Department of Public Safety and Correctional Services

Clinical Services & Inmate Health

Operations Manuals

Administration	Medical Records
Chronic Disease Management	Pharmacy Services
Infection Control	Pregnancy Management
Infirmary Care	Sick Call
Inmate Deaths	Substance Abuse
Medical Evaluations	

By signing this cover page, DPSCS officials responsible for the care and treatment of persons confined to their facilities give approval that the policies and procedures, reviewed and updated as needed annually and found herein, formally establish these processes to be acceptable to DPSCS.

Patricia Goins-Johnson, Executive Director Field Support Services

Sharon L. Baucom, MD Director of Clinical Services

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Date Reviewed	1/2013
	11/2014
	1/2015
	2/20/2016

Department of Public Safety and Correctional Services

Clinical Services & Inmate Health

Infirmary Care Manual

Date Reviewed	2/22/2012
	8/2013
	11/2014
	1/2015
	2/20/2016

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 1
INFIRMARY CARE GENERAL

I. Policy: All inmates in DPSCS regional infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures. **An inmate may not refuse placement/admission to the onsite infirmary, nor can they refuse transfer to another DPSCS medical facility for care. After the transfer is completed, the inmate may refuse care once they are seen by the medical personnel at the receiving site.**

II. Procedure:

A. Any inmate housed as a patient in the infirmary for treatment, observation, sheltered housing, or other medical care shall be placed on medical hold.

B. All DPSCS infirmaries shall be licensed by the State of Maryland and maintain DHMH certification of bed capacity.

C. All respiratory isolation beds will be maintained, inspected, and certified by the Department of Public Safety and Correctional Services industrial hygienist and contracted consultants. The State Chief Medical Officer or a designated health professional will determine the clinical indications for admission, as referenced in the Department of Public Safety and Correctional Services: Clinical Services Manual, DPSCS Medical contract, guidelines established by the Centers for Disease Control and Prevention (CDC), National Institute of Occupational Safety and Health (NIOSH), and Occupational Safety and Health Administration (OSHA), etc.

D. All DPSCS infirmary operations shall be promulgated in accordance with the following guidelines of the Patient Acuity Determination Process:

1. A patient acuity form shall be used to determine nursing staffing of the infirmary. The form is used to determine nursing staffing needs and to allocate necessary resources to match patient care needs. Every DPSCS Infirmary operation will include this analysis, as a daily routine procedure, in a log format available for DPSCS review.
2. The patient acuity form is used to determine patient acuity (See Infirmary Care Acuity Tool):
   a. Is placed on each infirmary patient chart, and is checked each shift with changes noted and is transferred to the staffing form. Staffing needs are determined from acuity calculations. Management will be notified if additional staffing is needed for any shift.
   b. Day shift: (8 a.m. – 4 p.m.) will determine acuity and plan staffing for the oncoming shift by 2 p.m.
   c. Night shift: (12 mid – 8 a.m.) will determine acuity and plan staffing for the oncoming shift by 6 a.m.
   d. Acuity Tool (points are as follows):

Confused/Disoriented Retarded/Unconscious	15
Vital Signs more often than four (4) hours	12
Special Teaching Needs	12
Special Education Needs	12
Continuous Observation	12
Incontinent/Diaphoretic	12
Sensory Deficits	8
Mobility Assistance	6
Respiratory Therapy (Oxygen)	6
Wound Skin Care	6
Provide Total Bath	5
Provide Nourishment	5

Intravenous Fluids/Lines	3
Total	___

3. Patient Classification Summary:

Level I	0-2	Points
Level II	21-40	Points
Level III	41-70	Points
Level IV	71+	Points

4. Consideration for additional staff will be advised if one RN has to care for more than two “Level 4” inmates and must be supported by the evaluation of need. The level of the additional inmate services required and evaluation of needs will determine the credential of additional providers to be considered.
5. Patient Classification For a Level Increase Additional Staff Consideration includes:
   a. Consideration of an additional CNA for Levels 1-2. Maximum of four (4) admissions.
   b. Consideration of an additional LPN for Level 3. Maximum of two (2) admissions.
   c. Consideration of an additional RN for Level 4. Maximum of two (2) admissions.
   d. A minimum of one RN and one LPN will staff each shift.
6. An infirmary log shall be maintained at each infirmary. It will include the following:
   a. The name, Identification number, admission and discharge diagnosis, disposition date and time of each infirmary admission, and discharge and community emergency room transfer and release.
   b. Identification of all pregnant women on the infirmary listing.
   c. A census report shall be made available, via e-mail, to a Utilization Management designee (copying the DPSCS Chief Nursing Officer and the ACOM) daily by 9 a.m. for the previous day. This will occur Monday through Thursday. The Friday, Saturday, and Sunday reports will be

submitted by 9 a.m. on the following Monday each week.

d. A census report of all pregnant women shall be submitted to the DPSCS: Clinical Services (DPSCS-CS) on a monthly basis. The report shall include the name, identification number, last menstrual period (LMP), trimester of gestation and estimated date of confinement, Rapid Plasma Regain (RPR), HIV status, high risk complications, and methadone maintenance.

7. The infirmary audits will be conducted by the contractor as referenced by its Continuous Quality Improvement (CQI) calendar.

III. References:

A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
B. NCCHC—Standards for Health Services in Prisions-2008
C. NCCHC---Standards for Health Services in Jails -2008 (JG08/P-G-08 Infirmary Care)
D. Clinical Practice in Correctional Medicine; Michael Puisis D.O et al—1999
E. DPSCSD 130-100, Section 160- Do Not Resuscitate
F. ACA Standards for Adult Correctional Institutions -4th Edition and ACA 2006 Standards Supplement
G. DPSCS Infectious Disease Manual
H. Advanced Directive/Living Will
I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227-a)
J. Appendix 2 DPSCS Infirmary Discharge Form (130-21 a)
K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)

IV. Rescissions: DCD 130-100 Section 120, March 1, 1994

V. Date Issued: July 15, 2007

Date Reviewed: September 17, 2009
November 30, 2010
September 19, 2011
October 15, 2012
May 23, 2013
July 5, 2013
December 3, 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 2
ADMISSIONS PROCEDURES

Part A
ADMISSIONS PROCEDURE: GENERAL INFORMATION

I. Policy: All inmates in DPSCS infirmaries both medical and mental health shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures. Informed consent for any and all medical/dental/mental health treatments, a "Consent to Treatment" form shall be completed before any medical/dental/mental health treatment or procedure may be performed. Emergency medical treatment shall be provided with or without consent as necessary for the health and well-being of the inmate. **An Inmate may not refuse placement/admission to the onsite infirmary, nor can they refuse transfer to another DPSCS medical facility for care. After the transfer is completed, the inmate may refuse care once they are seen by the medical personnel at the receiving site.** If the inmate is a minor, "Consent to Treatment" shall be obtained from the appropriate responsible person authorized to provide such a consent for that minor before any medical procedure is performed. (See Medical Records Manual – Chapter 1).

II. Procedure:

A. Inmates for whom off-site hospital care is not medically necessary but who require skilled nursing care and daily evaluation of their medical condition by a clinician will be placed in an appropriate infirmary for comprehensive care. These inmates will have vital signs measured as ordered by a clinician but no less than every shift and shall be weighed at least weekly.

B. Inmates shall be evaluated for admission to the infirmary by a licensed provider. An order, verbal or written by a provider must be completed before an inmate receives treatment in an infirmary setting. A midlevel provider shall have any admission order co-signed within twenty-four (24) hours by a physician. Only the Medical Director or his/her designate can admit inmates to the infirmary.

C. Prior to transferring an inmate to the infirmary documentation of a discussion of the case with the medical and/or psychiatric medical director by the clinician referring the inmate for admission shall be completed.

D. Within twenty-four (24) hours of notification of an admission into a mental health infirmary a medical consultation shall be completed and will include the following documentation:

1. Suspected somatic diagnosis if any
2. Stability /condition
3. Diet; activity
4. Vital signs
5. Admitting laboratory tests if indicated
6. Chronic care medications

7. Problem list
8. Other physician orders pertinent to the admitting diagnosis
9. History and physical examination shall be documented on the medical record by a provider within twenty-four (24) hours of admission to the infirmary utilizing the DPSCS Infirmary Admission History and Physical Form.
10. A MOLST Form shall be completed by the Physician or Certified Registered Nurse practitioner as a part of the admissions procedure.

E. A physician's evaluation including an individualized treatment plan shall be documented in the infirmary medical record within twenty four (24) hours of the infirmary admission.

F. Daily progress notes by the clinician shall be done and any abnormal laboratory tests or X-rays shall be addressed in the progress notes and the documentation signed with the provider's title, date and time of day.

G. A nursing care plan shall be developed and documented; including the date of each entry or revision in the infirmary medical record within twenty-four (24) hours of the infirmary admission,

H. Inmates who require monitoring or care by a licensed nurse for less than twenty-four (24) hours are eligible for observation status. Such inmates include but are not limited to:
1. Pre-operative or pre-procedure inmates requiring NPO (nothing by mouth) status or preparation of post hospital discharge inmates who require evaluation prior to return to housing

2. Inmates recovering from a clinical condition that rendered them temporarily unstable or altered state of consciousness (seizure or an insulin reaction, or other conditions). These inmates will be monitored and evaluated for stability with vital signs measured until considered out of risk by the admitting provider.

I. Inmates who cannot independently complete their activities of daily living due to chronic medical condition or advanced age are eligible for sheltered housing status. Nursing staff will provide necessary assistance with activities of daily living. These inmates will be evaluated at least monthly by a clinician and weekly by a professional nurse, have documented progress notes, and vital signs as per policy (See Chapter 3/Sections A and B of this Manual)

J. Inmates refusing to eat or who have an acute exacerbation of a chronic mental illness are eligible for infirmary admission at the direction of a psychiatrist or somatic clinician as appropriate. All admissions to medical infirmaries shall be permitted by the medical Director of the facility prior to admission. These inmates will be seen daily by a mental health professional and a somatic clinician and have vital sign measurement and nursing assessment on each shift.

K. Discharge summary of an inmate from the infirmary will be completed by a physician by using the DPSCS Infirmary Discharge form within twenty-four (24) hours of discharge.

III. References:

A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
B. NCCHC – Standards for Health Services in Prisons -2008
C. NCCHC –Standards for Health Services in Jails -2008 (*J-G-03/P-G-03 Infirmary Care*)

D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al – 1999
E. DPSCSD 130-100, Section 160 – Do not Resuscitate
F. ACA Standards for Adult Correctional Institutions – 4th Edition and ACA 2006 Standards Supplement
G. DPSCS Infectious Disease Manual
H. Advanced Directive/Living Will
I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227 aR)
J. Appendix 2 DPSCS Infirmary Discharge Form (130-21aR)
K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)
L. Appendix 4 Infirmary Care Acuity Tool
G. MOLST Form

IV. Rescissions: DCD 130-100 Section 120, March 1, 1994

V. Date Issued: July 15, 2007
Reviewed/Revised: September 17, 2009
Reviewed/Revised: September 9, 2010
Reviewed/Revised November 29, 1010
Reviewed September 19, 2011
Reviewed/Revised 8, 2012
Reviewed/Revised October, 2012
Reviewed/revised May 23, 2013
Reviewed/revised July 5, 2013
Reviewed/revised November 2014
Reviewed December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 2
ADMISSION PROCEDURES
Section B

ADMISSION PROCEDURE: MOLST
(Maryland Orders for Life-Sustaining Treatment)

I. Policy: DPSCS Clinical Services will provide a standardized medical order form covering options for CPR (Cardio-Pulmonary Resuscitation) and other life-sustaining treatments that is portable and enduring, is valid in all health settings (making it transferable to hospitals and other treating agencies), and which helps to increase the likelihood that a patient's wishes regarding life-sustaining treatment are honored. This is in accordance with the Maryland 1993 Health Care Decisions Act.

II. Procedure:

A. MOLST recognizes (as does the Health Care Decisions Act) that a patient:

1. Is presumed to have capacity until two physicians certify that the individual lacks the capacity to make health care decisions or a court has appointed a guardian of the person to make health care decisions.

2. If the individual lacks capacity, the attending and a second physician must certify in writing that the capacity is lacking.
    a. One of the physicians must have examined the patient within two hours before making the decision to declare capacity.
    b. Only one physician certification is needed if the patient is unconscious or unable to communicate by any means.
3. That if there is no health care agent, Maryland law specifies the type and order of the surrogate decision maker as follows:
    a. Guardian of the person.
    b. Spouse or domestic partner.
    c. Adult child.
    d. Parent.
    e. Adult brother or sister.
    f. Friend or other relative.
4. That all surrogates in a category (above) have the same authority, that all in an equal category must agree on a decision regarding life-saving measures, and that a physician may not withhold or withdraw life sustaining procedures if there is disagreement among persons in the same category. To resolve disputes among equally ranking surrogates:
    a. Hospitals and nursing homes are required to have a patient care advisory committee and issues are to be referred to them.
    b. The attending physician has immunity from following the recommendations of the advisory committee.

c. The process used in determining the correct surrogate decision maker will be documented in the medical Record.

B. An advanced directive can be made only by the patient and only he or she can revoke that directive except in the following instances:

1. The attending physician and a second physician has certified the patient as incapacitated.
2. There is certification by the attending physician and a second physician of:
   a. Terminal illness (defined as a condition that is incurable, there is no recovery despite life sustaining procedures, and death is imminent as defined by the physician.
   b. End stage condition. (Defined as an advanced progressive and irreversible condition, severe and permanent deterioration indicated by incompetency and complete physical dependency, or treatment of the irreversible condition would be medically ineffective.
   c. Persistent vegetative state. (Defined as an individual with no awareness of self or surroundings, and/or there is only reflex activity and low level conditioned reflexes.
3. Two physicians certify a treatment as medically ineffective for the particular patient. Medically ineffective is defined as a medical procedure that will not prevent or reduce the deterioration of the patient's health or prevent impending death.

C. Maryland MOLST is a standardized medical form covering options for CPR and other life sustaining treatments. It is portable and

enduring, valid in all health care settings, and helps to increase the likelihood that a patient's wishes regarding life sustaining treatments are honored.

1. It replaces the MIEMSS (Maryland institute for Emergency Medical Systems Services) and the Life Sustaining Treatment Options (LSTO) form that was previously used primarily in nursing homes.
2. The practitioner in using these forms is certifying that the order he or she is entering is the result of a discussion with and the informed consent of the:
    a. Patient,
    b. Patient's health care agent as named in the patient's advanced directive,
    c. Patient's guardian,
    d. Patient's surrogate, or
    e. Minor's legal guardian or another legally authorized adult.
3. If the patient or his/her surrogate declines to make selections regarding MOLST issues, the clinician will record this wish in the medical record and inform the patient that he or she will receive all care as provided by law and that CPR will be administered, and other treatments will be given.

C. The MOLST form and its accompanying patient instruction can be completed by any actively licensed Maryland physician or Maryland Certified Registered Nurse Practitioner (CRNP).

1. The physician or CRNP that signs the form is responsible for the patient medical orders.
2. At no time may a practitioner pre-sign any blank forms.
3. DPSCS medical and mental health vendor doctors and CRNPs shall initial specific treatment (patient selection) orders on the MOLST form.

4. The clinician shall review MOLST orders:
    a. Annually.
    b. When a patient is transferred between health care facilities (the receiving facility does the review.)
    c. When the patient is discharged.
    d. When the patient has a substantial change in health status.
    e. When the patient loses capacity to make health care decisions.
    f. When the patient changes his or her wishes. (can be done at any time).
5. To change a MOLST form, the clinician voids the existing MOLST form and completes and signs a new MOLST form that reflects the patient's wishes and current medical orders. Both old and new forms shall remain in the chart with dates of the completion of each and the date of the void and re-design of the new form on each.
    a. The original, a copy, and a fax of the MOLST form are all valid orders so the dates are of most importance to assure the patient's current wishes are honored.
    b. MOLST is printed on WHITE paper.

D. DPSCS requirements for completing the MOLST forms include a requirement for:
1. All persons receiving dialysis treatments.
2. All persons admitted to an infirmary for sheltered care.
3. All persons admitted to medical and mental health infirmaries.

E. Because the completion of an item on the MOLST form is considered to be a medical order, the clinician (physician or CRNP) will complete the MOLST forms while providing instruction to the

patient. MOLST covers the following areas of concern and choices will be explained to a patient by the clinician completing the forms. The forms follow the same order as the items covered in those forms as noted below. (For forms, see Attachments):

1. CPR choices include:
    a. Attempt CPR – If cardiac or pulmonary arrest occurs, CPR will be attempted.
    b. No CPR, Option A-1 Intubate – Comprehensive efforts to prevent arrest shall include intubation.
    c. No CPR, Option A-2 – Do not intubate. Do not intubate but use CPAP (Continuous positive airway pressure) or BiPAP (Bi-level positive airway pressure).
    d. No CPR – Palliative and supportive care only.
2. Artificial ventilation choices include:
    a. Accept artificial ventilation indefinitely, including intubation, CPAP, and BiPAP.
    b. Time limited trial of intubation.
    c. Time limited trial of CPAP and BiPAP but no intubation.
    d. No artificial ventilation: No intubuation, CPAP or BiPAP.
3. Blood transfusion choices include:
    a. Accept transfusion of blood products, including plasma, whole blood, packed red cells, or platelets.
    b. No blood transfusions with any of the above named products or artificial products on the market.
4. Hospital transfers choices include:
    a. Accept hospital transfer.

b. Hospital transfer only for limited situations, including severe pain or severe symptoms that cannot be controlled otherwise.
c. No hospital transfer, but treat with options available outside of the hospital.

5. Medical workup choices include:
   a. Accept any medical tests.
   b. Limited medical tests are acceptable when necessary for symptomatic treatment or comfort.
   c. No medical testing for diagnosis or treatment.
6. Antibiotic Choices include:
   a. Accept antibiotics.
   b. Oral antibiotics (not IV or IM).
   c. Oral antibiotics for relief of symptoms only.
   d. No antibiotics.
7. Artificially administered fluids and nutrition choices include:
   a. Accept artificial fluids and nutrition, even indefinitely.
   b. Accept time limited trial of artificial fluids and nutrition.
   c. Accept a time-limited trial of artificial hydration only.
   d. No artificial fluids or nutrition.
8. Dialysis choices include;
   a. Accept dialysis including hemodialysis and peritoneal dialysis.
   b. Accept time limited trial of dialysis.
   c. No dialysis.
9. Other orders:
   a. May be used to indicate preferences for other life-sustaining treatments such as chemotherapy and radiation.
   b. Should not be used for ambiguous phrases such as “comfort care.”

F. All matters discussed with the patient regarding MOLST issues shall be recorded in the medical record

1. The patient will be given a copy of the completed MOLST form within forty-eight (48) hours of its completion.
2. If the patient leaves the facility in less than 48 hours, he or she will be given a copy of the completed MOLST when they are discharged or transferred.

G. On discharge or transfer, the MOLST form shall accompany the patient to his or her new facility or location. The transferring facility shall keep the original form in the patient's medical record.

III: References: http://marylandmolst.org/
http://marylandmolst.org/docs/Maryland%20MOLST%20FAQs.pdf
http://www.oag.state.md.us/Healthpol/index.htm
http://www.hfam.org/event/maryland-molst-train-the-trainer-program-5/
Pending MOLST Legislation Title 10 DHMH Subtitle 01: 10.01.21

IV. Rescissions: INMATE DEATHS MANUAL:Chapter 2
INMATE INITIATED FORMS,Section A
DO NOT RESUSCITATE
INMATE DEATHS MANUAL: Chapter 2
INMATE INITIATED FORMS, Section B
ADVANCED DIRECTIVES

V. Date Issued: October, 2012
July 2013
December, 2015

Attachment A

INSTRUCTIONS

Completing the Form: The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician or nurse practitioner signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

Selecting CPR (Resuscitation) Status: EMS Option A-1 – Intubate, Option A-2- Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

> **No-CPR Option A: comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest/ DNR if Arrest – No CPR, This choice may be made either with or without intubation as a treatment option.** Prior to arrest, all interventions allowed under *The Maryland Medical Protocols for EMS Providers*. Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devises used for ventilatory assistance. In all cases, comfort measures will also be provided. No CPR if arrest occurs.
>
> **No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest. DNR if Arrest Occurs – No CPR.** Prior to arrest, interventions may include may include the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medication by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by the original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable *Maryland Medical Protocols for EMS Providers.* Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

Location of Form: The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders in a the patient's medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a coy and a faxed MOLST form are all valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

Reviewing the Form: These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians or nurse practitioners shall review and update if appropriate the MOLST orders **annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.**

Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician or nurse practitioner shall void the old form and complete, sign, and date a new MOLST form.

Voiding the Form: To void this medical order form, a physician or nurse practitioner shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician or nurse practitioner to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

Revoking the Form's DNR Order: In an emergency situation EMS providers, the DNR order in Section 1 may be revoked a any time by a competent patient's request for resuscitation made directly to responding EMS providers.

Bracelets and Necklaces: If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing. If a mental bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic alert requires a copy of this order along with an application to process the request.

How to Obtain this Form: Call 410-706-4367 or go to dhmh.maryland.gov/marylandmolst

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	□ Male □ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. Blank order forms shall not be signed. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply. Otherwise, leave this section blank.
I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:
_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person; or
_____ the patient's surrogate; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.
Or, I hereby certify that these orders are based on:
_____ instructions in the patient's advance directive; or
_____ certification by two physicians that CPR and/or other specific treatments will be medically ineffective.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary. If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

1 **CPR (RESUSCITATION) STATUS:** EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

_____ **Attempt CPR**: If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.
[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

_____

No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

_____ **Option A-1, Intubate**: Comprehensive efforts may include intubation and artificial ventilation.

_____ **Option A-2, Do Not Intubate** (DNI): Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

_____

_____ **No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

PHYSICIAN'S OR NURSE PRACTITIONER'S SIGNATURE (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

Patient Last Name, First, Middle Initial	Date of Birth	Page 2 of 2 □ Male □ Female

Order in Section 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Section 2 through 8, and only select one choice per applicable Section.

2 **ARTIFICIAL VENTILATION**

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit _____

2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.
Time limit _____

2d. _____ _ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

3 **BLOOD TRANSFUSION**

3a. _____ May give any blood produce (whole Blood, packed red blood cells, plasma or platelets) that is medically indicated.

3b. _____Do not give any blood products

4 **HOSPITAL TRANSFER**

4a. _____ Transfer to hospital for any situation requiring hospital-level care.

4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

5 **MEDICAL WORKUP**

5a. _____ May perform any medical test indicated to diagnose and/or treat a medical condition.

5b. _____ Only perform limited medical test necessary for symptomatic treatment or comfort.

5c. _____ Do not perform any medical test for diagnosis or treatment.

6 **ANTIBIOTICS**

6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

6b. _____ May use oral antibiotics administered indicated, but do not give intravenous or intramuscular antibiotics.

6c. _____ May use oral antibiotics only when For symptom relief or comfort.

6d. _____ Do not treat with antibiotics.

7 **ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION**

7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medially indicated.

7b. _____May give artificially administered fluids and nutrition, if medically indicated, as a trial. Time limit _____

7c. ___ May give fluids for artificial hydration as a therapeutic trial, but do not Give artificially administered nutrition. Time limit _____

7d._____ Do not provide artificially administered fluids or nutrition.

8 **DIALYSIS**

8a. _____May give chronic dialysis for end-stage Kidney disease if medically indicated.

8b. _____ May give dialysis for a limited period. Time limit _____

8c._____ Do not provide acute or chronic dialysis.

9 **OTHER ORDERS**

_____

_____

PHYSICIAN'S OR NURSE PRACTITIONER'S SIGNATURE (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician or NP sign, cut off strip, fold and insert in bracelet or necklace.

□ DNR A-1 Intubate □ DNR A-2 Do Not Intubate □ DNR B

Pt. Name _____ DOB _____

Phys./NP Name _____ Date _____

PHYS./NP Signature _____ Phone _____

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 3
MEDICAL MANAGEMENT OF INFIRMARY PATIENTS

Section A
ACUTE CARE PATIENTS

I. Policy: All inmates in DPSCS regional infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirements of health care contracts, law, and regulation and established procedures.

II. Procedure:

Infirmary patients shall be medically managed in accordance with the following guidelines; depending upon the level of infirmary care.

A. All DPSCS infirmaries shall have a licensed physician assigned the responsibility of the medical management of infirmary patients who will ensure compliance with the DPSCS medical contract.

B. All DPSCS infirmaries shall have twenty-four (24) hour physician on-call coverage daily except clinician services are available 24/7. At a minimum, the infirmary medical director shall be on-site within the infirmary area in accordance with the DPSCS medical contract designated hours.

C. All DPSCS infirmaries shall have twenty-four (24) hour on-site nursing coverage daily by a registered nurse within the infirmary area. If there is more than one (1) floor of infirmary beds in the facility, and RN specifically assigned to that floor will cover a designated infirmary area.

D. All inmates housed in the infirmary for comprehensive care shall have a nursing assessment once every shift documented in the medical record one of which

must be a daily comprehensive nursing assessment by a Registered Nurse to include: (S) subjective data; (O) objective data; (A) assessment, and (P) treatment care plan.

E. All inmates housed in the infirmary, except those who are in "sheltered housing" shall have a clinician assessment documented daily in the progress notes.

F. Progress notes shall include patient education and specific instructions as to disease process referenced. They shall include documentation of review of all laboratory testing, X-rays, and consultations that are abnormal with a plan of action or recommendation. The date and time of the note will be documented and signed by the writer/provider.

G. Nursing staff shall conduct safety and sanitation inspections on a daily basis to ensure a safe infirmary environment.

H. Inmates shall be admitted and discharged to and from the infirmary units and medically managed in accordance with the Clinical Services Manual.

I. The attending physician shall discuss medical treatment options with all terminally ill inmates admitted to the infirmary in accordance with the Clinical Services Infirmary Care Manual (Medical Orders for Life Sustaining Treatment).

III. References:

A. DHMH COMAR 10.07.12 Health Care Facilities with Correctional Institutions

B. NCCHC- Standards for Health Services in Prisons—2008

C. NCCHC- Standards for Health Services in Jails- 2008 (J-G-03/P-G Infirmary Care)

D. Clinical Practice in Correctional Medicine, Michael Puisis D.O. et al- 1999

E. DPSCSSD 130-100, Section 160- Do Not Resuscitate

F. ACA Standards for Adult Correctional Institutions- 4th Edition and ACA 2006 Standards Supplement

G. DPSCS Infectious Disease Manual

H. Advanced Directive/Living Will

I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227 aR)

J. Appendix 2 DPSCS Infirmary Discharge Form ((130-21 aR)

K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)

L. Appendix 4 Infirmary Care Acuity Tool

IV. Rescissions: DCD 130-100 Section 120, March 1, 1994

V. Date Issued: July 15, 2007

Date Reviewed: September 16, 2009
November 30, 2010
September 19, 2011
October 15, 2012
July 2013
December 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 3
MEDICAL MANAGEMENT OF INFIRMARY PATIENTS

Section B
SHELTERED HOUSING PATIENTS

I. Policy: Persons admitted to DPSCS infirmaries for the purpose of sheltered housing/ long term non-acute care shall have documented indications for admissions, a long term treatment plan, and documented discharge potential. Each shall be monitored by nursing and medical providers in accordance with the requirements of health care contracts, law, regulation and established procedures.

II. Procedure:

A. All DPSCS infirmaries shall have a licensed physician assigned the responsibility for medical management of infirmary patients who will ensure compliance with the DPSCS-Clinical Services Manual and the DPSCS medical contract.

1. All DPSCS infirmaries shall have twenty-four (24) hours physician on-call coverage daily seven days per week. At a minimum, the infirmary medical director shall be on-site within the infirmary area in accordance with the DPSCS medical contract designated hours.

2. All DPSCS infirmaries shall have twenty-four (24) hour on-site registered nursing coverage daily and that staff will be located within the infirmary area. If there is more than one floor of infirmary beds in a facility, an RN specifically assigned to that floor will cover a designated infirmary area.

B. Sheltered housing/ long-term non-acute care patients shall be seen and assessed by a physician no less than once every thirty days with documentation of his/her findings of that assessment in the Electronic Medical Record (EMR). They will be seen by nursing no less than once each shift for inquiries to general well-

being and inquiries as to needs. All visits shall be documented as completed with findings in the patient's medical record.

1. All non-acute patients will be seen more frequently if their medical/mental health conditions merit a need for clinical intervention. This includes additional vital signs over the required as stated in this policy.
2. These patients shall have a chart review no less than weekly with documentation of that review by the physician.
3. Inmates returning from the hospital after discharge from an inpatient, outpatient or emergency unit shall have infirmary patient status for at least 24 hours and after 24 hours may be evaluated by a physician to return to sheltered housing status.

C. All inmates housed in the infirmary for sheltered housing/long term non-acute care shall have:

1. A patient specific care plan reviewed and updated no less than once every 90 days at a treatment plan review multidisciplinary team meeting.
   a. Multidisciplinary team meeting for this purpose will be pre-scheduled for each three month period in advance of that period and the schedule will be made available to the DPSCS-Clinical Services Office and via the DPSCS Chief Nursing Officer.
   b. The multidisciplinary team shall consist of all persons treating the patient including medical, nursing, mental health, dietary, social work, physical and occupational therapy (if appropriate).
   c. All team meeting will generate minutes that will include the person reviewed for that day, those in attendance, changes in care/treatment plans to be implemented.
   d. All care/treatment plans shall reflect changes made at these meetings and will be signed by those persons participating in the treatment plan meeting.
   e. Nursing will document treatment plan meeting held in the electronic records of those patients reviewed immediately following each planning meeting.

2. Vital signs to include blood pressure, pulse, and respirations shall be obtained and documented at least once in each twenty-four hour period, unless a patient's condition indicates the need for more frequent vital signs. Abnormal vital signs shall be reported immediately to the clinician assigned to the infirmary patients.
3. All patients regardless of condition shall be weighed no less than once every week, and more frequently if medically indicated.
4. Disease specific testing such as spirometry, glucose testing shall be completed with the frequency ordered by the clinician.
5. Height and weight measurements will be completed at the time of the weekly nursing assessment.
6. A complete nursing assessment by a registered nurse once each week on a set day for that patient with documentation in the medical record to include:
    a. (S) Subjective data, (O) Objective data, (A) Assessment, and (P) treatment care plan.
    b. Progress notes shall include patient education and specific instructions as to disease process referenced.
    c. Notes shall include documentation of review of all laboratory testing, x-rays, and consultations that are abnormal with a plan of action or recommendation.
    d. The date and time of the note will be documented and signed by the writer/provider.

D. Nursing staff shall conduct safety and sanitation inspections on a daily basis to ensure a safe infirmary environment and report abnormal findings to the Infection Control Team for that facility.

E. Inmates shall be admitted and discharged to infirmary isolation units and medically managed in accordance with the DPSCS: Clinical Services Manual.

F. The attending physician shall discuss medical treatment options with all terminally ill inmates admitted to the infirmary in accordance with the DPSCS: Clinical Services Manual, (Medical Orders for Life Sustaining Treatment).

1. The results of this discussion shall be documented in the patient Progress Note.
2. Should a patient want to be a DNR, the appropriate forms (including EMS specific forms) shall be completed and maintained in the front of the medical record.
3. The DNR status alert pop-up shall also be activated in EMR.

III. References:

A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
B. NCCHC—Standards for Health Services in Prisons—2014
C. NCCHC ---Standards for Health Services in Jails---2014 (J-G-03/P-G_03 Infirmary Care)
D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al –1999
E. DPSCSD 130-100, Section 160- Do Not Resuscitate
F. ACA Standards for Adult Correctional Institutions—4th Edition and ACA 2006 Standards Supplement
G. DPSCS Infectious Disease Manual
H. Medical Order for Life Sustaining Treatment
I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227-aR)
J. Appendix 2 DPSCS Infirmary Discharge Form (130-21aR)
K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)
L. Appendix 4 Infirmary Care Acuity Tool

IV. Rescissions: DCD 130-100 Section 120, March 1, 1994

V. Date Issued: February 21, 2012
Reviewed: October 15, 2012
July 2013
December 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 4
TRANSFERS
(INCLUDING THOSE FROM/TO A COMMUNITY HOSPITAL)

Section A
SOMATIC INFIRMARY

I. Policy: All inmates in DPSCS regional infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures. **An Inmate may not refuse placement/admission to the onsite infirmary nor can they refuse transfer to another DPSCS medical facility or community hospital for care. After the transfer is completed, the inmate may refuse care once they are seen by the medical personnel at the receiving site.**

II. Procedure:

A. Inmates admitted to the infirmary who develop problems that cannot/should not be managed in the infirmary setting, shall be immediately transferred to an appropriate hospital for care.

B. A transfer note summarizing the medical indications for hospitalization shall be documented in the progress notes by a clinician and appropriate information regarding the inmate's condition including a copy of an advanced directive may accompany the inmate.

C. All inmates discharged from a community hospital for inpatient or outpatient services (ER visit, same-day surgery, etc.) shall be transferred to a DPSCS infirmary for evaluation in accordance with the following guidelines:

1. The Medical Director for the area to which a patient is to be transferred shall

approve the admission.

a. Medical Director shall notify the attending physician for the infirmary as well as the local Director of Nursing (DON) and Infirmary charge Nurse for the area by telephone
b. That call shall include a brief synopsis of the patient's condition and pending medical needs
c. The DON shall share with the Medical Director and the vendor's Statewide Director of Nurses any concerns such as necessary skills sets for a particular treatment or care, staffing issues, and determine how any deficits will be corrected before the patient is received
d. DON/designee shall make arrangements for all items that may not already be on hand before the patient's arrival. This will be done without delaying the patient transfer.
e. Needs may include a provision for external specialist to make regular visits for the purpose of providing care not available through the vendor's staff (such as but not exclusive to special infusion therapy or respiratory needs.)

2. All inmates shall be evaluated by a physician upon transfer from the community hospital prior to placement in general population or a DPSCS Infirmary.
3. The physician shall determine if infirmary admission is medically indicated or if the inmate can be housed in the general population.
   a. Any indication to admit or not to admit the inmate to the infirmary must be documented in the medical record.
   b. Any inmate who returns to a site where no clinician is available to assess the inmate for infirmary admission, must be evaluated by the infirmary nurse who will contact the on-call physician, review the case and document the decision to admit or not. If the inmate is to be admitted, the on-call physician shall also provide verbal admission orders to the infirmary nurse.
   c. The provider must then follow-up and sign the verbal order within twenty-

four (24) hours and see the inmate during his or her first full day following a return from the hospital or other infirmary.

4. A review of the treatment recommendations by the discharging physician of the community hospital should be documented in the medical record in the form of a progress note, for all inmates who are admitted to the infirmary upon return. If any recommended treatment(s) will not be followed, the rationale should be documented in the medical record with the alternative treatment considerations.
5. Temporary post hospitalization housing shall be handled in the following manner:
    a. Those persons returning who were housed just prior to hospitalization in facilities of the Baltimore Service Delivery Area (SDA) shall be returned to the Infirmary at MTC (The Ferlene Bailey Infirmary) for evaluation by a clinician for clearance to return to general population or special housing as appropriate and in collaboration with Custody housing assignment processes.
    b. Those persons returning from local community hospitals which may include Baltimore area hospitals and who were housed in the Jessup Service Delivery Area just prior to hospitalization shall be transported to the Jessup Regional Hospital/Jessup Correctional Institute Infirmary for evaluation by a clinician for clearance to return to general population or special housing as appropriate and in collaboration with Custody housing assignment processes.
    c. Those persons returning from the local community hospitals and who were housed in the Eastern or Western Service Delivery Areas just prior to hospitalization shall be transported to their respective SDA infirmary for evaluation by a clinician for clearance to return to general population or special housing as appropriate and in collaboration with Custody housing assignment processes.
    d. Persons from the Western Service Delivery Area that have had a twenty-three (23) hours admission shall be returned to their original Service

Delivery Area (Cumberland or Hagerstown) Infirmary where they shall be evaluated by clinician or Registered Nurse for clearance to return to general population or special housing as appropriate and in collaboration with Custody housing assignment processes.

D. All inmates admitted to the infirmary shall be placed on “Medical Hold” by the regional medical director or his/her designee through a written order on the medical record. Case Management shall be notified using the designated forms.

E. Inmates may be transferred from one DPSCS infirmary to another only with pre-approval of the DPSCS Chief Medical Officer/Medical Director or his/her designee. Phone permission/e-mail by the DPSCS Chief Medical Officer/Designee should be followed by written documentation and placed in the infirmary medical record. The regional Agency Contract Operations manager (ACOM) should be made aware of the transfer. The on-site medical provider at both the sending and receiving facility shall follow the “Notification Cascade” to include the following:

1. Security
2. Case Management
3. Warden’s Office
4. Agency Contract Operations Manager

F. Tuberculosis isolation cell transfers must include a communication to the Infectious Disease Director and the Infectious Disease coordinators for the regions. Any inmate occupying a respiratory isolation bed who is not a “rule out TB” case will be removed if the need for a respiratory bed arises in a region before transfers to alternative regions will be done.

G. Non TB observation patients who are temporarily housed in respiratory isolation units must be reported to the DPSCS TB Coordinator as soon as possible by cell phone, pager, voice mail, electronic mail, as inmates are moved twenty-four (24) hours a day, seven (7) days a week including holidays and weekends. It is the responsibility of the medical provider, who made the decision to admit to a respiratory isolation unit, to make certain the facility Infection Control Administrator is informed of the admission to the unit, who in turn shall alert

DPSCS Chief Medical Director of the admission to the unit.

H. Documentation of Hand Washing, Universal Precautions for Nursing and Custody, and inmate worker staff training on a scheduled quarterly basis through in-service training shall be made available to the ACOM.

I. Telemedical infirmary patients (TB, HIV, etc.) who are admitted to an infirmary and who are HIV positive and have not been presented for HIV telemedicine consultation will be incorporated into the next scheduled telemedical conferencing through coordination with the Regional Infectious Disease Coordinator. The attending Physician will present the clinical information without the inmate in attendance if circumstances prevent it. The provider will make sure that all the information required by the HIV directive (laboratory tests, medications, old medical record information, etc.) has been provided to the Infectious Disease Consultant at least one week prior to the presentation including CD4 count, viral load, primary diagnosis, medication regime, scans, and liver function.

J. In the event that any special equipment is needed, (such as but not limited to, intravenous needs, tube feeding, respiratory equipment, special beds, wound care, ambulatory assistance devices, etc.) the Medical Director or the Vendor's Director for utilization Review shall notify the DON and staff in the infirmary staff, so that the equipment can be available prior to placement of the patient in an infirmary bed.

    1. If equipment requires the implementation of skills that existing staff do not possess, home health or other specialists shall be maintained by the vendor to provide the special service to the patient for as long as it is needed.
    2. Infirmary staff shall receive training in the area of special care prior to the arrival of the patient and ongoing during the patient's stay.
    3. While no patient shall be placed until all supplies and special staff are available as needed for the care and safe treatment of a patient, there will be no more than a twenty-four (24) hour delay in the placement while arrangements are made.

III. References:

A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
B. NCCHC—Standards for Health Services in Prisons—2008
C. NCCHC---Standards for Health Services in Jails---2008 ((J-G-03/P-G-03 Infirmary Care)
D. Clinical Practice in Correctional Medicine: Michael Puisis D.O. et al -2006
E. DPSCSSD 130-100, Section 160—Do Not Resuscitate
F. ACA Standards for Adult Correctional Institutions –4th Edition and ACA 2006 Standards Supplement
G. DPSCS Infectious Disease Manual
H. Advanced Directive/Living Will
I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130—227 aR)
J. Appendix 2 DPSCS Infirmary Discharge Form (130-21 aR)
K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)
L. Appendix 4 Infirmary Care Acuity Tool

IV. Rescissions: DCD130-100 Section 120, March 2, 1994

V. Date Issued: July 15, 2007
Reviewed/Revised: September 22, 2009
December 7, 2010
September 15, 2011
October 2012
May 23, 2013
December 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 4
TRANSFERS

Section B
MEDICAL CLEARANCE FOR TRANSFERS TO MENTAL HEALTH UNIT

I. Policy: Medical clearance must be established prior to admitting an inmate to a mental health unit. No inmate may be transferred to the unit until this clearance is verified. Medical clearance is the process that results in a determination; that within reasonable medical certainty there is not a medical condition causing or contributing to the presenting psychiatric complaint; there is no concern at present of a medical emergency or a medical condition that cannot be safely managed on the intended mental health unit in conjunction with a medical provider designee; and that the inmate is medically stable to transfer to the mental health unit. **This clearance includes a direct evaluation of the inmate by a physician or physician assistant (PA) or nurse practitioner (NP) within 24 hours prior to admission.** Any correctional employee or contractual staff may refer an inmate to the psychology department for possible intervention, if he/she has reason to believe that the inmate may be in need of mental health services. If the inmate cannot be managed by the mental health department on an outpatient basis, a referral for evaluation and admission for treatment in the mental health unit may be initiated. **An inmate may not refuse placement/admission to the mental health unit nor refuse transfer to a medical infirmary or any other medical facility for care. After the transfer is completed, the inmate may, however, choose to refuse treatment.**

II. Procedure:

A. During business hours, (8:00am to 4:30pm) all referrals for mental health intervention will be addressed by the DPSCS psychology department. After business hours, when psychology staff are off-site, referrals will be directed to the on-site medical unit nurse.
B. The medical unit nurse then contacts the on-call psychiatry provider to discuss the case and arrive at a disposition/plan for the inmate.
C. Inmates being considered for transfer to the mental health unit must undergo a medical clearance process on a medical unit.
D. The referring psychology or psychiatry staff member must also alert the mental health unit nurse of a potential admission awaiting medical clearance.
    1. Upon arrival at the medical unit, a medical unit nurse reviews the Referral to Acute Mental Health Unit Form (Appendix A). If Parts 1, 2, and 3 are incomplete because no mental health professional was available, then the medical unit nurse shall complete parts 1, 2, and 3 of the Referral to Acute Mental Health Unit Form.
    2. The medical unit nurse shall complete Part 4 of the Referral to Acute Mental Health Unit Form (Appendix A - **MEDICAL CLEARANCE TEMPLATE FOR EPHR)** by obtaining the following information from the inmate/inmate health record:
        a. Medical Problems
        b. Vital signs
        c. Current medications
        d. Compliance with medications
    3. A medical provider then conducts a complete H & P, sufficient to screen for major medical problems to include a documented neurological examination.
        a. If the inmate presents as **suicidal**, a physician, PA or NP can conduct the physical exam.
        b. If the inmate presents with **altered mental status** (defined as not oriented to time place or person, semi-conscious, combative, hallucinating, etc.) a physician must conduct the physical exam.

4. The medical provider shall authorize or deny medical clearance for transfer to the mental health unit based upon the inmate's clinical presentation and findings of the H & P. The medical provider shall designate the inmate as one of four medical clearance classifications—MC-1, MC-2, MC-3, and MC-4 (See Appendix B).
5. The medical provider documents the exam and findings in the EHR and completes the remaining portion of Part 4 of the Referral to Acute Mental Health Unit Form.
    a. Decision on medical clearance
    b. Frequency of follow-up by medical providers, once the inmate is on the mental health unit
    c. Date/time of medical clearance
    d. Name/Signature/credentials
    e. Stable, not stable
6. The medical provider and the psychiatric provider on the mental health unit (or the on-call psychiatry provider, if no psychiatry provider is available) must communicate when clinically indicated to discuss:
    a. Any concerns raised by the receiving facility
    b. Any medications findings that will be of concern if the inmate is admitted to the mental health unit (MC-2 or MC-3)
    c. Any medical findings that will render the inmate not medically cleared and in need of admission to a medical unit (MC-1)
    d. A plan/disposition for an inmate who is refusing the physical examination (MC-2), MC-3, MC-4). If the situation is emergent or the inmate is not deemed competent to make the decision to refuse the examination, actions taken to keep the inmate safe will be initiated and the following will be notified.
        i. The Regional Medical Director and,
        ii. The Regional Chief Psychiatrist

7. Once medical clearance has been completed, the medical unit nurse contacts the mental health unit and faxes the completed Mental Health Unit Referral Form and confirms bed availability within the mental health unit.
8. Once medical clearance has been verified and a decision has been made to accept the inmate to the mental health unit, the medical unit nurse:
    a. Prepares the inmate's medications, medication administration record (MAR), medical chart and the original completed Mental Health Unit Referral Form
    b. Submits all of the above to custody for transportation with the inmate.

E. After business hours, if the medical provider is not on-site, an **alternate process** will be employed, allowing the on-site registered nurse to facilitate medical clearance with the on-call medical provider for an inmate classified as MC-2, MC-3 and MC-4, after all the steps below are completed. (MC-1 inmates are **not** to be transferred to the mental health unit).
    1. The medical unit nurse will complete the Transfer Screening Form, using information in the inmate's medical record.
    2. The medical unit nurse will obtain and share the following information with the on-call provider:
        a. A complete description of the events surrounding the inmate's condition prior to the call.
        b. A report on the inmate's vital signs to include blood pressure, temperature, pulse, respirations, and oxygen saturation.
        c. A report of any chronic illnesses, substance abuse, or mental health problems noted on the inmate's problem list.
        d. The date of the most recent assessment by a medical provider.
        e. Whom from the mental health staff has been apprised of the pending transfer including the source of the referral, and
        f. The medical unit nurse will document the conversation in the inmate's EHR and will include the date and time of the conversation, along with any orders received from the on-call medical provider via telephone call.

g. All orders from the on-call medical provider, including orders authorizing the medical clearance, and the patient's stability for transfer will be transcribed as telephone orders: and tasked in the EHR to the on-call medical provider who gave the verbal order. The on-call medical provider will review, accept and sign the tasked verbal orders in the EHR within 24 hours.

3. The alternate process shall require that the on-call medical provider contacts the designated on-call psychiatry provider and advise him/her of the inmate's current medical conditions and the recommendations for transfer to the mental health unit.
4. If there is a conflict between the medical provider and the psychiatry provider, the medical and psychiatry providers will refer the issue to the regional medical director and the chief psychiatrist for the region respectively for them to resolve the impasse. If still unresolved at this level, the regional medical/chief psychiatrists will consult the DPSCS Statewide Director for Mental Health to resolve the issues along with both contractors' statewide medical and mental health directors. If the Clinical disposition is still a concern the DPSCS statewide Director for mental health will contact the DPSCS Director of Clinical Services and Inmate Health to assist with the disposition.

F. If there are no beds available on the appropriate mental health unit, the inmate is to be placed in a safe cell until bed space is made available. If there are no safe cells, the mental health regional administration/on-call mental health provider shall seek approval for transfer of the inmate from the DPSCS Director of Mental Health/designee to another SDA for housing. A transfer to another SDA must be coordinated by the prospective nursing teams after approval has been sought by the mental health unit nurse from the regional mental health provider/on-call. All such transfers must receive approval by the DPSCS Director of Mental Health prior to transfer according to the transfer policy notification process. In certain situations (e.g., High risk inmates/high profile) staff may attempt to obtain one-to-one custody observation until a bed becomes available.

G. If an inmate is returning from an outside mental health or medical hospital to an inpatient mental health unit and was medically cleared at the hospital, there must be direct communication between the medical provider and the mental health unit psychiatry provider or on-call psychiatry provider prior to admission to the mental health unit, and the inmate must still be medically cleared by a DPSCS provider following the process assigned in Section B.

III. References:

A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
B. NCCHC—Standards for Health Services in Prisons –2014
C. NCCHC ---Standards for Health Services in Jails -2014 (J-G-03/P0G-03 Infirmary Care)
D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al -1999
E. ACA Standards for Adult Correctional Institutions -4th Edition and ACA 2006 Standards Supplement

IV. Rescissions: None

V. Date Issued: September 29, 2009
Date Reviewed: December 7, 2010
September 19, 2011
October 2012
May 23, 2013
September 2014
October 2015

Appendix A-Referral to Acute Mental Health Unit

REFERRAL TO ACUTE MENTAL HEALTH UNIT

Directions: Both sides of this form must be filled out and sent with an inmate referred to CMHC-J or CMHC-B. **Parts 1, 2 and 3** is to be filled out by a mental health care provider. **Part 4** is to be filled out by a medical health care provider. If a mental health care provider is not available, a medical health care provider must also fill out Parts I, II and III.

Part 1: Identifying Information

Inmate Name: _____ ID#: _____ Date of referral: _____

Assigned Institution: _____ Referral instituted by: _____

Current housing status: ☐ General Population ☐ Admin. Segregation ☐ Disciplinary Segregation

Part 2: Mental Health Information

A. Reason for Referral:_____
_____
_____
_____

B. Provisional Diagnosis:

Axis I: _____

Axis II: _____

Part 3: Historical Information:

A. Criminal History (include present conviction, sentence and mandatory release date)
_____
_____
_____

B. Mental Health and Addiction History (Include prior hospitalizations)
_____
_____
_____

C. Inmate Has **Known** History of:

☐ Self mutilation ☐ Fire setting ☐ Verbal altercations

☐ Sexual acting-out ☐ Throwing feces/urine

☐ Suicide gestures/attempts (Assessment of current suicidality)

_____

☐ History of Assaultive/Violent Behavior (Assessment of current risk for violence)

_____

D. Treatment interventions

_____

_____

_____

Signature: _____ Title/Position: _____

Print Name: _____

Part 4 of the Referral to Acute Mental Health Unit Form

MEDICAL CLEARANCE TEMPLATE FOR EPHR

PATIENT'S NAME:
ID NUMBER:
DATE OF BIRTH:
REFERRING INSTITUTION:
TODAY'S DATE/ TIME:

PSYCHIATRIC HISTORY:

Referring Staff member:

Psychiatric Diagnoses:

Suicide Gesture or Attempt? () YES ()NO
If "YES" Methodology:

MEDICAL HISTORY:

Past Medical History and Current status of Medical conditions:
patient on the Chronic Care Clinic (CCC) list? YES/NO
If YES, which CCCs? Endocrine, CV/Hypertension, Neuro, pulmonary COPD, Oncology, Pain management, Surgical
Date of last PPD :
Result:
Date of last RPR
Result:
Known Allergies:

Current Medical Complaints/ Concerns:
Substance Abuse History:
Last use of Substances?

LMP (Female patients):
Is patient pregnant? Yes No

Current Medications/ Dose/ Time last administered:

Review of Systems
Constitutional:
Respiratory:
Cardiovascular:
Gastrointestinal:
Genitourinary:
Musculoskeletal:

PHYSICAL EXAMINATION:

CURRENT VITAL SIGNS @ ----AM/PM: BP Temp
Pulse RR
Pulse Oximetry?

ATTENTION: Alert, Lethargic, Stuporous, Comatose, Fluctuating, combative Other ---

ORIENTATION: TIME: Date Day Month
Year Season
PLACE/ PERSON/ SITUATION:

Constitutional:
Neck / Thyroid:
Respiratory:
Cardiovascular:
Abdomen:
GU
Extremities:

Neurological Examination findings:
Any signs of trauma?
Any signs of drug intoxication or withdrawal?

DIAGNOSES:

INVESTIGATIONS:
Laboratory/ Imaging/ Other Tests ordered:

MC STATUS: ()MC-1 ()MC-2 ()MC-3 ()MC-4 which is assigned to what below?

( ) I have had adequate time to evaluate the patient, and the patient's medical condition is sufficiently stable that transfer to the MHU does not pose a significant risk of deterioration.
( ) I have had adequate time to evaluate this patient, and the patient's medical condition is sufficiently unstable that transfer to the MHU DOES pose a significant risk of deterioration
( ) I have had adequate time to evaluate the patient, and the patient's psychiatric condition is very likely a result of an organic medical/ neurological disorder. Transfer to MHU is not indicated.
( ) Patient is uncooperative with the medical clearance process. A Physician to Physician discussion between MH and Medical is required.

PLAN/ DISPOSITION: ----------

Name of Physician/ PA/ NP authorizing or denying medical clearance: ----------
Date/ Time: ----------

PATIENT'S NAME:
ID NUMBER:
DATE OF BIRTH:
REFERRING INSTITUTION:
TODAY'S DATE/ TIME:

After Business hours (Except MC1 and MC2 Patients):

Was this Clearance process done by the MD/PA/NP over the Telephone? ()YES ()NO

(If “YES” another Face to Face Medical clearance is required by next morning)

If “YES”, Name and Title of staff member filling out this form: ----------

If patient is medically cleared, are current Paper chart MAR and Medications sent with inmate to the MHU? ()YES ()NO

Appendix B

Medical Clearance for Mental Health Unit Referrals

MENTAL STATUS	MEDICAL EXAM (conducted by)	MEDICAL EXAM FINDING	CLASS	Medically cleared?	ACTION
SUICIDAL	Somatic MD/PA/NP	Negative/Stable	**MC-4***	Yes	Admit to MH unit -Conduct initial physical exam once on unit (somatic PA/NP/MD) -Provide follow-up as needed
SUICIDAL	Somatic MD/PA/NP	Unstable	**MC-3***	Yes	Admit to MH unit -Conduct initial physical exam once on unit (somatic PA/NP/MD) -Provide daily follow-up until somatic issue(s) stabilize
				No	Admit to Medical infirmary/Hospital -Conduct urgent mental health consult (psychiatric MD) -Provide daily follow up until mental status stabilizes
ALTERED MENTAL STATUS: Agitated, Bizarre, Combative, Confused etc. with a PAST HISTORY OF PSYCHOSIS	Somatic MD	Negative/Stable	**MC-2***	Yes	Admit to MH unit -Conduct initial physical exam once on unit (somatic MD) -Provide daily follow-up to rule out somatic issues (Somatic MD)
		Unstable		No	Admit to Medical infirmary/Hospital -Conduct urgent mental health consult (psychiatric MD) -Provide daily follow up until mental status stabilizes (MH professional)

ALTERED MENTAL STATUS: Agitated, Bizarre, Combative, Confused etc. NO HISTORY OF PSYCHOSIS	Somatic MD	Negative/Stable and Unstable	**MC-1**	No	Admit to Medical infirmary/Hospital -Conduct urgent mental health consult (psychiatric MD) -Provide daily follow up until mental status stabilizes

* If an inmate refuses the medical exam, there must be direct communication between the medical provider and the psychiatry provider regarding the safest placement for the inmate.

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 5
INFIRMARY CARE DISCHARGES

I. Policy: All inmates in DPSCS regional infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures.

II. Procedure:

A. Infirmary Discharges

1. An inmate may be discharged only if ordered by a licensed physician.
2. A physician will summarize the patient's treatment plan and need for scheduled follow up in a discharge note documented on the discharge summary within 24 hours of inmate's discharge from the infirmary. (Discharge Summary form).
3. The infirmary physician will communicate the discharge plan to the receiving physician before the discharge.

B. Infirmary to Infirmary transfers

1. A regional medical director, after consultation with DPSCS Executive Director of Clinical Services and Inmate Health, can request transfer of an infirmary patient to another region. At a minimum, prior to the transfer, the following needs to be completed.
2. Both regional medical directors need to document the request

via e-mail and summarize the points supporting the need for transfer and copy the Office of Case Management at Reisterstown Road Plaza after a verbal request to the DPSCS Director of Clinical Services and Inmate Health / designee. The following information required may be faxed to the receiving infirmary and the office of the DPSCS Director of Clinical Services and Inmate Health.

1. Problem list

2. Admission history and physical

3. Most recent progress notes

4. Short discharge transfer note

5. Most recent Medication Administration Record (MAR)

6. Any medical consultations pending or special requests, such as durable medical equipment.

III.References: A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions

B. NCCHC – Standards for Health Services in Prisons -2008

C. NCCHC –Standards for Health Services in Jails -2008 (*J-G-03/P-G-03 Infirmary Care*)

D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al – 1999

E. DPSCSD 130-100, Section 160 – Do not Resuscitate

F. ACA Standards for Adult Correctional Institutions – 4th edition and ACA 2006 Standards Supplement

G. DPSCS Infectious Disease Manual

H. Advanced Directive/Living Will

I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227 aR)

J. Appendix 2 DPSCS Infirmary Discharge Form (130-21aR)

K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)

L. Appendix 4 Infirmary Care Acuity Tool

IV. Rescissions: DCD 130-100 Section 120, March 1, 1994

V. Date Issued: July 15, 2007
Date Reviewed: September 22, 2009
November 20, 2010
September 19, 2011
October 15, 2012
July 11, 2013
December 2015

DEPARTMENT OF PUBIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 6
REPORTS

MANDATORY STATE REPORT ON INFIRMARY BED DAYS AND INFIRMARY ADMISSIONS

I. Policy: All reports to DPSCS (The Department of Public Safety and Correctional Services) form from all of its vendors/contractors regarding regional infirmaries shall have standardized practices and employ consistent definitions regarding those reports.

II. Procedure:

A. Maryland Department of Public Safety and Corrections recognizes that the contract with vendors to provide medical care to its detainees and inmates identifies beds in the Service Delivery Areas (SDAs) as follows:

1. Baltimore has
    a. 48 infirmary beds at MTC
    b. 12 infirmary beds (shared with mental health) at BCDC for females
    c. An additional 5 respiratory isolation beds at MTC
2. Eastern has
    a. 18 infirmary beds and
    b. 4 respiratory isolation beds (plus the ability to utilize an additional 24 beds – located in an administrative segregation observation area – for respiratory isolation in an emergency.)
3. Jessup has
    a. 24 infirmary beds at MCI-W

b. 22 Infirmary beds at JRH
c. 6 infirmary beds at JCI
d. An additional 5 respiratory isolation beds at MCIW

4. Western has
   a. 12 infirmary beds at MCIH in Hagerstown and
   b. 5 respiratory isolation beds at MCI H in Hagerstown
   c. 16 Infirmary beds at WCI in Cumberland and
   d. 12 respiratory isolation beds at WCI in Cumberland

B. There are an additional 262 beds for mental health infirmaries, and reports on the use of these beds shall replicate that described for the beds enumerated above.

C. All vendors will use the same reporting time period, a calendar month specifically dates 1 through 28, 29, 30 or 31 (dependent upon the number of days in a specific month) for each month. "Hybrid" months (those beginning in one calendar month and cycling through the next) will not be accepted.

D. An infirmary bed day will occur from 12:01 A.M. through Midnight of a stated day.

E. Infirmary bed days will be defined as one bed equals one day, regardless of the number of hours occupied or the number of persons that used the same bed within a twenty-four hour period.

F. Infirmary admissions will be defined as the individuals admitted to the infirmary for any of the acceptable reasons for infirmary admissions. There may be multiple admissions to one bed within any given day, and this number will address that issue.

G. Specific steps that the vendors will take to ensure that all numbers are accurately recorded and retrievable for future reference include:

1. The medical and mental health vendors will maintain all infirmary occupancy in electronic format. The electronic log will include at a minimum for each inmate patient:
   a. The Inmate/Detainee's name and DOC (Department of Corrections) number, and date of birth,
   b. The date and time of admission to the infirmary,
   c. The admitting clinician,

d. The Inmate's admitting diagnosis,
e. Other known diagnoses of the inmate,
f. A notation of any infectious processes,
g. The designated acuity level of each infirmary patient using approved acuity scale developed by the Department and update daily which can be found in Chapter One of the manual (General Infirmary Procedures), and
h. Date of discharge once known

2. Medical and mental health vendors will transmit their electronic logs to the utilization management vendor daily by 9:00 a.m. for the previous day. This will occur Monday through Thursday, Friday, Saturday, and Sunday reports will be submitted by 9:00 a.m. on the following Monday each week.
3. Vendors will include in the submission to the utilization management company a statement of occupancy and vacancy regarding infirmary beds to include the number of beds in each infirmary, the number occupied, and the number vacant each day. Any beds that are considered to be out of service for any reason must be named and the reason described.
4. The utilization management vendor will collate the material and develop a report for DPSCS from those logs and will submit that report to DPSCS by the fifth day of the month following the month that reflects the information in that report.
5. Electronic logs will be stored on dedicated "flash drives" or at the vendors' headquarters that will be produced upon demand by DPSCS Office of Inmate Health for the purposes of auditing, inquiries by oversight bodies, or any other reason for which they may be needed.

H. Medical and mental health staff maintaining logs will receive additional training and oversight to assure that the accepted transfer of information is made to the UM vendor on a daily basis.

III. References: Maryland State Stat Discussion/Recommendations

IV. Rescissions: None

V. Issued: September 17, 2008
Reviewed: September 22, 2009
November 30, 2010

September 19, 2011
November 11, 2011
July 2013
December 2014
December 2015

DEPARTMENT OF PUBIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 7
WOUND CARE MANAGEMENT

Section A
PREVENTION

I. Policy: Pressure wounds/ulcers will be prevented through the use of good nursing practice and attention to skin integrity.

II. Procedure:

A. All persons confined to bed or found to have limitations in mobility shall be observed for wound/ulcer development.

1. Nursing Care Plans shall identify mobility issues and address the Nursing Diagnosis of “Impaired Skin Integrity”
2. An observation sheet (Attachment A: Wound Care Flow Sheet) shall become part of the infirmary routine for all patients with that nursing diagnosis, and a sheet shall be initiated and completed daily as a part of the nurse’s assessment. This shall be a part of the routine even if no wound has developed if there is risk for that development to occur.
3. Wound measurements shall be taken and noted in the flow sheet no less than once a week.

B. Wound development prevention measures shall be taken for all patients with impaired mobility. Measures include, at a minimum:

1. Decrease or eliminate external pressure by assuring the use of clean, dry, bed linens that are pulled taut and kept wrinkle free, and by reducing additional linens or excess pads/waterproof items under the body.
2. Reduce moisture from incontinence or other sources.
3. Employ pressure relief devices if practical.

4. Reduce shear and friction by:
    a. Keeping head of bed raised less than 30 degrees unless contraindicated
    b. Supporting feet and legs whenever head of bed is elevated
    c. Support the feet if bed is flat and the inmate is at risk of developing pressure ulcers.
    d. Always flattening the bed prior to repositioning
    e. Using lifting devices such as draw sheets, transport boards, or mechanical lifts for patient movement. Staff will be careful not to "drag" inmate when repositioning
5. Be sure that patient is receiving adequate hydration and nutrition and address any underlying medical conditions that may contribute to wounding.

III. References:

IV. Rescissions: DCD 130-100 Section 120, March 1, 1994

V. Date Issued: January 2011
Reviewed: December 2011
July 2013
November 2014
December 2015

- **Attachment A**

MARYLAND DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
Wound Care Flow Sheet

DATE	TIME	PROGRESS NOTES
		S:
		O: Wound Type: Venous ف Arterial ف Diabetic ف Pressure ف Trauma ف
		Location:
		Stage: I ف II ف III ف IV ف
		Wound Bed: Granular ف Dry ف Moist ف Necrotic ف
		Partial Granulation ف Slough ف Epithealization ف
		Undermining: Yes ف Noف Location:
		Surrounding Skin: Intact ف Macerated ف Red ف Abrasions ف
		Drainage: Scant ف Moderate ف Saturated ف
		Color: Purulent ف Serous ف Serosanquinous ف
		Odor: Yes ف No ف
		Weekly Measurement: Length: cm
		Width: cm
		Depth: cm
		Tunneling: cm
		Undermining: cm
		Dressing Changed: Yes ف No ف
		How Patient Tolerated Dressing Change: No Pain ف Painful ف
		Circle response on pain scale: 1 2 3 4 5 6 7 8 9 10
		A:
		A: Potential for Impaired Skin Integrity secondary to:_____
		P: Wound Prevention Measures include clean dry sheets with minimal layers and no plastic next to the skin, frequent turning, use of transfer devices (State which:_____), bathing (frequency and type_____), specialty bed, patient education on movement. (Circle all that apply and add additional measures as necessary.)
		A: Impaired tissue integrity related to: Trauma ف Pressure ف Diabetes: ف
		Venous Stasis ف Arterial Insufficiency ف
		P: Wound exhibits signs of healing. Continue same treatment. ف
		Physician to evaluate for possible change in treatment. Wound is non - healing. ف
		A: Impaired wound integrity
		Wound has ___decreased ____ increased ____ is the same in size.
		Wound appearance ____ has _____ has not changed since last assessment.

		P: ____Continue current treatment.
		____Notify physician to evaluate wound and act on any new orders.
		Nurse's Signature: Date/Time:

NAME_____**DPSCS#**_____**LOCATION**_____

DPSCS Form 130-230aR (Rev. 10/99)

DEPARTMENT OF PUBIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

INFIRMARY CARE MANUAL

Chapter 7
WOUND CARE MANAGEMENT

Section B
STAGING AND TREATMENT OF WOUNDS

I. Policy: All wounds/ulcers will be staged by a Physicians and/or Certified Wound Care Nurses and/or Physicians. Appropriate care will be given to each wound/ulcer according following specific treatment protocols.

II. Procedure:

A. Wounds/Ulcers are staged according to their appearance, thickness, size, depth, presence/absence of drainage, and involvement of surround tissues.

1. A Stage 1 pressure ulcer is a non-blanchable redness of a localized area usually over a bony prominence. In darker pigmented skin, the area may not have visible blanching. Discoloration of the skin, warmth, edema, indurations or hardness may also be indicators. Treatment includes all steps described in Section 1 of this policy (Prevention) and:

a. Assess the patient's skin daily for any changes in status. Record findings.

b. Gently cleanse site using a mild soap, rinse and pat dry

i. If skin is very dry, apply a moisturizing cream

ii. If skin does not appear dry and care-giver is unable to relieve all sources of pressure, friction, shear or moisture, apply a skin barrier and let dry.

c. If patient is incontinent: apply a thin layer of moisture barrier ointment. Reapply after each incontinent episode and/or at least every 8 hours.

d. Care giver may want to use transparent dressing to protect the wound from further injury such as a hydrocolloid dressing. Steps include:

i. Choose a transparent dressing size that will cover about 1”-11/4” margin around the wound for best fit and adherence.
ii. Cleans area with normal saline.
iii. Remove the #1 paper backing from dressing while avoiding touching the adhesive.
iv. Apply adhesive side down to skin, working from #1 to #2.
v. Remove the #2 tab, mold and smooth onto skin and into skin folds.
vi. Hold in place for several seconds allowing the heat and slight pressure from care-giver’s hands to activate the adhesive.
vii. Removal of the paper strip along the edge of the dressing is optional.
viii. Dressing may be left in place for up to 7 days or changed after 3-5 days PRN for leakage, dislodgement or s/s of infection.
ix. Dressing must be dated and initialed at the time of application to assure timely replacement dressings (following clinician orders for changes).
x. Dressings shall be recorded in the patient’s medical record along with observations of the wound’s progress and reaction to treatment.

e. Hydrocolloid dressing may be another option for dressing. Steps for this dressing include:
i. Choose a dressing size that will cover about a 1”-1 ¼” margin around the wound for best fit and adherence. Dressing with a border eliminates the need to picture frame dressing with tape to prevent roll up. Choosing a sacral shape will conform to the sacral area and provide a border adhesive as well.
ii. Cleanse area with normal saline or a commercial wound cleanser.
iii. Peel back the paper lining of the dressing, apply over wound, and smooth dressing over the skin.
iv. Remove any additional paper tabs.
v. Hold in place for several seconds allowing the heat and slight pressure from your hands to activate the adhesive.
vi. Dressing should be left in place for 3-5 days or changed PRN for

leakage, dislodgement or s/s of infection.

vii. Dressing must be dated and initialed at the time of application to assure timely replacement dressings.

viii. Dressing shall be recorded in the patient's medical record along with observations of the wound's progress and reaction to treatment.

f. Hydrogel dressing present a third choice. Steps for use are as follows:
   i. Choose a dressing size that will cover about 1"-1 ¼" margin around the wound for best fit and adherence. Choosing a dressing with a border (island) is preferable, especially in hard to secure areas such as the sacral region. The border dressing does not require a secondary dressing to hold it in place. It also affords continuous visibility to the wound site to monitor for any changes that could occur prior to the next dressing change.
   ii. Cleanse area with normal saline or commercial wound cleanser.
   iii. Allow to air dry.
   iv. Dressing should be left in place for 3-5 days or changed PRN for leakage, dislodgement or s/s of infection.
   v. Dressing must be dated and initialed at the time of application to assure timely replacement dressing.
   vi. Dressing shall be recorded in the patient's medical record along with observations of the wound's progress and reaction to treatment.

g. Care giver shall make a referral to a Physician or Certified Wound Care Nurse for staging and additional direction on the type of dressing and/or care to be applied.

h. Care-giver shall document report all findings and provide an oral update to the provider following the patient.

2. A Stage II partial thickness skin loss involves the epidermis, and/or the dermis. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater. Treatment includes:
   a. If the wound is non-draining and skin is not fragile, the care giver shall:
      i. Assess the wound daily for changes in status, i.e.: infection drainage,

granulation, or necrotic tissue.

ii. Cleanse wound with normal saline.

iii. An optional skin sealant may be applied to the peri-wound skin and allowed to dry to avoid skin stripping upon dressing removal.

iv. Apply a transparent film over the wound site or apply a hydrogel wafer dressing to the wound, or apply a hydrocolloid dressing to the wound. (See instructions for each above)

v. Leave dressings in place for up to 7 days unless leakage occurs, dressing is dislodged, s/s of infection are evident, or if the wound has healed.

vi. Change no more often than 3 times in a 7 days period.

vii. Dressing must be dated and initialed at the time of application to assure timely replacement dressing.

viii. Dressings shall be recorded in the patient's medical record along with observations of the wound's progress and reaction to the treatments.

b. If the wound has fragile skin, either non-draining or draining, the care-giver shall:

i. Assess the wound daily for changes in status

ii. Cleanse the wound with normal saline and allow to air dry.

iii. Apply hydrogel sheet or hydrogel disc dressing over wound. (as described above)

iv. Secure the dressing in place with either a gauze bandage roll or secure in place with cloth tape as necessary to assure the wound remains covered.

v. Leave dressing intact for up to 7 days unless leakage occurs, the dressing is dislodged or s/s of infection occurs.

vi. Change no more than 3 times in a 7 day period.

vii. Dressing must be dated and initialed at the time of application to assure timely replacement dressing.

viii. Dressing shall be recorded in the patient's medical record along with observations of the wound's progress and reaction to treatment.

c. If the wound is possibly infected or the patient has a history of infected wound, the care-giver shall:
    i. Assess the wound daily for changes in status.
    ii. Cleanse the wound with normal saline or commercial wound cleanser and allow to air dry.
    iii. Apply non-occlusive dressing over the wound and secure in place with bandage roll or wrap if the skin is too fragile for adhesives, or if adhesives are not contraindicated then care-giver may secure with a Telfa type (non-stick) dressing.
    iv. Change every 1-3 days and PRN if leakage, dislodgement, or s/s of infection.
    v. Dressing must be dated and initialed at the time of application to assure timely replacement dressings.
    vi. Dressing shall be recorded in the patient's medical record along with observations of the wound's progress and reaction to treatment.
d. If the wound has moderate to high amounts of exudate (drainage), the care-giver shall:
    i. Assess wound daily for changes in status
    ii. Cleanse the wound with normal saline and allow to air dry.
    iii. Apply foam dressing or apply calcium alginate dressing (rope or sheet) that is then secured with a dressing and a bandage roll gauze. If adhesive is acceptable (i.e., there are no allergies or doctor does not want adhesives used), use cloth tape. (Following the directions above for dressing).
    iv. Change the dressing every 3-5 day or PRN for leakage, dislodgement or s/s of infection
    v. Dressing must be dated and initialed at the time of application to assure timely replacement dressings.
    vi. Dressing shall be recorded in the patient's medical record along with observations of the wound's progress and reaction to treatment.

3. A Stage 3 or 4 wound is a full thickness skin loss with extensive destruction,

tissue necrosis or damage to underlying structures such as muscle, tendon, ligament, joint capsule, or bone. It may present as a deep crater or tunnel into surrounding subcutaneous tissue.

a. A Stage III pressure ulcer is full thickness skin loss involving damage to or necrosis of subcutaneous tissue, which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a crater with or without undermining of adjacent tissue.
b. A Stage IV pressure ulcer is a full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures (tendon, ligaments, joint capsule, etc.). Undermining and sinus tracts may also be associated with Stage IV pressure ulcers.
c. Treatment Guidelines for both are the same.
d. If the wound is shallow, non-necrotic with no to minimal exudate:
    i. Assess daily for any changes in status i.e. infection, drainage, granulation tissue, or necrotic tissue,
    ii. Cleanse the wound with normal saline and allow to air dry.
    iii. (Optional) Apply a skin sealant wipe to the peri-wound skin and allow to dry, to avoid skin stripping upon dressing removal.
    iv. Following the directions above for dressing, apply either a hydrocolloidal dressing or a hydrogel disc/wafer following the directions for dressings above.
    v. Change every 3-5 days or PRN leakage or dislodgement or s/s of infection.
    vi. Dressing must be dated and initialed at the time of application to assure timely replacement dressings.
    vii. Dressing shall be recorded in the patient's medical record along with observations of the wound's progress and reaction to treatment.
    viii. Dressing shall be recorded in the patient's medical record along with observation of the wound's progress and reaction to treatment.
e. If the wound is deep, non necrotic and no to minimal drainage:
    i. Assess daily for any changes in status i.e. infection, drainage,

granulation tissue, or necrotic tissue.

ii. Cleanse the wound with normal saline and allow to air dry.
iii. Apply choice impregnated gauze and cover with Telfa-like dressing
iv. Cover with a secondary dressing
v. Change daily and PRN for leakage, dislodgement or s/s infection
vi. Dressing must be dated and initialed at the time of application to assure timely replacement dressing.
vii. Dressing shall be recorded in the patient's medical record along with observations of the wound's progress and reaction to treatment

f. If the wound is shallow with moderate to large amounts of drainage :
   i. Assess daily for any changes in status i.e. infection, drainage, granulation tissue, or necrotic tissue.
   ii. Cleanse the wound with normal saline and allow to air dry.
   iii. Apply either a foam dressing or calcium alginate dressing
   iv. Change every 3-5 days or PRN if leakage, dislodgement, or s/s of infection
   v. Dressing must be dated and initialed at the time of application to assure timely replacement dressings.
   vi. Dressings shall be recorded in the patient's medical record along with observations of the of the wound's progress and reaction to treatment.

g. If the wound is deep with moderate to large amounts of exudate:
   i. Assess daily for any changes in status i.e. infection, drainage, granulation tissue, or necrotic tissue.
   ii. Cleanse the wound with normal saline and allow to air dry.
   iii. Lightly pack wound with calcium alginate dressing (rope)
   iv. Cover with secondary non-irritating dressing such as Telfa dressing
   v. Change daily and PRN for leakage, dislodgement, and s/s of infection
   vi. Dressing shall be recorded in the patient's medical record along with observation of the wound's progress and reaction to treatment.

B. All observations, treatments, and outcomes shall be documented in the patient's medical record and an oral report provided to the provider following the patient.

C. All wounds being addressed throughout any given month shall be documented using Attachment A in Excel format which shall be forwarded to the DPSCS Director of Nursing monthly with Infection Control reports.

III. References: Clinical Services Manual – Chapter 7- Wound Care Management Section B- Staging and Treatment of Wounds

IV. Rescissions: DCD 130-100 Section 120, March 1, 1994

V. Date Issued: January 2011
December 2011
July 2013
November 14, 2014
December 2015

Attachment A

DPDS and DPSCS Wound Care
Patients for the Month Of

SDA:_____Facility: NBCI

Infirmary Patients

Last Name	First Name	DOC #	Wound Location	Stage	Enduration in mms	Erythema Y/N	Color	Drainage Y/N	Color of Drainage	Odor (describe)	Antibiotics (name and route of administration)	Type Dressing	Description of removed dressing	Cultured/ Date of culture	Seen by ID Specialist/ Date	Comments

Patients Seen At Dispensary

Last Name	First Name	DOC #	Wound Location	Stage	Enduration in mms	Erythema Y/N	Color	Drainage Y/N	Color of Drainage	Odor (describe)	Antibiotics (name and route of administration)	Type Dressing	Description of removed dressing	Cultured/ Date of culture	Seen by ID Specialist/ Date	Comments