension, dyslipidemia, arrhythmia, CHF, and valvular disease;
   d) GI/Hepatic diseases, including cirrhosis, alcoholic liver disease, and inflammatory bowel disease;
   e) Endocrine diseases, including diabetes mellitus and thyroid disease;
f) Hematologic/Oncologic diseases, including anemia (to include sickle cell), bleeding or coagulation disorders, and cancer;
g) Chronic infectious diseases, including HIV/AIDS, hepatitis, and tuberculosis;
h) Miscellaneous chronic conditions, including kidney disease, transplants, and chronic pain; and,
i) Chronic mental illness, including but not limited to, mood disorders and psychotic disorders.

3) Documentation in the patient’s health record should confirm that all clinicians are following disease guidelines by:
   a) Determining the frequency of follow-up based on level of disease control;
   b) Monitoring the patient’s condition and status and initiating management and treatment plans to improve the outcome;
   c) Indicating the type and frequency of testing and therapeutic regimens;
   d) Providing the patient with appropriate instructions and education for diet, exercise, medications, etc.; and
   e) Justifying clinical decisions that are at significant variance from the guidelines.

4) The advanced clinical provider and RNs are responsible for recording all chronic illnesses onto the Master Problem List.

5) TechCare’s Chronic Care Module will be utilized as a tracking system to maintain lists of patients with chronic care needs.

IDENTIFYING CHRONIC ILLNESSES
1) Patients will be screened for the presence of chronic illnesses during the health care intake process.
2) Patients with known or reported chronic illness will have this documented on the Receiving Screening form by selecting the appropriate chronic care category which will set the chronic care flag and also schedule the initial chronic care visit.
3) Patients newly diagnosed with a chronic health condition will have the corresponding chronic care flag set at the time of the diagnosis.
4) An advanced clinical provider will be responsible for ordering any medically necessary medications and laboratory or diagnostic tests prior to the initial chronic care visit.
5) The initial chronic care visit and corresponding data for patients with stable disease will be completed within 45 days of arrival to the institution or time of diagnosis, unless clinical documentation by a provider justifies delaying or advancing the initial chronic care visit to a different date. Patients with newly diagnosed or unstable disease must be seen within a timeline determined by clinical judgment based on the patient’s disease and disease status.

INITIAL CHRONIC CARE VISIT
1) The designated health care staff is responsible for reviewing intake information at the time the patient is seen at the initial chronic care visit.
2) A qualified health care provider will develop treatment plans for all chronic care patients, including diagnostics, medications, other therapeutic measures and patient education, at the time of the first chronic care visit.
3) All patients with chronic diseases will be tracked using TechCare’s chronic care tracking features.
CHRONIC CARE NURSING RESPONSIBILITIES
1) Scheduling necessary clinical appointments that are not auto scheduled by TechCare chronic care module.
2) Obtaining appropriate information to update the patient’s record, including, at a minimum, complete vital signs and weight for use on the day of the clinic visit.
3) Monitoring medication adherence and counseling patients noted to be non-adherent, documentation of which will be entered into the progress notes.
4) Reinforcing and in some cases, initiating patient education related to specific processes, medications, health promotion, disease prevention strategies, and the keeping of follow-up appointments, with all areas discussed being documented in the progress notes.

ADVANCED CLINICAL PROVIDER RESPONSIBILITIES
1) Obtaining subjective and objective information via a thorough history and a disease process and a complaint focused physical exam.
2) Recording and/or updating the Master Problem List if applicable.
3) Monitoring changes in the patient’s condition.
4) Developing and updating the treatment plan based on the inmate’s disease control and status.
5) Writing orders as follows:
   a) Medications – the practitioner must ensure that the quantity of medication ordered is of a sufficient number to meet the patient’s needs until the next scheduled visit. Trial medication or medications to be titrated should be ordered in small quantities to minimize waste. Stable medications should be ordered in longer duration to minimize the need for re-ordering between chronic care provider visits.
   b) Laboratory and diagnostic tests – order all testing needed prior to the next scheduled visit with results to be available within 1 week prior to the next visit;
   c) Therapeutic diets and other special needs orders – if clinically indicated, specify the type and duration of diet, which should be in effect, as well as specifying any nutritional supplements, as medically indicated. Specifying other medically indicated special needs, such as low bunk or extra mattress;
   d) Follow-up visits – schedule the next clinic appointment in a time frame appropriate to the patient’s clinical status; and
   e) Other – any other orders or management plan to be carried out.
6) Monitoring medication adherence by reviewing the eMAR.
7) Providing and documenting patient education related to specific disease process, health promotion/maintenance, disease prevention, medication, etc. in the progress note or chronic care form.
8) Altering the management plan as clinically indicated in an effort to improve diseases control for those patients found to have a poor or worsening status.
9) Documenting review of all test results and follow-up procedures.
10) Overseeing the overall care for all applicable patients to ensure that the actions of nursing staff are accurate and all clinical information has been documented.
11) Following nationally recognized clinical guidelines in treatment of chronic illness. Resources and guidelines contained within TechCare and on NaphCare online should be used when appropriate. UpToDate is also available to providers to use as needed.

REFUSAL OF CHRONIC CARE TREATMENT
1) The nurse will use a progress note to document patient counseling addressing the potential health risks and dangers for all patients refusing chronic care monitoring.
2) If applicable, the patient will sign a Release of Responsibility with a provider.
3) The patient will continue to be scheduled for follow-up according to risks and disease severity, but at a minimum of every twelve months. All efforts will be taken by health care staff to encourage the patient to agree to be monitored and treated.

TRANSFER SCREENING PROCESS
1) Prior to patient transfer to another correctional facility, a licensed health care staff member will review the health record to determine if the patient has a chronic illness and, if so, will provide information on the dates last seen for those illnesses by sending a release summary to the receiving facility.
2) For newly patients from another correctional facility, the licensed health care staff involved in the intake process will review the health record and determine if the patient has a chronic illness and place any appropriate chronic care flags at the time.

TREATMENT OF SPECIAL NEEDS PATIENTS
1) Appropriate health care staff will develop individualized special needs treatment plans for every patient who is identified with a special needs, including, but not limited to:
   a) Chronic illnesses;
   b) Seriously communicable disease;
   c) Physical disability;
   d) Terminal illness;
   e) Developmental disability;
   f) Mental health disorder or suicidal;
   g) Serious substance use/abuse or MAT participation;
   h) Renal disease requiring dialysis;
   i) Difficulty with activities of daily living;
   j) Pregnancy;
   k) Frail or elderly patients;
   l) Adolescents incarcerated in an adult facility; and
   m) Suspected victims of physical or sexual abuse.
2) At a minimum, treatment plans should include:
   a) The frequency of follow-up for evaluation and adjustment of treatment modality;
   b) Type and frequency of diagnostic testing and therapeutic regimens;
   c) Discussion of short term goals and methods of achieving them for the next encounter;
   d) Individual and group counseling; and
   e) Instructions regarding diet, exercise, adaptation to the correctional facility; and medication when appropriate.
3) Special needs patients will be identified in TechCare by setting the appropriate flag. Later, if the special need is resolved or determined not to apply, the flag will be deleted. A list of special needs patients can be obtained at any time using the “Reports” section of TechCare or an Advanced Search by patient flag.

4) The timing for creation of a special needs treatment plan will be depending upon acuity. Initial treatment plans may be made around the time of intake, around the time of the Health Assessment, or around the time of the initial provider visit.

5) Special needs should be listed on the master problem list in the patient’s health record. The special needs treatment plan will be recorded in the progress notes or appropriate chronic care medical or mental health form.

6) Should the health status of a patient improve or deteriorate, health care staff will develop a revised special needs treatment plan.

7) Patients with terminal illnesses will be managed at the institution as long as the medical needs can be adequately addressed. When medical and/or nursing care demands exceed the capability of the institution, the patient will be transferred to another facility capable of providing the needed care.

8) Patients experiencing difficulty with mobility or activities of daily living (feeding, dressing, etc.) will be managed according to provider orders and medical need.

9) Health care staff will notify the institutional authority or designee for mitigation consideration if the medical condition of the patient should be accommodated when security staff plan a disciplinary action.

INMATES WITH MENTAL HEALTH SPECIAL NEEDS

1) Patients who have serious and persistent mental illness or are developmentally disabled will be referred to mental health.

2) Treatment plans for mental health conditions should address:
   a) Inmate’s problems and strengths;
   b) Involvement of the patient in the development of the plan;
   c) Relapse prevention risk management strategies (which include signs and symptoms associated with relapse or recurring difficulties);
   d) How the patient thinks a relapse can be prevented;
   e) How best to help the patient manage crisis; and
   f) Documentation of treatment goals and objectives, interventions necessary to achieve those goals, and notations of clinical progress.

3) A special needs treatment plan will be developed or revised for every patient expressing suicidal ideation. These should include a mental health staff member as well as the inmate in order to address relapse prevention and should include:
   a) A description of signs, symptoms, and the circumstances under which the risk for suicide is likely to occur;
   b) How reoccurrence of suicidal thoughts can be avoided; and
   c) Actions the patient and staff can take if the thoughts reoccur.

4) If the patient is placed on suicide watch, an individualized treatment plan should be developed which addresses the suicidal ideation expressed by the patient as well as the treatment intervention to discontinue suicide watch as soon as possible.

AIDS TO REDUCE EFFECTS OF IMPAIRMENT
1) Medical and dental orthoses, prostheses, and other aids to reduce the effects of impairment should be supplied in a timely manner when a patient’s health would otherwise be adversely affected, as determined by the treating provider based on medical necessity.

Related Forms

Authorization for Release of health Information

Authorization for Release of Health Information – Spanish

Offsite Referral

Release of Responsibility

Release of Responsibility - Spanish

References

Patients with Chronic Disease and Other Specialty (J-E-06). National Commission on Correctional Health Care: Standards for Health Services in Jails, 2018.


Section F: Special Needs and Services

J-F-02 Infirmary Level Care

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Infirmary Level Care (J-F-02)

ACA Standard: Infirmary Care (4-ALDF-4C-09)

Purpose

To establish appropriate care guidelines to meet the serious health needs of patients.

Policy

Infirmary level care and observation care may be provided at institutions for patients who have health conditions, which require observation or higher-level health care, but do not require admission to a licensed hospital or skilled nursing facility.

Procedure

INFIRMARY LEVEL AND OBSERVATION UNIT GENERAL PROCEDURES

1) The purpose of infirmary level care orders is to manage patients with specific types of illness or those who require skilled nursing care or assistance with activities of daily living (e.g., complex wound care, IV fluids and/or medications, and withdrawal management).

2) Conditions that may require a patient’s treatment to be conducted in an observation unit can include, but are not limited to, asthma controlled with nebulizer therapy, seizure disorder, influenza or gastroenteritis, or for validation of stated symptoms (i.e., monitoring a patient reporting heavy vomiting).
   a) In the event an observation unit is not located onsite, the patient may be directly transferred to the infirmary unit or hospital as medically indicated.

3) All patients ordered into infirmary level care or into an observation unit will be within sight or hearing of a staff member able to have a qualified health care professional respond in a timely manner.

4) Determining the number of sufficient qualified health care staff to deliver infirmary level care is based on the number of patients, severity of illness, and level of care required for each patient.

5) Nursing services will be provided under the daily supervision of a registered nurse. A registered nurse will evaluate compliance with current treatment plans on infirmary level care patients daily, at a minimum.

6) All nursing protocols and procedures will be consistent with state law and licensing requirements.
Patients admitted to infirmary level care will be on the order of an advanced clinical provider and will meet criteria for admission. Examples of admission criteria:

a) Patients with acute or chronic medical conditions requiring nursing care, but not requiring hospitalization; and
b) Patients with mental health disorders requiring increased observation, medication, or restraints, but not requiring hospitalization.

As clinically indicated, an advanced clinical provider will give an order for admission into infirmary level care. A nursing assessment will be completed upon admission and orders obtained as soon as possible. An advanced clinical provider will evaluate the patient the next day that he or she is on site.

An advanced clinical provider will evaluate each patient admitted to infirmary level care as indicated by the patient’s individualized treatment plan. An advanced clinical provider will be available to nursing staff by phone and/or TechCare alert at all times. All rounds and pertinent findings are to be documented in TechCare.

Documentation in TechCare should include:

a) The admitting order for all patients placed in infirmary level care or the reason for placement in the observation unit, including treatment and monitoring plan;
b) Admission in the Infirmary admission management area of TechCare; and
c) An assessment of the current status and plan for follow-up care upon discharge from infirmary level care or the observation unit.

Training will be provided to all nursing and health care staff to ensure they are proficient and have met certification standards, including nursing procedures, use of supplies, and the operation of durable medical equipment.

Patients for whom the severity of the medical condition exceeds the criteria for placement in an observation unit will be immediately referred to the advanced clinical provider for an evaluation.

Inmates will be provided with verbal orientation to infirmary level care or observation unit procedures upon admission, which will be documented in the health record.

Patients may not refuse placement in infirmary level care or an observation unit if the admitting provider deems it medically necessary to observe or house the inmate in a specific location. Patients can however, continue to refuse the offered treatments.

**MONITORING AND DOCUMENTATION OF INFIRMARY LEVEL CARE INMATES**

1) Nursing documentation will require an admission note which includes, at a minimum, a chief complaint, vital signs, relevant history, relevant observations, admission assessment, and nursing plan of care.

2) Vital signs are to be measured and documented at least once per shift or as ordered by the advanced clinical provider.

3) All medication is to be documented on the patient’s eMAR.

4) All lab results, EKGs, and x-ray reports should be kept in the patient’s chart. TechCare will automatically generate results in the patient’s health record where applicable.
5) A progress note will be documented in the health record reflecting the plan for any patient admitted to infirmary level care.

6) A note will be documented in the health record by the advanced clinical provider upon discharge from infirmary level care and will clearly reflect the patient’s discharge diagnosis and care plan.

7) At the time of discharge, nursing documentation will include a nursing discharge assessment, inmate education, and a follow-up plan.

Related Forms

No relevant forms for this policy.

References


Section F: Special Needs and Services

J-F-03 Mental Health Services – MH Programs and Residential Units

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Mental Health Services (J-F-03)
NCCHC Opioid Standard: Treatment Plans (O-E-04)
NCCHC MH Standard: Mental Health Programs and Residential Units (MH-G-02)
ACA Standard: Mental Health Programs (4-ALDF-4C-29)

Purpose
To ensure that patients receive appropriate mental health services. The goal of this standard is to help those patients with mental health problems to maintain their best level of functioning.

Policy
Where contracted to provide mental health services, Proactive will provide mental health services to all patients, as required.

Procedure
1) When provided onsite, without a residential unit, mental health programs are approved by the responsible mental health clinician and include:
   a) Defined goals;
   b) Mental health staff;
   c) Individual treatment plans; and
   d) Protocols for patient follow-up at least every 60 days and as clinically indicated.
2) When provided on-site, acute mental health residential units for patients with serious health needs when will include:
   a) Mental health staff assigned to the unit twenty-four hours per day.
   b) Orientation and training for correctional officers assigned to the unit;
   c) Daily evaluation for patients housed in the unit;
   d) Programs and therapies, as needed;
   e) Individual treatment plans; and
   f) Housing in a clean, safe and therapeutic environment conducive to stabilization, including facilities necessary for maintaining personal hygiene.
3) Non-acute mental health residential units, when provided onsite, will include:
   a) A defined scope of care;
   b) Programming or therapies as needed;
c) A sufficient number of mental health staff assigned to the unit;
d) Individual treatment plans;
e) Orientation and training for correctional officers assigned to the unit; and
f) Housing in a clean and safe environment, including facilities necessary for
   maintaining personal hygiene and guidance for ADL, if necessary.

Related Forms

No relevant forms for this policy.

References

Mental Health Services (J-F-03). National Commission on Correctional Health Care: Standards
   for Health Services in Jails, 2018.

Treatment Plans (O-E-04). National Commission on Correctional Health Care: Standards for
   Opioid Treatment Programs in Correctional Facilities, 2016.

Mental Health Programs and Residential Units (MH-G-02). National Commission on
   Correctional Health Care: Standards for Mental Health Services in Correctional Facilities.

Mental Health Program (4-ALDF-4C-29). American Correctional Association: Performance

Section F: Special Needs and Services

J-F-03 Mental Health Services - Behavioral Consultation

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Mental Health Services (J-F-03)

NCCHC Opioid Standard: Treatment Plans: (O-E-04)

NCCHC MH Standard: Behavioral Consultation (MH-G-06)

ACA Standard: Mental Health Referrals (4-ALDF-4C-31) Special Needs Inmates (4-ALDF-4C-40)

Purpose
To establish guidelines for the psychological support to patients when needed.

Policy
Mental Health staff will be available to provide consultative and support services to all patients admitted to the facility, and will provide necessary training to all correctional staff that interacts with patients to help them recognize mental illness.

Procedure
1) On request, mental health staff will consult with facility staff regarding mental health needs for patients.
2) Mental health related training for correctional officers will include:
   a) Recognition of signs and symptoms of mental illness and suicide risks;
   b) Signs and symptoms of substance abuse;
   c) Communication skills for managing patients with mental health and substance use disorders;
   d) Suicide prevention procedures;
   e) Recognition and management of patients with mental illness and substance use disorders; and
   f) Recognition and management of sexual assault victims.
3) Mental health staff shall provide behavioral consultation services when needed as follows:
   a) Assist patients in coping with the psychological effects of a chronic or communicable disease;
   b) Provide support to patients who are physically or developmentally disabled;
c) Assist patients in dealing with the consequences of disability during incarceration, and aid in developing appropriate social skills;

d) Offer counseling to victims of sexual assault;

e) Provide counseling and support to pregnant inmates to minimize postpartum depression and anxiety;

f) Where applicable, discussing and providing health services information to patients on educational, vocational, and residential treatment plans; and

g) Provide counseling and support to elderly or terminally ill patients.

4) Any consultation services provided to patients will be noted in a progress or appropriate mental health form in TechCare

Related Forms

No relevant forms for this policy.

References


Mental Health Referrals (4-ALDF-4C-31); Special Needs Inmates (4-ALDF-4C-40. American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section F: Special Needs and Services

J-F-03 Mental Health Services

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Mental Health Services (J-F-03)

NCCHC Opioid Standard: Treatment Plans (O-E-04)

NCCHC MH Standard: Basic Mental Health Services (MH-G-01)

ACA Standard: Mental Health Program (4-ALDF-4C-27-28)

Purpose

To ensure patients receive appropriate health care services which include mental health services. The goal of this standard is to help those patients with mental illness maintain their best level of functioning.

Policy

For all patients who require mental health services, Proactive will provide those services in an effort to identify, assess, and link patients with services specific to their needs.

Procedure

1) All patients will receive a Mental Health Screen within 14 days. Every effort will be made to implement Proactive’s proactive care model in the facility, which typically has the Mental Health Screen completed at booking with a receiving scree and physical assessment.

2) If deemed appropriate, referrals will be made to qualified mental health professionals for further mental health evaluation. Referral and/or admission to licensed mental health facilities will be ordered for patients whose needs exceed the treatment capabilities of the facility.

3) On-site treatment services may include, but are not limited to:
   a) Mental health screening and evaluation;
   b) On-site and off-site crisis intervention;
   c) Psychotropic medication management, as appropriate;
   d) Individual counseling;
   e) Group counseling and/or psychosocial/psychoeducational programs; and
   f) Treatment documentation and follow-up

4) When commitment or transfer to an inpatient psychiatric setting is clinically indicated:
   a) Required procedures are followed;
   b) The transfer occurs in a timely manner;
c) The patient is safely housed and adequately monitored until the transfer occurs.

5) Patients receiving basic mental health services are seen as clinically indicated. Those patients with chronic mental health needs are seen according to their individual treatment plan.

6) Detection, diagnosis and treatment of mental illnesses, including drug diversion and substance use/abuse services, are provided by a collaboration of mental health staff and psychiatric providers.

7) Mental health treatment goals include:
   a) Stabilization and/or resolution of mental illness;
   b) Prevention of mental health decompensation;
   c) Development of an understanding of the mental illness and factors contributing to the mental illness;
   d) Development of self-improvement; and
   e) Development of skills to cope with and overcome disabilities associated with various mental health disorders.

8) Coordination of care between mental health, medical, and substance abuse treatment will be sufficient for proper integration of patient management so that all needs are met.

9) Informed consent for mental health treatment must be obtained and documented for all patients.

Related Forms

No relevant forms for this policy.

References


Section F: Special Needs and Services

J-F-04 Medically Supervised Withdrawal and Treatment - Medication Assisted Treatment

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medically Supervised Withdrawal and Treatment (J-F-04)

NCCHC Opioid Standard: OTP Admission Process (O-E-01); Medically Supervised Withdrawal (O-E-05)

ACA Standard: Detoxification (4-ALDF-4C-36); Management of Chemical Dependency (4-ALDF-4C-37)

Purpose

To establish guidelines for Proactive’s participation in Medication assisted Treatment (MAT) programs.

Policy

Proactive will participate in Medication Assisted Treatment (MAT) to the extent that the following are met: (1) the treatment is beneficial to Proactive’s patients; (2) the treatment is within the scope of Proactive’s contractual terms and consistent with policies and procedures of the client jurisdiction; (3) the treatment is consistent with Proactive’s existing licensures and expertise; and (4) the treatment is consistent with local, state, and federal laws. Because of existing regulatory and licensure restrictions, Proactive in many cases may be unable to participate in some forms of Medication Assisted Treatment, at least until such time as the requisite licenses and regulatory approvals are secured. Meanwhile, Proactive adopts this policy to guide participation in Medication Assisted Treatment programs in our contracted facilities. Proactive recognizes that there are both opioid based and non-opioid based Medication Assisted Treatment programs. For purposes of this policy and procedure, opioid based MAT is defined as patients who are taking one of the following agents: oral methadone or oral buprenorphine based medications (Subutex, Suboxone). At this time, Proactive is not providing longer-acting formulations of these medications. Non-opioid based MAT is defined as patients who are provided naltrexone in either oral or injectable form (Vivitrol).

Procedure for MAT Continuation

1) Patients will be screened per Proactive protocols regarding substance use, both prescription and illicit, as outlined in J-E-02 Receiving Screening; J-E-04 Initial Health Assessment, and J-E-05 Menatl Health Screening and Evaluation.

2) Patients who are already participating in MAT programs within the community will be requested to sign a Release of Information so that more information about their
medication regimen can be obtained from the community provider or previous detention facility. This information should include at a minimum:

a) Name of facility and treating physician;

b) Name and dose of medication obtained there;

c) Date of last administration;

d) Date of last evaluation or visit; and

e) Ability for a community OTP to provide the patient their medication while in the correctional facility.

3) Patients may also request evaluation and treatment for substance use disorder and/or substance use withdrawal directly via contact with health staff, facility staff referral, or submission of health needs request.

4) For those patients receiving MAT in the community, Proactive will need to be provided with documentation showing the patient has been educated about the proposed MAT program and the risks and benefits of the medication regimen.

5) All patients requesting continuation of MAT while in custody will consent to and submit a Urine Drug Screen.

6) If a patient reports Medication Assisted Treatment but has a urine drug screen showing use of other illicit drugs, MAT may be discontinued at the medical provider’s discretion. Note, however, that the provider may elect to continue MAT therapy in such instance, if the provider believes that continuation of MAT therapy is in the best interest of the patient. If there is to be an interrupt in treatment, the patient will be instructed to follow-up with their community provider for reinstitution of care after release from jail. Protocols for medically supervised withdrawal may be instituted for the patient as clinically indicated.

7) After confirmation of community compliance with MAT, and clearance for any contraindication to its continuation, prescription orders will be written by a provider licensed to prescribe MAT.

a) Naltrexone

i) If the patient enters the facility on naltrexone, this medication may be continued in the oral or injectable form during the patient’s incarceration depending on availability of specific formulation at the facility. Upon discharge, patients taking oral formulations of naltrexone may be transitioned back to the injectable form (Vivitrol) where available.

ii) Prior to administration, the patient will be scheduled for a naltrexone challenge – 25 mg by mouth – and observed for 90 minutes to ensure no allergic reaction or precipitation of withdrawal.

iii) If the patient is to receive the extended release injectable version of Naltrexone while in custody, the community entity involved as noted above will need to obtain this medication in their provider’s name and have it brought to the jail for administration to the patient.
iv) Proactive will need notification at least 72 hours in advance of the patient’s release in order to have time to obtain the injection from the community entity or order via pharmaceutical company sample product programs, where available, and set up an administration time.

v) The community entity will need to communicate with Proactive the date of the patient’s first appointment for community MAT care to be continued.

vi) Upon receipt of the injectable medication, the patient will be scheduled for administration of the extended-release Naltrexone preferable no more than 24-48 hours before release.

vii) The patient will be injected with the medication using the proper medical procedure for extended release Naltrexone and monitored for 10 minutes post-injection.

b) Buprenorphine

i) If a patient enters the facility on an oral buprenorphine based medication, it can be continued once verified by their pharmacy, and no contraindications are determined to be present by Proactive medical staff. If buprenorphine based medications are not available as MAT medication in a given facility for any reason, the patient will be evaluated for other MAT options and/or medically supervised withdrawal as clinically indicated.

ii) Orders may be obtained from DEAX licensed Proactive staff and/or contracted employees.

iii) Buprenorphine administration will follow facility procedures as outlined in J-F-04 Medically Supervised Withdrawal and Treatment and J-F-04 Medically Supervised Withdrawal and Treatment-Pregnancy Management.

c) Methadone

i) Patients entering the facility on methadone will be evaluated by Proactive medical staff and a determination made based on clinical factors to decide if they remain on methadone during their stay with courtesy dosing from the outside community OTP prescriber, or are converted to oral buprenorphine during the stay. They will be given the option of returning to methadone after release. If no opioid-based MAT medications are available in a given facility for any reason, the patient will be evaluated for other MAT options and/or medically supervised withdrawal as clinically indicated.

ii) For patients who are maintained on oral methadone, attempts will be made to acquire the medication from a community methadone clinic.
8) Proactive will assist patients in our contracted facilities in need of initiation or continuation of MAT medication under the conditions set forth below:
   a) The patient will need to have an evaluation performed by qualified health staff, either in-house or from the community, to determine if the patient qualifies for treatment.
   b) If the patient is deemed to be an appropriate new candidate for MAT, then there must be a community entity willing to accept this patient upon release that has the ability to provide all of the requisite follow-up care plan called for by the selected MAT therapy.
   c) The patient must sign releases of information to allow 2-way communication between the community entity and Proactive.
   d) The patient will be given information that outlines policies and procedures, patient rights and responsibilities, and risk and benefits of MAT options available.
   e) The provider and patient will form an individualized treatment plan for MAT considering all medications available to the patient at the facility.
   f) Procedures for initiation of the chosen medication will follow the procedure as outlined above for MAT continuation.

9) If a patient on opioid based MAT therapy attempts to divert medications, the patient will be immediately disqualified from further opioid based MAT. Protocols for medically supervised withdrawal may be instituted for the patient as clinically indicated.

10) If opioid based MAT medications are discontinued for any reason, the patient may be offered non-opioid based MAT therapy as clinically indicated, along with consideration for medically supervised withdrawal.

11) Any patient not clinically appropriate for placement on MAT will be referred for other appropriate treatment alternatives as clinically indicated.

12) Pregnant patients will be maintained on opioid based MAT medications throughout the duration of their pregnancy consistent with Proactive’s policy on Medically Supervised Withdrawal and Treatment-Pregnancy Management.

Related Forms

Proactive Naltrexone Education

Proactive Oral Naltrexone Consent Form

Proactive Long Acting Naltrexone Consent Form

References

Detoxification (4-ALDF-4C-36); Management of Chemical Dependency (4-ALDF-4C-37). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section F: Special Needs and Services

J-F-04 Medically Supervised Withdrawal and Treatment – Pregnancy Management

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medically Supervised Withdrawal and Treatment (J-F-04)

NCCHC Opioid Standard: Counseling and Care of the Pregnant Inmate (O-G-02)

ACA Standard: Detoxification (4-ALDF-4C-36); Management of Chemical Dependency (4-ALDF-4C-37)

Purpose

To establish guidelines for the observation and treatment of pregnant patients manifesting symptoms of intoxication or withdrawal from alcohol and/or drugs.

Policy

All patients entering the institution will be screened for any history of manifesting symptoms of intoxication or withdrawal from alcohol or other drugs. Patients who may be intoxicated or experiencing withdrawal symptoms will be identified and managed in accordance with their medical needs. Pregnant patients with opioid history will be maintained on appropriate SAMHSA approved medications.

Procedure

PREGNANT INMATES WITH OPIATE DEPENDENCY

1) At intake, usual procedures will be followed to identify pregnant patients and obtain a history of drug use:
   a) Pregnancy test and urine drug screen; and
   b) Completion of receiving screen, comprehensive detox screen, and physical assessment.

2) If the patient claims to be enrolled in an Opioid Treatment Program (OTP), verification from the OTP will be immediately attempted. If verified, information will be obtained verbally and documented in the medical record, with proper records requested. Such information should include at a minimum:
   a) Name of treating physician or clinic;
   b) Daily dose of methadone, and when last received at the clinic;
   c) Date of last obstetrical evaluation, if known; and
   d) If and when the OTP may provide continuing methadone for the patient at the detention facility.
3) If the patient claims to be on a prescribed opioid medication, verification from the pharmacy and/or prescriber will be immediately attempted. Such information should include at a minimum:
   a) Name of treating physician or facility;
   b) Name and dosage of medication;
   c) Date of most recent refill; and
   d) Date and time of most recent dose taken.
4) If the patient claims to be on illicit opioid drugs, further history should be taken, including at a minimum:
   a) Names of drugs;
   b) Usual amount taken;
   c) Length of time taken; and
   d) Date and time of most recent use.
5) If a provider is present at the facility, the nurse should contact the provider to evaluate the patient and provide further recommendations.
6) If a provider is not present at the facility, the nurse should take the following steps:
   a) Initiate COWS monitoring assessment protocol and determine the patient’s current COWS score, but do not administer any medications recommended at this time. Place the patient in the detox dashboard.
   b) Check fetal heart tones and record results in TechCare. If no fetal heart tones are detected, or there is concern for fetal well-being, the patient should be sent to the local ER for further assessment.
   c) Contact the on-call or StatCare provider to alert them that the patient has been admitted and to obtain further treatment recommendations.
   d) If a patient is confirmed to be receiving methadone in the community and is stable on this medication, the patient should be maintained on methadone for the duration of her pregnancy if possible. If it is expected to be > 24 hours before the patient can be evaluated by the community methadone prescriber or if the patient begins to experience significant withdrawal symptoms before the methadone can be dosed, the provider may choose to bridge her with buprenorphine (see Buprenorphine Bridging below) or send the patient to the hospital for further evaluation.
   e) If a patient is confirmed to be receiving methadone in the community but cannot be continued on this treatment in the jail, please contact a corporate provider for assistance with creating an alternative treatment plan.
   f) If a patient is not receiving community methadone maintenance therapy, she should be considered a candidate for buprenorphine maintenance and treatment can be managed by on-site providers (see below section Buprenorphine Treatment in Pregnant Patients).
g) Patients should remain on COWS assessments until they are felt to be on a stable dose of either buprenorphine or methadone. They should not receive the prompted clonidine or other comfort medications, however, as these medications are or may be contraindicated in pregnancy. COWS is only being used as an assessment tool for symptom management and control in this situation.

h) If at all possible, the patient should be placed in some form of housing that allows the health care staff to have frequent access to them for COWS monitoring.

i) A patient appointment should be made with the obstetrician in accordance with a high risk pregnancy.

j) If a patient is felt to need opioid maintenance therapy with either buprenorphine or methadone the TechCare flag “Pregnancy – Opiate Maintenance” should be set in the patient’s chart for tracking purposes.

METHADONE TREATMENT IN PREGNANT PATIENTS

1) As stated above, if a patient is confirmed to be receiving methadone in the community and is stable on this medication, the patient should be maintained on methadone for the duration of her pregnancy if possible.

2) If a community-based OTP will provide the ongoing methadone therapy, in their clinic or within the facility, on the next regular working day (i.e., Sunday – Thursday), the nurse should communicate with the provider and the Health Services Administrator to expedite these arrangements. If the patient will be seen off-site, then a UM off-site order should be entered on an Urgent basis to schedule the off-site visit.

3) If a community-based OTP will not be providing the ongoing methadone therapy at the facility on the next regular working day (i.e., Friday and Saturday) the nurse should communicate with the on-site provider about the intake of a pregnant patient on opioids so that an alternative treatment plan can be created.

   a) The provider will then be responsible for ensuring that the pregnant patient receives appropriate treatment to prevent opioid withdrawal. If an X-licensed (DATA 2000 Waiver) provider is available, then buprenorphine can be prescribed (see Buprenorphine Bridging below). If no X-licensed provider is available, the provider may either contact the StatCare team by phone at 888-735-4913 to assist with management or write a methadone prescription for an emergency 3-day supply of treatment with the prescription specifying that it is for fetal viability. This should be done in a timely fashion (i.e., within 24 hours) so that it may be filled through the back-up pharmacy. For patients who have been on a known and verified dose of Methadone in the community, this dose should be verified.

4) If the patient is sent off-site for methadone prescribing/dosing, the referral request form should request an evaluation of the stability of the pregnancy and an assessment of the possible need for methadone therapy to prevent opioid withdrawal for the protection of
the fetus. The referral request form should specify that if methadone maintenance therapy is being recommended, the consultant determine the daily dose and provide this dose to the patient at that appointment.

5) If the off-site provider does not recommend methadone therapy, then any other recommendations should be handled in the usual manner and discussed with the on-site provider.

6) If the patient has been enrolled in a community-based OTP, but the OTP will not be providing the ongoing methadone therapy at the facility, communication with the OTP must still be documented. The OTP should be notified both when the patient is admitted into the facility and when released from the facility, so that the OTP may suspend its prescribing of methadone for that period and keep the patient enrolled for reentry upon release.

7) Opioid positive pregnant females should never undergo medically supervised withdrawal during pregnancy. They should continue buprenorphine or methadone at least until delivery.

BUPRENORPHINE TREATMENT IN PREGNANT PATIENTS
NOTE: To prescribe or dispense buprenorphine in a setting other than a traditional Opioid Treatment Program, a physician must possess a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver and may not treat more than 30 patients with buprenorphine products at any one time during the first year following waiver receipt. Mid-level providers may also prescribe buprenorphine with proper training and licensing. Please refer to state specific guidelines for details on prescribing regulations.

If there is a site provider with an active DEA DATA 2000 waiver, the following procedure may be used:

1) The advanced clinical provider will complete additional history, physical, and diagnostic workup for comorbidities that may affect the use of buprenorphine, including liver disease, renal disease, and the use of any sedating medications.

2) Provider will document details of opioid use, including type of drug used, and frequency and timing of most recent dose.

3) Consultation with and referral to medical and psychiatric provider specialists will be undertaken as necessary.

4) Documented verbal or written informed consent will be obtained from the patient for buprenorphine treatment. This consent will be scanned into TechCare.

BUPRENORPHINE INDUCTION AND ONGOING TREATMENT

1) The patient will be placed on Clinical Opioid Withdrawal Scale (COWS) monitoring prior to buprenorphine induction.
2) The goal of the induction phase is to determine the dose of buprenorphine at which the patient has minimal opioid withdrawal symptoms and minimal or no side effects.

3) The first dose of buprenorphine should be administered when the patient is exhibiting withdrawal as assessed by the advanced clinical provider or COWS scale (score ≥ 9), in order to prevent precipitated withdrawal.
   a) Expected times from the last opioid dose to the first dose of buprenorphine are:
      i) Short-acting opioids such as heroin and oxycodone: 10 – 12 hours;
      ii) Sustained release opioids such as Oxycodone SR and fentanyl patch: 12 – 24 hours.
   b) The patient’s last reported heroin use should have been at least 12 hours prior to first buprenorphine dose. The last reported methadone use should have been at least 24 hours prior to first buprenorphine dose.
   c) At no time should the first dose of buprenorphine be delayed more than 24 hours, regardless of score without a provider assessment and approval.

4) The target dose of buprenorphine is typically between 8 and 16mg per day. This may be dosed once to twice daily depending on patient dose and facility/patient preference.

5) The maximum dose typically required is 16 mg per day.

6) On the first day of buprenorphine administration:
   a) The preferred initial dose of buprenorphine is 2-4 mg.
   b) The patient may be reassessed with COWS or provider assessment two hours later, and given another dose if COWS score remains elevated or if signs and symptoms of withdrawal are still present. Doses typically increase by 2 mg until symptoms abate.
   c) This cycle may be repeated until withdrawal signs and symptoms abate.

7) On the second day of buprenorphine administration:
   a) The total dose from the first day will be administered, plus additional dosing per provider order if withdrawal is not adequately managed.
   b) Reassessment will take place at least twice daily for any ongoing signs or symptoms of withdrawal until patient is removed from COWS assessments and the detox dashboard.

8) On subsequent days of buprenorphine administration the daily dose will be given based on the total dose administered on the final day of induction (again typically 6 -16 mg/day total dose).

9) Patients should be removed from COWS assessments once they are on a stable dose of buprenorphine with COWS scores < 2 consecutively for at least 36 hours after the last buprenorphine dose adjustment made. These patients may be released to general population if needed.

BUPRENORPHINE MAINTENANCE AND RECOMMENDATIONS
1) Patients being managed by on-site provider for their opioid maintenance should be evaluated at least monthly by the prescribing provider:
   a) At this monthly visit the provider should address:
      i) Cravings;
      ii) Tolerance signs/symptoms;
      iii) Side effects of treatments;
      iv) Any other factors that may interfere with successful continuation of buprenorphine for the duration of the pregnancy; and
      v) Recovery management.

2) During the third trimester of pregnancy, the plasma half-life of buprenorphine decreases and clearance increases with the increased blood volume. Dose adjustments may need to be made to avoid withdrawal symptoms.

3) LFTs should be checked at the beginning of therapy and monthly while on maintenance. Hepatitis B and C should also be checked at the initiation of treatment. As these are routinely checked by OB providers this does not need to be repeated if results can be verified.

4) These patients should be considered as high-risk obstetrical cases and, hence, should be followed by high risk OB. Good communication with this provider is essential to a successful pregnancy outcome.

BUPRENORPHINE BRIDGING
1) The patient will be placed on Clinical Opioid Withdrawal Scale (COWS) monitoring prior to buprenorphine induction.
2) A signed buprenorphine consent must be obtained and scanned into the patient’s TechCare chart.
3) The first dose of buprenorphine should be administered when the patient is exhibiting withdrawal as assessed by the advanced clinical provider or COWS scale (score ≥12). If given prior to a score of 12 this medication can precipitate severe opioid withdrawal.
   a) Only the first dose requires a score of 12, subsequent dosing should only be based on the score if the dose is being titrated by the provider.
4) The preferred initial dose of buprenorphine is 2 – 4 mg.
5) The patient may be reassessed with COWS or provider assessment two hours later, and given another dose if COWS score remains elevated or if signs/symptoms of withdrawal are still present.
6) This cycle may be repeated until withdrawal signs and symptoms abate.

OFF-SITE BUPRENORPHINE MANAGEMENT
1) In the event that there are no X-waivered providers available to prescribe and maintain buprenorphine at the site, these patients may be treated by community-based OTP in a
similar manner to those receiving methadone treatments (see the Methadone Treatment in Pregnant Patients section above).

a) The main difference between these sets of patients is that the buprenorphine patients should return from the off-site visit with a signed prescription for buprenorphine. Upon receipt of the signed prescription, the nurse should immediately contact the local back-up pharmacy to dispense a patient-specific supply to the facility.

METHADONE VERSUS BUPRENORPHINE TREATMENT
1) If the patient has been actively participating in a local methadone program, treatment with methadone will be continued.
2) If the patient has not been participating in a methadone program, on-site buprenorphine management is preferred. The provider may choose to enroll the patient in a methadone program if buprenorphine treatment cannot be safely initiated (e.g., if a buprenorphine-prescribing physician is not available).

POSTPARTUM PERIOD
1) If the patient receiving maintenance treatment gives birth while still incarcerated, medically supervised withdrawal may be carried out as ordered by the advanced clinical provider as clinically indicated.
   a) No set dosage reduction schedule will be established for all women following birth, as patients on higher doses of buprenorphine may need a longer period to withdraw than those patients on lower doses.
   b) The dose reduction should not exceed 10% of the previous days’ dose for methadone.
2) Patients expected to remain incarcerated <30 days after delivery or who otherwise are not felt to be safe to undergo medically supervised withdrawal from opioids may be continued on maintenance therapy per the on-site providers discretion.

EDUCATION AND LOGISTICS
1) The Health Services Administrator is responsible for:
   a) Ensuring that staff involved in the administration of buprenorphine and care of patients receiving buprenorphine are educated on:
      i) Drug risks;
      ii) Adverse events;
      iii) Signs/symptoms of withdrawal; and
      iv) Medication administration (sublingual tabs, monitored dosing, etc.).
   b) Ensuring proper buprenorphine security and storage.
2) If buprenorphine treatment is necessary but the facility’s waived physician is unavailable or unreachable, the corporate Chief Medical Officer may be contacted to discuss treatment options until the on-site physician is available to assess the patient.

3) Community follow-up for continuation of opioid maintenance therapy should be made prior to patient release from the facility. The patient must receive written instructions on the date, time and location of the appointment.

4) Patients should be provided with a prescription for buprenorphine at time of release that is in a quantity sufficient to last until they are seen by their community provider.

Forms

Buprenorphine Consent for Pregnancy

References


Detoxification (4-ALDF-4C-36); Management of Chemical Dependency (4-ALDF-4C-37). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section F: Special Needs and Services

J-F-04 Medically Supervised Withdrawal and Treatment

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medically Supervised Withdrawal and Treatment (J-F-04)

NCCHC Opioid Standard: Medically Supervised Withdrawal (O-E-05)

NCCHC MH Standard: Patients with Alcohol and Other Drug Problems (MH-G-05)

ACA Standard: Detoxification (4-ALDF-4C-36); Management of Chemical Dependency (4-ALDF-4C-37)

Purpose
To establish guidelines for the observation and treatment of patients manifesting symptoms of intoxication or withdrawal from alcohol and/or drugs.

Policy
All patients entering the institution will be screened for any history of manifesting symptoms of intoxication or withdrawal from alcohol or other drugs. Patients who may be intoxicated or experiencing withdrawal symptoms will be identified and managed in accordance with their medical needs.

Procedure
1) Upon entry to the correctional institution, the patient’s medical history of alcohol and drug use will be obtained as an integral part of the intake/booking procedure to identify and manage any intoxication or withdrawal symptoms, along with obtaining a urine drug screen as clinically indicated.
2) Proactive’s protocols are consistent with nationally accepted guidelines and will be utilized as written. Any alteration to the assessments must be preapproved by a corporate Chief Medical Officer.
3) Protocols for intoxication and medically supervised withdrawal are established by Proactive and approved by the responsible physician.
4) Medically supervised withdrawal will be done under the supervision of an advanced clinical provider in accordance with local, state, and federal laws and Proactive’s approved protocols.
5) Proactive will encourage that patients be housed in an area that is safe and effective for monitoring of possible withdrawal symptoms.
6) An patient exhibiting severe, life-threatening symptoms will be transferred to a contracted, licensed, outside medical facility for stabilization.
7) Individuals at risk for progression to more severe levels of withdrawal are kept under close observation by health care staff and if severe withdrawal symptoms are observed, the advanced clinical provider is consulted promptly.

8) If a pregnant patient is admitted with a history of any alcohol or drug use, an immediate referral will be made to the advanced clinical provider so that the dependence can be assessed and treated appropriately. See J-F-04 Medically Supervised Withdrawal and Treatment – Pregnancy Management.

9) A patient who appears to be intoxicated or experiencing symptoms of drug or alcohol withdrawal will be referred to the health care staff for evaluation of symptoms, including, but not limited to:
   a) Drowsiness;
   b) Agitation/Anxiety;
   c) Nausea/Vomiting/Diarrhea;
   d) Odor of alcohol;
   e) Slurred speech;
   f) Disorientation to person, place, or timeline;
   g) Lack of coordination;
   h) Change in pupil size; or
   i) Psychosis.

10) The Health Services Administrator will ensure training in the recognition of signs and symptoms for chemical dependency and withdrawal for health care staff during the orientation process and annually.

11) The advanced clinical provider may keep a patient who is exhibiting mild to moderate symptoms of withdrawal or acute intoxication under observation as deemed necessary.

12) All initial and ongoing assessments will be documented in TechCare and may include the use of standardized instruments such as the Clinical Institute Withdrawal Assessment of Alcohol (CIWA), the Clinical Opiate Withdrawal Scale (COWS), and others as clinically indicated and approved by the corporate Chief Medical Officer.

13) The patient’s individual care plan will include referral to mental health and chemical dependency programs within the institution when appropriate if available.

14) Appropriate institutional staff will be notified when a patient requires specialized placement and observation.

15) Disorders associated with alcohol and other drugs are recognized and treated as medically indicated.
ALCOHOL WITHDRAWAL

1) Patients with a history of significant and/or frequent alcohol on the Receiving Screening will have a Comprehensive Detox Screen completed during the booking process and, if indicated will be placed on CIWA-A assessments for monitoring

2) Unless there are allergies or contraindications, patients are placed on:
   a) Comfort medications to aid with symptom management. Comfort medications for alcohol withdrawal include Zofran, Maalox, Imodium, and Bentyl.
   b) Folic acid, thiamine and a multivitamin daily x 7 days.
   c) Keppra 500 mg BID x 7 days for seizure prophylaxis.
   d) These medication protocols can be found in the guidelines section of TechCare and are started under the order of an advanced clinical provider.

3) CIWA-A scores of ≥8 will prompt staff to contact an advanced clinical provider for initiation of Librium. Doses of Librium are scored as follows:
   a) CIWA-A score of 8-15: Librium 50 mg now.
   b) CIWA-A score 16-25: Librium 100 mg now.
   c) CIWA-A score >25: Contact provider for additional orders. Patient is experiencing severe withdrawal.

4) Adjunct dosing is a “loading dose” of 50 mg of Librium given during the first 24 hours of alcohol withdrawal in some patients. Adjunct Librium dosing may be prompted if:
   a) On the Comprehensive detox screen it is documented that the patient:
      i) Has been through alcohol withdrawal or treatment for alcohol use;
      ii) Has ever had withdrawal related seizures or hallucinations;
iii) Has comorbid health conditions (liver disease, heart/lung disease, diabetes) that make the patient higher risk for withdrawal related complications.
   b) The initial CIWA score is >20.
5) CIWA-A monitoring is continued for a minimum of 72 hours and can be discontinued once CIWA-A scores are < 7 on 3 consecutive assessments.

BENZODIAZEPINE WITHDRAWAL
1) Patients with a history of significant and/or frequent benzodiazepine use on the Receiving Screening will have a Comprehensive Detox Screen completed during the booking process and, if indicated, will be placed on CIWA-B assessments for monitoring.
2) Patients with a positive urine drug screen for benzodiazepines may also be placed on CIWA-B assessments.
3) Unless there are allergies or contraindications, patients are placed on:
   a) Comfort medications to aid with symptom management. Comfort medications for benzodiazepine withdrawal include Zofran, Maalox, Imodium, Ibuprofen, and Bentyl.
   b) Folic acid, thiamine and a multivitamin daily x 7 days.
   c) Keppra 500 mg BID x 7 days for seizure prophylaxis.
   d) These medication protocols can be found in the guidelines section of TechCare and are started under the order of an advanced clinical provider.
4) CIWA-B scores > 9 are the indication for initiation of a 6 day Librium taper. The taper is as follows:
   a) Day 1: 50 mg three times a day;
   b) Day 2: 25 mg morning and afternoon and 50 mg at night;
   c) Day 3: 25 mg three times a day;
   d) Day 4: 25 mg twice a day;
   e) Days 5 and 6: 25 mg once a day.
5) Patients may also be placed on Librium tapers prior to a CIWA-B score of 9 at the discretion of an advanced clinical provider.
6) CIWA-B monitoring is continued for a minimum of 72 hours and can be discontinued once CIWA-B scores are < 7 on three consecutive assessments.

OPIOID WITHDRAWAL
1) Patients with a history of significant and/or frequent opioid use on the Receiving Screening will have a Comprehensive Detox Screen completed during the booking process and, if indicated, will be placed on COWS assessments for monitoring.
2) Patients with a positive urine drug screen for opioids may also be placed on COWS assessments.
3) Unless there are allergies or contraindications, patients are placed on comfort medications to aid with symptom management. Comfort medications for opioid withdrawal include Zofran, Maalox, Imodium, Ibuprofen, and Bentyl.

4) There are currently two different protocols for opioid withdrawal management:
   a) Clonidine based protocol: COWS scores of 7 – 24 prompt dosing with Clonidine 0.1 mg. Scores > 24 prompt the staff to contact an advance clinical provider for additional orders.
   b) Buprenorphine based protocol: COWS scores of ≥ 9 are the indication for initiation of a 5 day buprenorphine taper. The taper is as follows:
      i) Days 1 and 2: 4 mg twice a day
      ii) Day 3: 4 mg in the morning and 2 mg in the evening
      iii) Day 4: 2 mg twice a day
      iv) Day 5: 2 mg in the morning.

5) COWS monitoring is continued for a minimum of 72 hours and can be discontinued once COWS scores are < 7 on 3 consecutive assessments.

OVERDOSE AND POISONING
1) Health Care staff responding to a patient with possible overdose or poisoning will:
   a) Check vital signs;
   b) Observe skin color; lesions, rashes, and presence of diaphoresis;
   c) Assess for breath odor;
   d) Evaluate neurologic function, including mental status, pupil size and reaction to light, nystagmus, and gag reflex;
   e) Gather the following information, when appropriate:
      i) Material Safety Data Sheet for the chemical or ingredient if the toxic substance is known;
      ii) Route of administration; and
      iii) Known medical problems and allergies.

2) Staff will manage a case of probable overdose or poisoning with the following steps, as appropriate to the situation:
   a) Call the poison control hotline for guidance if substance and/or appropriate management is unknown;
   b) Deliver supplemental oxygen;
   c) Establish an IV and infusing normal saline or lactated ringers solution as medically indicated;
   d) Contact Emergency Medical Services for transport to a local emergency department;
   e) If neurologic depression, obtain finger stick blood glucose level and give Glucagon, juice, etc. to raise blood glucose if needed;
f) If patient is apneic and/or has signs, symptoms, or a history suggestive of opioid intoxication, administer naloxone;
   i) Emergency administration of naloxone requires subsequent provider order;
   ii) The goal of naloxone administration is not a normal level of consciousness, but adequate ventilation;
   iii) Patients administered Naloxone with positive response should be sent to the emergency department for further follow up given the naloxone duration of effect is dependent on the opioid ingested by the patient.

3) If a provider is not present during patient evaluation and initial management, nursing staff will complete the Overdose/Poisoning Nursing Protocol in TechCare,
   a) If a prescription is given via this protocol due to an emergent life-threatening situation, the medication will be ordered in TechCare with the site Medical Director as the prescribing physician.

Forms

Proactive Naltrexone Education

Proactive Oral Naltrexone Consent Form

Proactive Long Acting Naltrexone Consent Form

References


Detoxification (4-ALDF-4C-36); Management of Chemical Dependency (4-ALDF-4C-37). American Correctional Association: Performance Based Standards for Adult Local Detention Facilities, Fourth Addition, 2004.

Section F: Special Needs and Services

J-F-05 Counseling and Care of the Pregnant Inmate

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Counseling and Care of the Pregnant Inmate (J-F-05)
NCCHC Opioid Standard: Counseling and Care of the Pregnant Inmate (O-G-02)
NCCHC MH Standard: Counseling and Care of the Pregnant Inmate (MH-G-07)
ACA Standard: Pregnancy Management (4-ALDF-4C-13)

Purpose

To ensure that pregnant patients receive appropriate prenatal care, obstetrical services for labor and delivery, and postpartum care.

Policy

Proactive will provide health care to address the unique needs of female patients with regard to family planning, pregnancy, prenatal care, and postpartum care while incarcerated. Proactive assumes no financial responsibility for newborn care and/or treatment.

Procedure

1) All pregnant patients will be provided with timely and appropriate prenatal obstetrical care consistent with the community standards of care, including, but not limited to:
   a) Medical examinations by a provider qualified to provide prenatal care;
   b) Prenatal laboratory and diagnostic tests in accordance with national guidelines;
   c) Orders and treatment plans documenting clinically indicated levels of activity, nutrition, medications, housing, and safety precautions; and
   d) Counseling and administering recommended vaccines in accordance with national guidelines.

2) A list with phone numbers will be maintained for all obstetrical services and community hospitals on an Emergency Contact Numbers document for referral.

3) Documentation of the patient’s prenatal history noted on the off-site health care referral will accompany the pregnant patient to the hospital.

4) Documentation of appropriate postpartum care will be maintained by the advanced clinical provider in the patient’s health record.

5) During the course of the pregnancy the flag for Pregnancy will be set and added to the problem list. Pregnancy shall be considered a special need.
6) All females of childbearing age (15-54) will receive a pregnancy test at the time of booking.

7) Pregnant patients with active opioid use disorder receive evaluation upon intake, including offering and providing medication-assisted treatment (MAT) with methadone and buprenorphine. See Proactive policy J-F-04 Medically Supervised Withdrawal and Treatment-Pregnancy Management.

8) Pregnant patients with active opioid use disorder receive evaluation upon intake, including offering and providing medication-assisted treatment (MAT) with methadone and buprenorphine. See Proactive policy J-F-04 Medically Supervised Withdrawal and Treatment-Pregnancy Management.

9) Patients on MAT will be given information regarding neonatal abstinence syndrome and its management.

10) Emergency delivery kits are available in the facility.

11) The advanced clinical provider will evaluate the pregnant patient within seven days of notification of a positive pregnancy test.

12) Pregnant women are given comprehensive counseling and assistance from either the medical/mental health staff or a community agency in accordance with their expressed desires regarding their pregnancy and whether they elect to keep the child, use adoption services, or have an abortion.

13) Pregnant women with serious mental illness require specialized psychosocial and psychopharmacological monitoring by the mental health staff.

14) Pregnant women with serious mental illness require specialized psychosocial and psychopharmacological monitoring by the mental health staff.

15) Mental health staff should consult with medical staff regarding any psychotropic medication use due to possible deleterious effects on a developing fetus.

16) Restraints will not be used on patients during active labor and delivery.

17) Restraints will not be used on patients during active labor and delivery.

18) Proactive will encourage that custody restraints, if used at other points of the pregnancy and the postpartum period, be limited to handcuffs in front of the body.

19) When obstetrical care is provided by an outside contractor (e.g., OB/GYN physician), copies of pertinent diagnostic results and evaluations should be requested and filed in the medical record. Charting using forms such as those developed by the American College of Obstetrics and Gynecology (ACOG) or equivalent, is encouraged. Use of TechCare OB Module is also encouraged.

20) Pregnant patients shall be ordered appropriate preventive interventions, including the prescribing of prenatal vitamins and a pregnancy diet.

   a) These orders should continue throughout the postpartum period and during the period of lactation for those expressing breastmilk while in custody.
Figure: TechCare screenshot showing the pregnancy flag.

Related Forms

Emergency Contact Numbers

Obstetrical Tracking Log

References


Section F: Special Needs and Services

J-F-06 Response to Sexual Abuse

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Response to Sexual Abuse (J-F-06)

NCCHC MH Standard: Federal Sexual Assault Regulations (MH-B-04); Response to Sexual Assault (MH-B-05)

ACA Standard: Sexual Assault (4-ALDF-4C-22, 1-4)

Purpose

To provide timely medical and psychological intervention for sexual abuse and assault.

Policy

Proactive will provide all victims of sexual assault, abuse, or allegations prompt response with access to medical treatment which includes evidence preservation and a mental health evaluation for emotional support.

Procedure

REPORTING REGULATIONS

1) Health care staff will follow all protocols for reporting to the designated institutional authorities and will comply with the Prison Elimination Act (PREA) rules governing the facility.

2) Appropriate screening questions will be asked during the intake process, which will include a history of victimization and abuse.

3) Health care staff will submit incident reports for all evaluations of patients related to alleged sexual abuse with twenty-four hours of the event.

4) The Health Services Administrator will submit a monthly report of all medically triaged alleged sexual abuse patients to the institutional authority upon request.

PROCEDURES IN THE EVENT OF SEXUAL ABUSE

1) Health care staff will treat all patients in a neutral and non-judgmental manner. No details of the event will be solicited by the health care staff.

2) Health care staff will coordinate their activities with all first responders, investigators, and the institutional authority as required.

3) The designated Sexual Abuse Response Team (SART) shall be activated as soon as possible in any situation where forensic evidence is to be collected.
4) Emergency medical treatment may be provided by onsite health care staff as needed. No attempt will be made to clean or treat the victim unless the injuries are such that not treating them would cause deterioration of the victim’s medical condition.
   a) The victim shall be transported to the emergency department for examination and additional treatment.

5) A mental health professional will be contacted for counseling and follow-up.

6) In the case of rape or sexual offenses where evidence may be available, the victim and perpetrator (if known) should not be allowed to shower or wash in any manner. Clothing and bed linens should be treated as evidence.

7) The onsite provider will review all treatment recommendations from the offsite provider and issue appropriate orders.

8) For offender victims and perpetrators, medical staff will ensure provisions are made for testing for sexually transmitted diseases, unless already completed by emergency department personnel. Prophylactic treatment will be offered, as appropriate.

9) Emergency contraception is made available to female victims of sexual assault.

10) Any recommendations for special housing or a change in housing will be provided to the institutional authority.

11) Health care staff will not collect forensic medical information or evidence from an alleged perpetrator.

TRAINING

1) All health care staff members will be trained in sexual abuse prevention, detection, assessment, and evidence preservation; how to respond effectively; and on reporting procedures for suspicions of sexual abuse.

2) All health care staff will be trained in the standards of the Prison Rape Elimination Act (PREA) and the institution’s policies and procedures for sexual assault.

Related Forms

Offsite Referral

Sexual Assault Information

References


Section F: Special Needs and Services

J-F-07 Care for the Terminally Ill

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Care for the Terminally Ill (J-F-07)

ACA Standard: Special Needs Inmates (4-ALDF-4C-40)

Purpose

To address the needs of terminally ill patients.

Policy

Proactive will provide programs, including pain management and palliative care, to terminally ill patients unless it is determined by the responsible physician that care in a community setting is medically preferable.

Procedure

1) Consistent with any state regulations, when a patient is diagnosed as terminally ill, the Health Services Administrator will notify the jail administration of the patient’s condition and diagnosis and will provide the information and paperwork needed to assist in expediting an early release for the patient if possible.
   a) Once the patient has qualified for early release, attempts will be made to contact the family for input on the placement of the patient after his or her release from the facility;
   b) Should no family be available, outside agencies will be contacted to assist in the placement of the patient in a hospice or palliative care program upon release; and
   c) Upon release of the patient, medical records will be transferred with the patient to ensure continuity of care.

2) If the facility has a hospice program, care will be provided for inmates who have a terminal illness and a prognosis of months, and must include initiation of the following:
   a) If the inmate is informed of his qualifications for the procedures and must agree to be placed on hospice care;
   b) The health care professionals have received training in basic hospice theory and techniques;
   c) If inmate workers or volunteers are used to provide services to inmates in the hospice program, they must be properly trained and supervised by qualified medical staff;
   d) Documentation of appropriate palliative therapies; and
   e) The program must be consistent with any state regulations.
3) Advance directives, health care proxies, and “do not resuscitate” (DNR) orders are available when medically appropriate.

Related Forms

DNR Order

DNR Order – Spanish

Living Will

Living Will – Spanish

Medical Power of Attorney

References


Section G: Medical-Legal Issues

J-G-01 Restraint and Seclusion

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Restraint and Seclusion (J-G-01)

NCCHC MH Standard: Restraint and Seclusion (MH-I-01)

ACA Standard: Use of Restraints (4-ALDF-4D-21)

Other Applicable Standard: CCR Standard: Title 15, Section 1056 Use of Restraint Devices; IMQ Standard: 315. Use of Restraints

Purpose

To establish criteria and procedures for the application and use of mechanical restraints and/or seclusion with patients who require them for clinically indicated reasons, and to establish procedures for health staff to follow when monitoring and caring for patients placed in custody-ordered restraints for any reason.

Policy

Restraints and/or seclusion will be used by custody for the safety of a person and the security of the institution. Restraints and/or speculation are not to be used for the convenience of staff.

Restraints: Proactive may recommend the use of restraints for clinical reasons only when less restrictive means are not effective and only for the shortest amount of time possible. Generally, seclusion should be recommended before the use of restraints. In shorty, it is Proactive’s intent to recommend mechanical restraints as a clinical intervention only as a last resort; to encourage our custody partners to minimize the use of restraints for other purposes, and to educate and train our custody partners on the mortality and health risks that may be associated with use of restraints.

Seclusion: Seclusion should also only be recommended when less restrictive means are not effective and only for the shortest amount of time possible.

Procedure

RESTRAINT PROCEDURES

1) Since the level and type of restraint measures used is dependent on many facility, staff, and patient safety factors, it is Proactive’s belief that decisions on when to initiate mechanical restraints should very rarely be necessary.

2) If mechanical restraints are ordered for any reason by either medical or custody staff, the following steps must be followed:

   a) Before considering the use of therapeutic mechanical restraints, staff will attempt to assist the patient by less restrictive interventions, including, but not limited to:
i) Talking to the patient in a calm manner in an attempt to de-escalate the situation;
ii) Placing the patient in therapeutic seclusion without resorting to the use of therapeutic restraints, if possible;
iii) Offering voluntary medication with an order by an advanced clinical provider; and
iv) Administering emergency/involuntary medication as appropriate and consistent with Proactive policy with an order by an advanced clinical provider (see Proactive Emergency Psychotropic Medication Policy).

b) Notification and approval by a Proactive advanced clinical provider is to occur prior to any recommendation by Proactive for the use of restraints.

c) Approved and/or consultation regarding any use of emergency involuntary medication or any clinical recommendation for the use of restraints may be obtained from a STATCare corporate provider 24 hours a day, 7 days a week, by calling 888-735-4913.

d) When feasible, staff will encourage patient compliance during the application of any mechanical restraints by calmly explaining the restraint procedure, reason for the need to restrain, and the behavior required to terminate the use of restraints.

e) Patient should be restrained only in situations in which, due to self-destructive or violent behavior, there is imminent threat of harm to the patient, to others, or to property, and custody and health staff feel less restrictive means have proven to be ineffective or have been tried and not achieved their objective.

3) Upon notification of the planned or emergent use of mechanical restraints, health staff will review the health record for any contraindications prior to restraint, when possible. Correctional staff should be notified as soon as possible if contraindications are noted during the review.

   a) In the event health staff is not on duty at the time restraints are initiated, it is expected that health staff review the health record and initiate monitoring upon arrival.

   b) Should the health care staff note improper use of restraints, which may jeopardize the health of a patient, all concerns will be immediately relayed to the appropriate institutional authority.

4) In patients with medical or mental health complicating factors, health staff will assist custody staff in determining the timing of restraints and step down to less restrictive measures, when possible.

5) When custody staff implements mechanical restraints, the advanced clinical provider will be notified for initial orders for timing of nursing and/or mental health evaluations, and the treatment plan will include a plan for removing patients from restraints as soon as possible.
a) Only authorized restraints may be used on patients who are experiencing mental or physical crisis. These must be designed specifically for therapeutic restraint. The patient will be placed in appropriate restraints similar to those that would be used on patients in the community.
b) All mechanical restraints will be applied by security staff.
c) Proactive will work with custody to ensure that patients are not restrained in a manner which could jeopardize their health.
   i) Potentially harmful objects that might interfere with the restraints will be removed for the patient while he/she is restrained.
   ii) As appropriate, clothing should be removed as soon as possible to minimize the possibility of patient self-injury with a hidden object, and the patient should be provided a suicide-resistant gown/blanket. If possible, same sex staff should remove the patient’s clothing. Every effort will be made to ensure patient dignity.
   iii) The patient is not to be restrained in an unnatural position (for example, hog-tied, face-down, spread-eagle).
   iv) An advanced clinical provider may recommend modifications to the standard position due to medical reasons or other clinical indication. This will be clearly documented in the patient health record.

6) The physical care of the patients in restraints will be monitored regularly by an advanced clinical provider, health care, and custody staff as outlined below:
   a) Liquids will be offered at least once every two (2) hours while the patient is awake;
   b) Observation for signs of circulatory or respiratory distress, abrasions, irritation, injury, or other dysfunction will occur every 15 minutes while the patient is in restraints, unless an advanced clinical provider determines that a more or less frequent observation schedule is clinically indicated (not to exceed 60 minutes);
   c) Monitoring of extremities for color, temperature, and pulse will also occur every 15 minutes while the patient is in restraints, unless an advanced clinical provider determines that a more or less frequent observation schedule is clinically indicated (not to exceed 60 minutes);
   d) Vital signs will be monitored and recorded at least every shift and more frequently as needed;
   e) Meals will be provided, which may consist of foods not requiring the use of utensils;
   f) Elevation and lateral turning of the patient’s head will occur when providing food or liquid to prevent aspiration;
   g) With the assistance of the correctional staff, range of motion exercises will be provided every two (2) hours while the patient is awake; and
   h) Toileting needs are to be offered hourly.
7) Every effort will be made to minimize the length of time it is necessary to keep a patient in restraints.

8) Prior to the end of the restraint period, security and treatment staff will consult to evaluate any further needs of the patient and may consider a transfer order to inpatient psychiatric treatment or any other appropriate medical or mental health care interventions.

9) A nurse will schedule and implement a review of the patient in restraints every (15) minutes for the duration of the restraint, unless an advanced clinical provider determines that a more or less frequent observation schedule is clinically indicated. However, the timing interval for checks shall not exceed 60 minutes. If the patient appears to be asleep at the scheduled review time, it is permissible to document on the Restraint/Seclusion Observation Log that the patient was reviewed, appeared to be in no distress, and the decision was made not to disturb the patient. However, the circulation and respiration status will continue to be observed and documented at each observation interval.

10) Nursing and/or mental health staff will communicate with the patient in restraints at every observation interval when the patient is awake to assess the need for continued restraint by custody staff. Nursing and/or mental health staff will assess the patient’s compliance with restraints and possible removal from restraints at every observation interval in order to notify custody staff of the patient’s compliance. The advanced clinical provider will be contacted for his or her agreement to discontinue observation by medical and mental health staff upon custody decision and consent to remove the restraints.

11) Restraints should be recommended for removal when a patient is clinically assessed by the advanced clinical provider, or nursing/mental health staff in consultation with the advanced clinical provider, and the determination is made that the patient is no longer a risk of harm to self or others, is no longer agitated, and is able to verbalize the ability to maintain control of his/her behavior.

12) Restraints will be removed by security staff with the assistance of health care staff, if requested.

**SECLUSION PROCEDURES**

1) Before recommending to custody the use of clinically-indicated therapeutic seclusion, staff will attempt to assist the patient by less restrictive interventions, including but not limited to:
   a) Talking to the patient in a calm manner in an attempt to de-escalate the situation;
   b) Offering voluntary medication with an order by an advanced clinical provider; and
   c) Administering emergency involuntary medication as appropriate and consistent with Proactive policy with an order by an advanced clinical provider (see Proactive Emergency Psychotropic Medication Policy).
2) Whenever feasible, staff will encourage patient compliance with therapeutic seclusion by calmly explaining the seclusion procedure, the reasons for the decision to use therapeutic seclusion, and the behavior required to terminate the use of therapeutic seclusion.

3) With regard to clinically recommended therapeutic seclusion, the following policies and procedures apply:
   a) The Health Services Administrator, an advanced clinical provider, or mental health staff will be notified when a patient is placed in therapeutic seclusion with documentation included in the patient’s health record.
   b) Patients are to be secluded only in situations in which, due to self-destructive or violent behavior, there is an imminent threat of substantial harm to the patient, to others, or to property as a result of the patient’s mental or physical illness; and less restrictive means have been proven to be ineffective or have been tried and not achieved their objective.
   c) Therapeutic seclusion is a less restrictive means to achieve the objective of patient stabilization and will be considered prior to the use of therapeutic restraints.

4) The physical care of the patients in therapeutic seclusion will be maintained regularly by health care staff as outlined below:
   a) If liquids are not available in the seclusion room, liquids should be offered at least once every two (2) hours while the patient is awake;
   b) Meals will be provided, which may consist of foods not requiring the use of utensils;
   c) If a toilet is not available in the seclusion room, toileting needs are to be offered hourly;
   d) PRN ordered for therapeutic seclusion are expressly prohibited; and
   e) Every effort will be made to minimize the length of time it is necessary to keep a patient in therapeutic seclusion.

5) Prior to the end of the seclusion period, security and treatment staff will consult to evaluate any further needs to the patient and may consider a transfer order to inpatient psychiatric treatment or any other appropriate medical or mental health intervention.

6) Nursing staff, institutional staff, and/or mental health staff schedule and implement a review of any patient in clinically-recommended therapeutic seclusion at irregular intervals of no more than fifteen (15) minutes by a qualified health care professional for the duration of the seclusion. If the patient appears to be asleep at the scheduled review time, it can be documented on the Restraint/Seclusion Observation Log by nursing or the mental health staff that the patient was reviewed, appeared to be in no distress, and the decision was made not to disturb the patient.

7) Therapeutic seclusion can be removed when a patient is clinically assessed with the assistance of nursing and mental health staff, by the advanced clinical provider, to no longer be a risk of harm to self or others, is no longer agitated, and able to verbalize the ability to maintain control of his/her behavior.
8) The patient will be reviewed from therapeutic seclusion by security staff with the assistance of health care staff, if requested.

DOCUMENTATION PROCEDURES
1) The Restraint/Seclusion Observation Log will be initiated immediately.
2) Documentation by medical and/or mental health staff is to include the following information:
   a) The patient’s behavior immediately prior to the decision to use restraints or seclusion;
   b) The clinical justification for the use of restraints or seclusion rather than less restrictive interventions;
   c) Documentation of physician notification;
   d) The type of restraint or seclusion ordered;
   e) The patient’s behavior during the application of restraints or seclusion;
   f) Date and time that restraints were applied;
   g) Progress note updates; and
   h) Justification to remove the patient from restraints or seclusion.
3) Documentation pertaining to the use of physically immobilizing restraints or seclusion must be written prior to the staff existing the site upon completion of their staff.
4) The advanced clinical provider must be consulted at a minimum of six (6) hour intervals for the duration of the restraint.

QUALITY ASSURANCE REVIEW
1) The application of therapeutic restraints and seclusion will be an annual component of the Proactive CQI program.

STATE REGULATIONS
1) Recognizing that state regulations regarding the use of restraints and seclusion may differ between states, each Proactive, facility will, in conjunction with the corporate office, create an addendum to this policy as necessary to conform to state regulations regarding the use of restraints and seclusion.

For further guidance:
See J-G-03 Emergency Psychotropic Medication Clinical Guidelines for Emergency Psychotropic Medication

Related Forms
Restraint-Seclusion Observation Log
References


Use of Restraint Devices, CCR Title 15, Section 1058. California Code of Regulations: Minimum Standards for Adult and Local Detention Facilities.

Section G: Medical-Legal Issues

J-G-02 Segregated Inmates

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Segregated Inmates (J-G-02)

NCCHC MH Standard: Segregated Inmates (MH-E-07)

ACA Standard: Segregated Inmates (4-ALDF-2A-45); (4-ALDF-2A-56)

Purpose

To ensure that health care staff monitors the health of facility detainees who are placed in segregated housing.

Policy

Proactive will provide all detainees who are placed in segregation with the equivalent access to health care as those in the general population.

Procedure

1) Upon any placement into segregation, correctional staff will notify the health care staff as soon as possible. The health care staff will review the patient’s health record for information regarding medications, pending health care appointments or consultations, health conditions which may require assessments or treatments, with particular attention to mental health conditions. This review is documented in the health record.

2) Health care staff will make medical rounds on all individuals placed in segregation as follows:

   a) Medical rounds will occur for those in extreme isolation daily. Mental Health staff will make rounds in extreme isolation segregation once weekly.

   b) Medical or mental health care staff will make rounds in segregation three times per week for all those patients that have limited contact with staff or other individuals.

3) All rounds will be documented on the Administrative Segregation Log and/or in TechCare Segregation Rounds under Admission Management. This will include the date and time of contact and the signature of the health staff member making the rounds if not electronic.

4) If a health issue is identified, documentation is to be written in the patient’s health record.

5) Request for sick call will be made in writing utilizing the Sick Call Request form. Actual assessments will be made and documented in the health record.
6) Segregated patients with a health complaint requiring assessment will be evaluated in an adequately equipped clinic in the immediate area or in the main clinic at the health care staff’s discretion and with consideration of necessary security precautions. The health record will be available for all patient encounters.

7) Health care staff will make arrangements for all necessary health care to be delivered to segregated patients, including, but not limited to:
   a) Providing medications at the next medication administration;
   b) Notifying correctional staff of the date and time of health appointments in order for security to escort the patient to the health care unit, if applicable;
   c) Scheduling health assessments or treatments; and
   d) Notifying mental health as necessary.

8) An in-person physical assessment is not required for patients placed in segregation unless review of the health record or communication from the correctional staff indicates the patient have a health-condition requiring immediate evaluation or use of force has occurred.

9) In the event of use-of-force, a complete health evaluation will be conducted in accordance with Proactive’s policy and procedure (See J-E-08 Nursing Assessment Protocols and Procedures-Evaluation Following Use of Force). This will not include a rectal or pelvic exam unless medically indicated.

10) Patients not on the self-administration of medication program will receive medications delivered by appropriately trained staff.

11) Health staff will promptly identify and inform custody officials of patients who physically or psychologically deteriorating and those exhibiting other signs or symptoms of failing health. Any significant health findings are documented in the patient’s health record.

12) When a patient is released from segregation, correctional staff will notify the health care staff and pertinent documentation will be collected and filed. Medications to be self-administered may be returned to the patient if appropriate, and those on routine pill call will return to normal procedures.

Related Forms

Administrative Segregation Log

Segregation Round Guidelines

Sick Call Request

References


Section G: Medical-Legal Issues

J-G-03 Emergency Psychotropic Medication

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Emergency Psychotropic Medication (J-G-03)

NCCHC MH Standard: Emergency Psychotropic Medication (MH-I-02)

ACA Standard: Involuntary Administration (4-ALDF-4D-17)

Purpose

To provide guidelines and requirements consistent with the standard of care for the use of emergency psychotropic medication in the treatment of severe agitation and/or mental illness. As used here, the term “Emergency Psychotropic Medication” includes medication to stabilize a patient who is currently an immediate danger to self or others. The use is restricted to patients suffering from a serious mental illness and/or the use of chemical restraint in emergency situations where it is not possible to obtain the patient’s informed consent and it is impossible or infeasible to obtain a court order in a timely manner. This policy is also addresses the monitoring of patients after any involuntary medication administration (e.g., court ordered medication).

Policy

When emergency medications are indicated, the prescribing practitioner will attempt to obtain the patient’s informed consent. In all situations involving involuntary, emergency chemical restraint, the principles of good professional practice will prevail. For emergency involuntary psychotropic medication to be approved, it must be demonstrated that the treatment is in the patient’s best clinical interest. Utilization of emergency psychotropic medication without a court order will only be used where a patient is a danger to self or others and only in situations where it is not reasonable or possible to secure a court order in advance of administering emergency, involuntary medication. Emergency psychotropic medication will not be used as a punishment or for the convenience of staff or as a substitute for activities or treatment. Emergency psychotropic medications will only be used when less invasive and restrictive means have not been effective. Emergency psychotropic medication will only be used where authorized by an advanced clinical provider. Emergency psychotropic medication may not be administered repeatedly for a duration of more than 72 hours. Emergency, involuntary, psychotropic medication administered without a court order must be discontinued at the earliest possible time.

Procedure

IN Voluntary Administration in Emergency Situations

1) Before considering the use of emergency psychotropic medications, staff will attempt to assist the patient by less restrictive interventions, including, but not limited to:
a) Speaking with the patient in a calm manner in an attempt to de-escalate the situation;
b) Offering oral or injectable medication voluntarily if ordered by an advanced clinical provider.

2) Whenever feasible, staff will encourage patient compliance with oral or intramuscular emergency psychotropic medications by calmly explaining the reasons for the decision to use them and the behavior required to avoid current and potential future use of them.

3) With regard to clinically ordered emergency psychotropic medications, the following policies and procedures apply:
   a) Patients are to be emergently involuntarily medicated only in situations in which, due to imminent or threatened self-destructive or violent behavior, there is an imminent threat of substantial bodily harm to the patient or to others as a result of the patient’s mental or physical illness, and less restrictive means have been proven to be ineffective or have been tried and not achieved their objective.
   b) The medical staff requesting the medication must discuss the case with an advanced clinical provider and describe:
      i) The patient’s condition;
      ii) The threat posed;
      iii) The rationale for involuntary emergency psychotropic medications;
      iv) Other interventions without success; and
      v) Treatment plan goals for less restrictive treatment alternatives when the patient’s behavior permits.
   c) Emergency psychotropic medication is a less restrictive means to achieve the objective of patient stabilization than therapeutic seclusion and/or restraint.
   d) It may sometimes be necessary to therapeutically restrain the patient in order to administer emergency psychotropic medication – for the safety of both the patient and the staff. Please refer to the policy located under J-G-01 Restraint and Seclusion policies.
   e) The most commonly suggested initial psychotropic medication for emergency use for agitation is Lorazepam 2 mg.
      i) Geodon may be added to this at a dose of 20mg if signs of psychosis are evident.
      ii) Lorazepam 2 mg can be repeated every 10 minutes as needed up to 3 doses and a maximum total dose of 6mg of Lorazepam.
      iii) Other options include Haldol 5 mg with Benadryl 50mg and Lorazepam 2mg IM.
      iv) Final medication dosage, including choice of medication used, is made by the ordering provider.
      v) See also Detox Guidelines for Methamphetamine Overdose
f) A clinical provider or qualified nursing staff must document follow-up face-to-face assessment and care appropriately:
   i) Within an hour of administration of oral medication, and again within 24 hours of administration;
   ii) Within 15 minutes of intramuscular medication, and then at 3 successive 30 minute intervals or until the patient is no longer requiring monitoring;
   iii) These encounters will include:
       a. Vital signs;
       b. Assessing mental status and behavior;
       c. Evaluating for adverse events, reactions, complications, and changes to clinical picture, and
       d. Observation of patient’s behavior and any psychiatric symptoms observed.

g) Any patient requiring multiple doses of Emergency Psychotropic Medication in 72 hours will have a review of their record and treatment plan documented by a mental health provider, to record the reason for repeated use and discuss long term and alternative plans.

h) All involuntary psychotropic medication administration to a patient may be documented on the Emergency Psychotropic Medication Administration Report in TechCare. This should include, but is not limited to:
   i) Response and behavior monitoring pre-administration;
   ii) The threat posed by the patient;
   iii) The reason for forcing the medication;
   iv) Other treatment attempted if applicable;
   v) Response and behavior monitoring post-administration; and
   vi) Review of the treatment plan for less restrictive treatment alternatives.

i) State statutes, to the extent more restrictive than this policy, will further dictate whether and how emergency psychotropic medications may be involuntarily administered.

4) The following policies apply for the routine use of involuntary psychotropic medication (non-emergent):
   a) First time doses of involuntary medications in a patient naïve to that treatment should be monitored at the same nursing intervals as outlined for emergent involuntary medication.
   b) Repeat doses or initial doses of medications the patient has a history of receiving can be monitored at the discretion of the provider or as indicated by the judgment of the administering nurse.

FOR FURTHER GUIDANCE
See Care Guidelines
Related Forms

Emergency Psychotropic Medication Administration Report

Emergency Psychotropic Medication Administration Follow-up and Discharge Report

References


Section G: Medical-Legal Issues

J-G-04 Therapeutic Relationship, Forensic Information, and Disciplinary Action

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Therapeutic Relationship, Forensic Information, and Disciplinary Action (J-G-04)

NCCHC Opioid Standard: Forensic Information (O-I-01)

NCCHC MH Standard: Forensic Information (MH-I-03)

ACA Standard: Special Management Inmates (4-ALDF-2A-56); Body Cavity Search (4-ALDF-2C-05)

Purpose

To clarify that the participation of the health services staff in the collection of forensic information is generally not allowed.

Policy

Health staff should avoid participating in the collection of forensic information that may affect the integrity of the therapeutic partnership with their patients.

Procedure

1) Medical and mental health staff members do not participate in the collection of information for forensic purposes. Participation in these activities undermine the credibility and treatment confidentiality of the professional with the patients.

2) Health care staff members do not perform body cavity searches for contraband, nor train correctional staff in performing body cavity searches.

3) In the case of sexual assault or abuse, the patient victim may be referred to an offsite emergency provider for assessment and treatment.

4) Health care staff members may test blood or urine for alcohol or other drugs or perform body cavity searches when done for medical purposes by order of an advanced clinical provider and with patient consent.

5) Requests for participation in collection of information for forensic purposes, such as conducting body searches for contraband or providing psychological evaluations of patients for use in adversarial proceedings, will be referred to outside sources.

6) Health services staff may collect specimens for DNA analysis if:
   a) Complying with state law;
   b) The patient has provided voluntary consent;
c) The health care staff does not participate in any punitive action taken if the patient refuses.

7) Health staff do not participate in disciplinary action nor are compelled to provide clinical information solely for the purposes of discipline.

8) Treatments and medications are never withheld as a form of punishment.

9) Segregation and restraints are never clinically implemented as disciplinary action.

Related Forms

No relevant forms for this policy,

References


Section G: Medical-Legal Issues

J-G-05 Informed Consent and Right to Refuse

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Informed Consent and Right to Refuse (J-G-05)

NCCHC Opioid Standard: Informed Consent and Right to Refuse (O-I-02)

NCCHC MH Standard: Informed consent and Refusal of Mental Health Care (MH-I-04)

ACA Standard: Informed Consent and Right to Refuse (4-ALDF-4D-15)

Purpose

To ensure patients have the information necessary to make informed decisions regarding treatment, procedures, and examination and establish procedure related to a patient’s refusal of health care treatment.

Policy

Informed consent will be obtained from patients for examinations, procedures, and treatments received for health care purposes. Exceptions to obtaining informed consent will be in compliance with state and federal laws or public health requirements. Patients have the right to refuse health treatment and care.

Procedure

INFORMED CONSENT

1) Upon entry to the correctional institution, all patients will be asked to read and sign a general informed consent document, which will serve as consent to perform non-invasive examinations, procedures, and treatment until the patient’s release from the institution.

2) Patients unable to speak, read, or write English or Spanish (i.e., visually or hearing impaired, non-English or Spanish speaking, etc.) will have the consent communicated and explained in a method they understand.

3) Patients whose condition requires an invasive examination, procedure, or treatment will be asked to read and sign an Informed Consent for each occurrence. The consent form will also be signed by a health services staff member as a witness.

   a) Prior to obtaining specific informed consent, the responsible advanced clinical provider will explain the medical problem requiring the procedure or treatment, the purpose of the procedure or treatment, the associated benefits and risks of the medication or treatment, any alternative treatment available, and the prognosis if the treatment or procedure is refused.
b) When an invasive procedure is to be conducted by an outside medical facility, that medical facility is responsible for obtaining any applicable informed consent.

c) Patients considering enrollment in MAT while in custody will be informed of any necessary coordination and communication with courts, facility staff, and outside community OTP partners. Consent will be obtained in writing from the patient prior to enrollment.

REFUSAL OF HEALTH CARE SERVICES

1) Documentation of health evaluation or treatment refusal must include the following:

a) The specific type of treatment being refused and the potential consequences of refusing treatment;

b) Non-adherence counseling will be documented in the patient record if the patient continues to be non-adherent following three non-adherence counseling sessions, the advanced clinical provider will counsel the patient once again and document the counseling session in the progress notes;

c) The Release of Responsibility – Specific Procedure form will be read and signed by the patient that refuses treatment in the presence of a witness and recorded in TechCare.

   i) Signing of this form will be witnessed by a member of the health care staff;

   ii) In the event the patient refuses to sign a Release of Responsibility – Specific Procedure form, the medical staff member will complete the form and write “patient refuses to sign” in the space for signature. The signature of both the medical staff member and witness are required.

d) Patients refusing treatment for established chronic care conditions will be monitored through the appropriate chronic care clinic and re-counseled regarding their current condition and the consequences of continued refusal at each CCC visit. This information will be documented in the progress notes.

   i) At the discretion of the advanced clinical provider, these patients will not be required to sign a Release of Responsibility – Specific Procedure form during each visit.

   ii) If a patient infrequently refuses to take a prescribed medication, it is not necessary to obtain a signed Release of Responsibility – Specific Procedure form. The refusal is to be documented on the eMAR.

   iii) If a patient frequently refuses to take prescribed medication(s), a medical staff member will provide non-adherence counseling to be documented in the progress notes. If the patient continues to be non-adherent following three non-adherence counseling sessions, a Release of Responsibility – Specific Procedure will be completed.
e) Refusals of medical treatment for serious conditions will be communicated to the facility’s Medical Director. The Chief Medical Officer may be consulted for advice and guidance.

f) If the advanced clinical provider questions or is unsure that the patient is a competent adult, a referral to mental health will be made. The mental health advanced clinical provider will be responsible for determining the patient’s competency.

g) A psychiatric evaluation will be requested for all patients who have or have had a mental health diagnosis and refuse treatment. For patients with a mental health diagnosis, who also have a serious medical condition where a refusal may result in irreversible consequences, refusals will be communicated to the corporate Chief Medical Officer for advice and guidance.

h) In circumstances involving infectious diseases, including but not limited to tuberculosis and syphilis, the patient refusing treatment can be placed in medical isolation for the protection of other patients and correctional staff until treatment is accepted and the patient is no longer infectious.

   i) At the discretion of the advanced clinical provider, a court order may be sought for any patient who continues to refuse consent for required infectious disease examination or testing for longer than thirty (30) days.

i) Patients have the right to accept treatment following a refusal. The advanced clinical provider will then evaluate the patient to determine whether the previous treatment recommended to the patient remains appropriate. All appropriate treatment will be explained to the patient by the advanced clinical provider and documented in the progress notes.

j) The patient who decides to accept treatment after a refusal will be eligible to resume treatment. If the order is still active, the treatment will resume unless contraindications to this treatment have been established by the advanced clinical provider. Orders that have expired or have been discontinued will require orders by the Advanced Clinical Provider.

k) Patients may not sign a blanket refusal for all treatment. Rather, patients may refuse care on a case-by-case basis after the medical staff member has discussed the specific risks and alternatives.

EXCEPTIONS TO OBTAINING INFORMED CONSENT

1) Informed Consent is not required for examinations, procedures, and treatments involving medical emergencies which are life-threatening and require immediate medical intervention for the safety of the patient or emergency care of patients who do not have the capacity to understand the information given (i.e., unconscious or mentally ill patients who are dangerous to self or others).
2) Informed Consent is not required for examinations related to detection of certain communicable diseases such as tuberculosis and syphilis.
3) Parental consent for performing examinations, procedures, and treatments for juveniles is not required if the correctional facility is the legal guardian for the juveniles in custody.
4) In circumstances where health care providers proceed without informed consent, all aspects of the patient’s condition and the reasons for intervention will be thoroughly documented in the health record and will be in accordance with the state and federal laws and regulations.

Related Forms
No relevant forms for this policy,

References


Section G: Medical-Legal Issues

J-G-06 Medical and Other Research

Effective Date: 01/01/2020

Policy Revised:

NCCHC Standard: Medical and Other Research (J-G-06)

NCCHC Opioid Standard: Medical and Other Research (O-I-03)

NCCHC MH Standard: Research (MH-I-05)

ACA Standard: Medical and Other Research (4-ALDF-4D-18)

Purpose

To clarify Proactive’s stance regarding research involving patients.

Policy

Proactive is dedicated to the care and well-being of each patient provided treatment. To this end, Proactive will not pursue any endeavor in which patients are used as subjects for biomedical, chemical, behavioral, or other research without ensuring first that study parameters are consistent with established ethical, medical, legal, and regulatory standards for human research.

Procedure

1) Collection of aggregate data and reporting of information may be permitted with the written approval of the institutional authority and the Medical Director. The Chief Executive Officer must be notified by the Medical Director of this action.

2) Proactive will work in consultation with community researchers in the event a patient is involved in an existing clinical trial or research and may elect to continue the treatment protocol pending a case-by-case review completed at the corporate level.

3) In the event a patient is involved in an existing clinical trial or research, and withdrawal from the research is indicated after a review at the corporate level, health care staff will work in consultation with community researchers to ensure withdrawal from the research protocol is done to minimize any harm to the health of the patient.

4) CQI studies are not considered research for purposes of this policy.

Related Forms

No relevant forms for this policy,

References

Medical and Other Research (O-I-03). National Commission on Correctional Health Care: Standards for Opioid Treatment Programs in Correctional Facilities, 2016.


Glossary

Revision Date:

Activities of Daily Living (ADL) - Ambulation, bathing, dressing, feeding, and toileting, or other ordinary daily tasks.

Acute Care Residential Unit - Dedicated housing area offering stabilization and programming as indicated for those inmates who are mentally unstable, psychotic, or waiting for placement in an inpatient psychiatric facility.

Administering Medication - The act in which a single dose of an identified medication is given to a patient.

Administrative Review - An assessment of correctional and emergency response actions surrounding a patient death. Its purpose is to identify potential areas where Proactive's operations, policies or procedures may be improved.

Advanced Clinical Provider - Physician, Nurse Practitioner, Physician Assistant, Psychiatrist, or Dentist.

Adverse Clinical Event - An injury or death caused by medical management rather than by patient's underlying disease or condition.

Aids to Impairment - Including, but not limited to, eyeglasses, hearing aids, canes, crutches, or wheelchairs.

Authorized Restraints - Devices designed specifically for restraint. Examples of typical restraint devices are fleece-lined leather, rubber, or canvas hand and leg restraints, 2-point and 4-point restraints, and restraint chairs. Metal or hard plastic devices (such as handcuffs and leg shackles) are not used for clinically ordered restraint.

Basic Orientation - Orientation received the first day of on-site service for all Proactive staff. At a minimum, this orientation is to include the Basic Orientation as set out in the Employee Orientation Checklist and a tour of all health care units, as well as an introduction to the health care and ancillary staff.

Case Report—Factual Summary - A summary of the medical, mental health, correctional and emergency response actions surrounding an inmate's suicide or serious suicide attempt. This summary is typically completed by the Health Services Administrator or the facility's Mental Health Director/Coordinator, along with the members of the facility's Morbidity and Mortality Committee.

Chemical Dependency - The state of physiological dependence on alcohol, opioids (any preparation or derivative of opium, as well as any synthetic narcotic that resembles an opiate in
action, but is not derived from opium), stimulants (i.e., amphetamines, cocaine, methamphetamines), hypnotics, depressants, and sedative hypnotic drugs.

Chronic Care Clinics - Periodically scheduled encounters between an Advanced Clinical Provider and an inmate with a chronic disease.

Chronic Disease - An illness or condition that affects an inmate's well-being for an extended interval, usually (at least) six (6) months, and generally is not curable, but can be managed to provide optimum functioning within any limitations the condition imposes on the inmate.

Clinical Encounters - Interactions between patients and health care providers that involve a treatment and/or exchange of confidential information.

Clinical Mortality Review - An assessment, completed at the corporate level, of the clinical care provided and the circumstances leading up to a death. Its purpose is to identify any areas of patient care or Proactive's policies and procedures that can be improved.

Close Suicide Watch - The observation of a suicidal inmate at staggered intervals not to exceed every 15 minutes with documentation as observation occurs (e.g. 5, 10, 7 minutes).

Communicable Diseases - Infectious diseases that are transmitted to others sexually (e.g., syphilis, gonorrhea, Chlamydia), through the respiratory system (e.g., pulmonary tuberculosis) or by infected blood (e.g., hepatitis, HIV).

Community Medical Provider - Most recent Physician, Nurse Practitioner, Physician Assistant, Psychologist, or Dentist who provided health services (medical, mental health, dental) in the community setting.

Competent Adult - Any person who is of sound mind, eighteen (18) years of age or older.

Concurrent Review - Contact between the UM Nurse and off-site provider to ensure the most appropriate setting, treatment plan, and timely preparation for discharge and continuum of care for inpatient hospitalizations.

Confidential Documentation - Any individually identifiable health, protective health information (PHI) or administrative documentation which should not be disclosed as a result of certain confidences instructed to the health care provider. Health documentation includes, but is not limited to, any information that relates to the past, present or future physical, dental, or mental health condition of an individual or relates to the provision of health care, including, but not limited to, demographic information, progress notes, test results, health summaries, criminal history printouts. Personnel documentation, includes, but is not limited to, personnel rosters, addresses, telephone numbers, schedules. Administrative documentation includes, but is not limited to, incident reports, citations, investigative reports, or management reports.

Constant Suicide Watch - The continuous, uninterrupted observation of a suicidal inmate with the inmate remaining in the line of sight of staff at all times. Documentation is required at staggered intervals, not to exceed 5 minutes.
Continuing Education - Training or staff development activities, including any training offered by the facility's health services, community, or professional organization seminars or conferences related to their job duties.

Continuous Ambulatory Peritoneal Dialysis (CAPD) - A prescribed amount and type of fluid manually exchanged for a prescribed number of times per day in the Peritoneal Cavity through a PD catheter located in the abdomen.

Continuous Cycling Peritoneal Dialysis (CCPD) - A prescribed amount and type of fluid exchanged by a programmed machine (called a cycler) for a prescribed number of times during the night while the patient sleeps through a PD catheter located in the abdomen. Sometimes a manual exchange is performed midday in addition to the night time cycler exchanges. The basic process of the PD treatment is (1) drain; (2) fill; and (3) dwell. Usually people using peritoneal dialysis for renal replacement therapy have had training and successful demonstration of performing the treatments on their own.

Continuous Quality Improvement (CQI) - A program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve care, and resolve identified problems.

Corporate Continuous Quality Improvement Committee - A Corporate committee charged with the responsibility to carry out the objectives of the Continuous Quality Improvement Program.

Credentialing - A review process whereby the qualifications of health professionals required for employment are verified.

Critiques - Documentation of drills or actual events that occur relating to emergencies, including response time, names and titles of health staff, as well as the roles and responsibilities of all participants. The critique contains observations of staff response to the drill and is used to identify and improve, if indicated, emergency responses by health staff.

Custody Restraints - An intervention initiated by correctional staff to use devices to safely limit a patient's mobility in a crisis in order to maintain the safety of the patient and security of the correctional facility.

DEA-Controlled Substances - Medications that come under the jurisdiction of the Federal Controlled Substance Act.

Decision-Making Capacity - The ability to understand and appreciate the nature and consequences of options and choices available regarding health care decisions, including the benefits and disadvantages of such choices and to reach an informed decision regarding available choices.

Dental Staff - Those persons who, by virtue of their training and experience, are qualified to provide dental care within the provisions of the applicable state's licensure laws, policies and
guidelines. Dental Staff includes licensed dentists, dental hygienists and dental assistants. Dental clerical/support staff is also included as far as access to documentation and under no circumstances is to provide clinical services.

Detoxification - The process by which an individual is gradually withdrawn from a drug by the administration of decreasing doses of the drug upon which the person is physiologically dependent or one that is cross-tolerant to it or one that has been demonstrated to be effective on the basis of medical research.

Developmentally Disabled - Inmates who may need rehabilitation planning assistance in accepting the limitations of their conditions and special attention to their physical safety in the correctional environment.

Diet Non-Adherence - Missing either six (6) meals a week or fifteen (15) meals a month of a prescribed diet.

Directly Observed Therapy (DOT) - Medications which do not meet the criteria for self-administration, will be administered on an individual dose basis as directly observed therapy by personnel trained to administer medication(s).

Discharge Planning - The process of providing necessary follow-up health services before the inmate is released to the community.

Dispensing - The placing of one or more doses of a prescribed medication into containers that are correctly labeled to indicate the name of the patient, the contents of the container, and all other vital information.

Disposal - The destruction of medication on its expiration date or when retention is no longer necessary or suitable (e.g., upon discharge of the inmate from the institution) or upon provision of medication to the former inmate upon his or her discharge from the facility, if applicable.

Distribution - The system for delivering, storing and accounting for medications from the source of supply to the nursing station or point where they are administered to the patient.

Early Release - Refers to the release of an inmate before the expiration of his or her sentence based on the inmate's terminal condition. This is also known as medical parole or compassionate release in some states.

Emergency - An unexpected health need that cannot be deferred until the next scheduled sick call or clinic.

Emergency Complaint - A complaint filed by an inmate citing impending or current harm to the health, safety or welfare of the inmate.

Emergency Situation - An event in which a patient is refusing psychotropic medication and poses an imminent danger to himself or others.
Error Reporting System - Policies and procedures that outline how health staff voluntarily identify and report all clinical errors, whether the error occurs by omission or commission.

Forced Blood Draw - Blood that is drawn from a patient without his/her consent in order to monitor or evaluate the efficiency of a psychotropic medication.

Formulary - A written list of prescription and non-prescription medications that is ordinarily available to authorized prescribers working in the facility, in a format comparable to formularies used in the community.

Frail/Elderly - Inmates who frequently suffer conditions that impair their ability to function in activities of daily living (feeding, bathing, etc.). These individuals may require environments that provide assisted living services or skilled nursing care.

Harassment - Includes, but is not limited to, unwelcome sexual advances, requests for sexual favors, other verbal or physical conduct of a sexual nature; threatening or menacing behavior; derogatory statements directed at or about another person.

Health Assessment - A systematic, hands-on, collection of data, both subjective and objective, incorporating the health history and review of all body systems to determine the inmate's current state of health. The exam involves the inspection, palpation, auscultation and percussion of the inmate's body to determine the presence or absence of physical signs of disease.

Health Care - The sum of all actions, preventive and therapeutic, taken for the physical and mental well-being of a population, including medical, dental, mental health, nutrition and other ancillary services.

Health Care Complaint - A right to question or complain about the health care system.

Health Care Grievance - A way to provide health staff with valuable feedback regarding opportunities for improving health services.

Health Care Liaison - A person without a health care license trained by the responsible physician in limited aspects of health care coordination.

Health Care Staff - All qualified health care professionals who by virtue of their training and experience are qualified to provide health care within the provisions of the state's licensure laws, policies and guidelines. Health Care Staff can include licensed Physicians, Certified Registered Nurse Practitioners, Licensed Practical Nurses, Licensed or Certified Medical Technicians, Qualified Health Care Providers contracted by Proactive, Mental Health Staff or Dental Staff. Health Care clerical/support staff is also included as far as access to documentation and under no circumstances is to provide clinical services.

Health Education - Information on preventing disease and maintaining a healthy lifestyle.
Health Services Administrator - A person who by virtue of education, experience, or certification, is capable of assuming responsibility for arranging all levels of health care and ensuring quality and accessible health services for patients.

Health Services Report - Statistical data obtained monthly, which includes, census, deaths, screenings and evaluations, infirmary/observation information, sick calls, chronic care clinics, off-site services, on-site specialty clinics, diagnostic services, dental services, ancillary services, and infectious disease reports.

Hemodialysis - Removal of waste products, as well as free water from the blood when the kidneys are in renal failure through outpatient or inpatient therapy.

Hospice Program - A program that delivers palliative care (medical care and support services aimed at providing comfort). Treatment is focused on symptom control and quality of life issues, rather than attempting to cure conditions.

Implied Consent - Where consent to treatment, examinations or procedures is assumed by patient request following an explanation of the nature, risks and benefits and alternative or in life-threatening conditions that require immediate intervention for the safety of the patient or emergency care of patients who do not have the capacity to understand the information given.

Incident Report - Factual statements by individuals involved in a specific episode of care (e.g., Code response). The facts as presented in Incident Reports are part of the data used for Administrative and Clinical Mortality Reviews.


In-Depth Orientation - All full-time Proactive health care staff must complete this orientation within ninety (90) days of employment.

Infection Control - Procedures addressed in the Infection Control Program policy and procedure.

Infirmary - An area within a facility accommodating two (2) or more inmates for a period of twenty-four (24) hours or more expressly set up and operated for the purpose of caring for inmates who need nursing care, but who are not in need of hospitalization.

Infirmary Care - Inpatient care provided to inmates with an illness or diagnosis that require medication and/or therapy, assistance with activities of daily living or other nursing care on a daily basis. The care is provided under the direction of an Advanced Clinical Provider and under the daily supervision of a registered nurse (minimum eight (8) hours per day).

Informed Consent - The written agreement to a treatment, examination or procedure by the patient after the patient receives the material facts about the nature, consequences and risks of the
proposed treatment, examination or procedure; the alternatives to it; and the prognosis if the proposed treatment is not undertaken.

Institution Emergency - Any situation that threatens the security of the institution, including, but not limited to, riot, hunger strikes, disturbances, escapes, the taking of hostages, tornado, flood, earthquake, arson, kitchen explosion, mass arrests, bomb threat, power outage, or any other man-made or natural occurrence, internal or external.

Institutional Authority - On-site correctional security and administrative staff.

Invasive Procedures - Surgical procedures requiring local, regional or general anesthesia, endoscopic procedures, amniocentesis or procedures involving barium swallows enemas or the injection of dye.

Isolation - The separation of infected or those suspected of being infected from others during a period of communicability to prevent or limit direct or indirect transmission of infection. Housing in a separate room with a separate toilet, hand-washing facility, soap, single-service towels, and with appropriate accommodations for showering is recommended.

Legend Medication - Medication(s) required by Federal and State law to be dispensed and administered only in response to an order from a Proactive Advanced Clinical Provider.

MAC - Medical Administrative Committee.

Man-Down Drill - A simulated emergency affecting one individual who is in need of immediate medical intervention, involving life-threatening situations commonly experienced in correctional institutions.

Mass Disaster Drill - A simulated emergency involving multiple casualties that require triage by health care staff.

Medical Diets - Specific instructions to the facility kitchen that result in a modification to the standard diet, ordered as a part of a treatment plan for a medical condition. Medical diets do not include modification for other reasons, such as religious or other beliefs, security concerns, food preferences, sports activities, etc.

Medical Isolation - Locations within a correctional institution in which inmates are isolated from the general population and who receive services and activities apart from other inmates.

Medication Administration Orientation - Qualified health care staff will receive medication administration training during orientation prior to administering any medications. Training will be repeated and documented on an annual basis for non-licensed staff. In-service education on medication administration will be provided as needed for review and to update staff regarding changes in standard operating procedures.
Medication Administration Record (MAR) - The legal document upon which administration of medication is documented.

Medication Distribution System - The system of delivery, storage of and accounting for drugs from the course of supply to the point at which they are administered to the inmate.

Medication Non-Adherence - Missing two (2) consecutive doses of medication or more than 25% of medication prescribed during a seven (7) day period for non-SAM/KOP medication or missing more than 25% of medication prescribed during a thirty (30) day period for SAM/KOP medications. Inmates on insulin, TB prevention drugs, antiretroviral therapy and anti-HCV therapy should be considered non-adherent after missing one (1) dose.

Medication Variance - A medication variance is broadly defined as a dose of medication that deviates from the physician's order as written in the inmate's health record or from standard policy and procedure.

Mental Health Evaluation - A detailed clinical assessment conducted by Qualified Mental Health Professional for patients identified in the screening process as having mental health needs.

Mental Health Program - Organized outpatient intervention, including individual or group interventions for inmates regardless of housing assignment.

Mental Health Screen - A detailed clinical assessment conducted by either Proactive Mental Health Staff or Proactive Health Care Staff who have received training in identifying individuals in need of mental health services, performed on all patients. This process includes behavioral observation, inquiry into mental health history, and an assessment of suicide potential. This assessment is designated to further identify patients with a serious mental illness and patients with other mental health needs and leads to a referral for complete Mental Health Evaluation.

Mental Health Services - A variety of psychological, psychosocial and pharmacological therapies used to treat the symptoms of mental illness.

Mental Health Staff - Qualified Health Care Professionals who have received instruction and supervision in identifying and interacting with individuals in need of mental health services.

Mental/Emotional Abuse - Includes, but is not limited to, derogatory statements directed at or about another person designed to elicit a mental and/or emotional response, statements designed to demean another person, verbally threatening or implying a threat to another person.

Near-Miss Clinical Event - An error in clinical activity without a consequential adverse patient outcome.

Non-Acute Care Unit - Short-term or permanent housing for inmates who are chronically mentally ill or experiencing situational stress.
Non-Adherence with Medication(s) - Missing two (2) consecutive days or 25% of a total dose in a one (1) week period. Individuals on insulin, anti-retroviral therapy or other medications determined by the prescriber to be crucial will be non-adherent after missing one (1) dose.

Non-Formulary Medication - Medication not identified or listed on the approved Proactive Pharmaceuticals Formulary.

Non-Invasive Procedures - Routine physical examination, laboratory tests, skin tests and injections.

Non-Serious Condition - A condition for which no serious complications are anticipated if the condition is untreated.

Nursing Protocols - Written instructions or guidelines that specifies the steps to be taken in the evaluation of an inmate's physical status and includes treatment of minor conditions.

Observation Units - A designated medical area or bed(s) expressly set up and operated for the purpose of observing or treating inmates for clinical conditions.

Oral Care - Includes instruction in oral hygiene (plaque control, proper brushing of teeth) and examination, and treatment of dental problems.

Oral Examination - Performed only by a licensed dental staff and completed within twelve (12) months of admission, including taking or reviewing the patient's oral history, an extraoral head and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer, and adequate illumination.

Oral Screening - Completed within fourteen (14) days of admission to the facility, including visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist.

Oral Treatment - Treatment provided according to a treatment plan based upon a system of established priorities for care, including a full range of services that in the supervising dentist's judgment are necessary for proper mastication and maintaining the inmate's health state, not limited to extractions.

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

Outcome Quality Improvement Study - Examines whether expected outcomes of patients' health care were achieved. Primary focus of a study may be on "high volume", "high risk", or "problem-prone" services of care.

Over-The-Counter Medication (OTC) - Medications that are approved by the Food and Drug Administration (FDA) for sale or distribution without a prescription.
Pandemic - An episode of infectious disease that is spreading through the patient population of the correctional facility.

Patient Safety Systems - Practice interventions designed to prevent adverse or near miss clinical events.

Peer Review - A process wherein, at set intervals or by special requests, the medical practices and management of a given practitioner are reviewed by another practitioner at the same or higher level. Peer Review operates under the umbrella of CQI, but is a special kind of review that follows specific rules and enjoys protection from discovery. The clinical performance of the facility's primary care providers is reviewed at least annually.

Peritoneal Dialysis - Removal of waste products and fluid from the blood into the peritoneal cavity by diffusion through the peritoneal membrane.

Pharmacy and Therapeutics Committee - An interdisciplinary professional group formed to address procedural, clinical and therapeutic issues related to the provision of pharmaceutical services.

Pharmacy Protocol Manual - A comprehensive manual that details practices and procedures for on-site pharmacy staff.

Physical Abuse/Corporal Punishment - Includes, but is not limited to, touching a person in a threatening manner, harming another person's body; physically harming another as a consequence to a perceived intentional or unintentional action.

Physical Disabilities - Mobility/sensory impairment(s) (i.e., amputation(s), paraplegia, quadriplegia) requiring assistive devices such as canes, crutches, or a wheelchair. This also include visual, hearing or speech impairment(s).

Policy - Proactive's official position on a particular issue related to operations.

PRN Medications - Pro re nata, meaning, "as needed" medications that are not scheduled, but instead, administration is left to the Qualified HealthCare Professional or the patient's prerogative.

Procedure - Describes in detail how the policy will be carried out.

Process Quality Improvement Study - Examines the efficiency of the health care delivery process. Primary focus of a study may be on "high volume", "high risk", or "problem-prone" services of care.

Procuring - The act of ordering medications for the facility.

Professional Health Care Staff - Licensed, registered or certified health care staff whose position requires credentials that meet state credentialing laws.
Property Damage - Includes, but is not limited to, denting, scratching, breaking or destroying personal possessions or material goods.

Prospective Review - Review prior to the delivery of non-emergent care to establish medical necessity, assure quality, minimize iatrogenic harms, and ensure most appropriate and most cost-effective care.

Prostheses - Artificial devices to replace missing body parts such as limbs, teeth, eyes, or heart valves.

Psychological Autopsy—Case Report Analysis - A review of the medical, mental health, correctional and emergency response actions surrounding an inmate's suicide or serious suicide attempt. Its purpose is to identify areas where facility operations, policies, and procedures can be improved. The summary is typically completed by the primary site psychiatric provider and is presented for review to the Corporate Chief Psychiatrist, Corporate Mental Health, and Morbidity and Mortality Committee. The results of the Case Report- Analysis are then presented to the Health Services Administrator at the facility where the incident occurred.

Psychotropic Medication - Medications employed to treat symptoms of mental illness. These medications include any medications approved by the FDA for the treatment of psychiatric illness as well as those medications commonly used in the private sector for treatment of psychiatric illness.

Qualified Mental Health Professionals - Includes psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

Receiving Screen - A system of structured inquiry and observation administered to all new inmates, including transfers, designated to (1) identify any health care needs; (2) identify and meet any known or easily identifiable health needs requiring urgent attention; and (3) prevent inmates who pose a health or safety risk to themselves or others from being admitted to the institution's general population.

Responsible Health Care Authority - Health Services Administrator, Physician, or agency designated to have the final authority at a given facility regarding clinical issues.

Retrospective Review - Review of treatment performed after discharge (or after services are rendered) to ensure quality and appropriateness of care.

Rounds - A daily, weekly or three times weekly visit to isolation/segregation areas to visually inspect all inmates housed there and gives each the opportunity to voice a concern and request general medical information or services.

Safe Cell - Designated cells within each institution for the placement of inmates on a suicide watch status. Safe cells must allow clear visibility to all areas of the cell in order to allow for continuous visual observation. Safe cells must be suicide resistant and may include, but are not limited to,
stainless steel fixtures, fine mesh screens over windows, and no exposed plumbing or other objects from which a person could hang or otherwise commit self-harm. The cells must be outfitted with suicide resistant mattresses.

Segregation - Locations within a correctional institution in which inmates are isolated from the general population and who receive services and activities apart from other inmates.

Self-Administration of Medication (SAM) - A program that permits responsible inmates to carry and administer their own medication(s); also known as keep-on-person (KOP) medication.

Self-Care - Care for a condition that can be treated by the inmate and may include self-administered medication.

Serious Adverse Event - An event after health care treatment that results in hospitalization or death.

Serious Condition - A condition for which, if untreated, may result in irreversible loss of life, limb or function or harm to the patient or others.

Serious Medical Condition - A medical condition, which if untreated may result in irreversible loss of life, limb or function, or the development of more than minimal discomfort.

Serious Mental Illness - A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity for reality testing or ability to cope with the ordinary demands of life within the correctional environment, manifested by substantial pain or disability. Serious mental illness requires a mental health diagnosis, prognosis, and treatment, as appropriate, by mental health staff.

Serious Suicide Attempt - Any attempt to commit suicide that requires emergency medical treatment by an advanced-level provider.

Sexual Abuse - Includes, but is not limited to, subjecting another person to sexual contact by persuasion, inducement, enticement, or forcible compulsion; subjecting to sexual contact another person who is incapable of giving consent by reason of his/her custodial status; and raping, molesting, prostituting or otherwise sexually exploiting another person.

Sexual Assault - A sexual act that is coercive or assaultive in nature and that involves the use or the threat of force.

Sexual Contact - Includes, but is not limited to, the intentional touching, either directly or through clothing, of the genitalia, anus, groin, breasts, inner thighs, buttocks or any unwanted touching of any person with an intent to abuse, humiliate, harass, degrade, arouse or gratify the sexual desire of any person.

Sheltered Housing - A protective environment that does not require twenty-four (24) hour nursing care.
Sick Call - The system through which inmates receive health care for non-emergency illness or injury.

Special Mental Health Inmates - Includes inmates with basic psychotic disorders or mood disorders (e.g., manic-depressives), self-mutilators, sex offenders, substance abusers, aggressively mentally ill, those with post-traumatic stress disorders, and suicidal inmates.

Special Needs Inmates - Includes those with chronic diseases or conditions that require regular care.

Special Needs Treatment Plan - A document outlining the course of treatment for the inmate receiving health care, who has an identified special need. The Special Needs Treatment Plan includes the inmate's diagnosis, specific problems, goals, objectives, and designates staff responsibility for interventions, target dates, and outcomes. Specific individual Special Needs Treatment Plans are preferable although notation in the progress notes is another way of documentation (i.e., SOAP - subjective, objective, assessment, plan).

Specialty Care - Specialist-provided mental health care (i.e., psychiatry, neurology, neuropsychology, and addiction medicine) provided at a facility, specialty care clinic, or specialist's office.

Staff - Certified Medical Assistant, Certified Nursing Assistant, Emergency Medical Technician, Health Care Technician, Licensed Practical Nurse, Pharmacy Technician, or Registered Nurse.

Standard Precautions - Combine the major features of universal precautions (designed to reduce the risk of transmission of blood borne pathogens) and body secretion isolation (designed to reduce the transmission of pathogens from moist body substances), and apply them to all patients receiving care, regardless of their diagnosis or presumed infection status.

Standard Unit Inventory (SUT) - A supply of medications located outside the pharmacy, which will be signed out on an individual dose-by dose basis.

Standing Operating Procedures - A set of instructions covering those features of operation, which lend themselves to a definite or standardized procedure without loss of effectiveness.

Sterilization - The process of eliminating all microbes.

Suicide - A death that occurs at the hand of the deceased.

Suicide Watch - Defines a level of increased supervision and observation of inmates believed to be at risk for suicide. Mental Health Staff or correctional personnel may authorize a Suicide Watch. Two levels of Suicide Watch used are Constant Suicide Watch and Close Suicide Watch.

Tabletop Exercises - Discussions about health staff's projected response to emergencies.
Telemedicine - The use of video conferencing, telecommunications internet transfer, or other electronic and digital means utilized by providers.

Terminally Ill - An inmate whose physical condition has deteriorated to the point where he or she has a prognosis of months rather than years.

Therapeutic Restraints - A therapeutic intervention initiated by medical or mental health staff to use devices designed to safely limit a patient's mobility in a crisis due to physical or mental illness.

Therapeutic Seclusion - A therapeutic intervention initiated by medical or mental health staff to use rooms designated to safely limit a patient's mobility in a crisis due to mental or physical illness. Rooms used for therapeutic seclusion must allow clear visibility to all areas of the room to allow for continuous observation.

Transfer Inmate - An inmate transferred from one correctional facility to another or brought to the facility with an already established health record for their current incarceration (i.e., off-site treatment, off-site court appearance).

Treatment Plan - A document, typically developed by an Advanced Clinical Provider that outlines the course of treatment for the inmate receiving health services. Specific individual treatment plans are preferable although notation in the progress notes is another way a treatment plan can be documented (i.e., SOAP- subjective, objective, assessment, plan).

Triage - Assessment of injured for severity of need to determine who is in need of help and who can wait.

Universal Precautions - An approach to infection control. All human blood, body fluids containing visible blood and certain other body fluids will be considered potentially infectious material.

Use of Force - Physical force used to compel an inmate to take action against his/her will or to prevent an inmate from taking action that would be damaging to him/herself, other persons, or property. This does not include the routine use of restraints during transport.

Within Sight or Hearing - The inmate can gain the health care staff's attention through visual or auditory signals. Call lights and buzzer systems may be used, but the use of non-medical staff does not constitute compliance.

Written Agreement - A contract, letter of agreement, or memorandum of understanding between Proactive, and a hospital, clinic, or specialist for the care and treatment of patients.