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.

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	2/20/2016

Department of Public Safety and Correctional Services

Clinical Services & Inmate Health

Medical Evaluations Manual

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	1/2015
	2/20/2016

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 1

MEDICAL INTAKE

Section A

Medical Intake Process Part I: The IMMS

(Incorporates Previous Accept Reject Policy)

I. Policy: All inmates newly admitted to DPSCS facilities shall receive a medical intake evaluation immediately upon an inmate's entrance from the community that will:

Identify and address any urgent medical/mental health/dental needs of those arrestees/detainees/inmates admitted to any DPSCS facility and/or is transferred from a detention facility to Patuxent Institution or a Division of Correction facility.

Identify and triage arrestees/detainees/inmates with Known or easily identifiable chronic health needs that require medical intervention.

Identify and isolate arrestees/detainees/inmates who appear potentially contagious or have communicable diseases.

Identify and facilitate intervention for arrestees/detainees/inmates that may be at risk for suicide.

Identify and facilitate intervention for arrestees who have a history of acute or persistent and serious psychiatric illness, or developmental disabilities.

Identify at an early time arrestees/detainees/inmates that may be at risk for heat related health issues if placed in non-air conditioned environments.

II. Procedures:

A. Initial Intake Processing:
   1. Initial Intake screening shall be conducted by an RN or higher medical level staff in collaboration with correctional officers and remaining medical and mental health staff. The processing shall include the following:
      a. All arrestees shall have an initial observation screening by the RN before being accepted into Intake facilities.
         i. The full screening as described below will not proceed unless the arrestee is deemed acceptable for continued detention secondary to an observed medical or mental health condition that would prohibit continuation of the process.
         ii. Any inmate who presents to Intake sally port unconscious, semi-conscious, bleeding or otherwise obviously in need of immediate medical attention shall be identified prior to screening completion, rejected for admission, and referred to an Emergency Department for care.
   2. This process shall be completed upon arrival to the facility, prior to custody exchange, while the patient is still in the custody of Police to ensure that the arrestee is medically and mentally stable to complete the booking process.

B. Completion of the Intake Screening Process
   1. The Intake Screening Process shall be completed by an RN or higher level of staff once it is determined that the arrestee/detainee can be admitted, i.e., has no medical condition that would prohibit admission.
      a. Medical personnel will screen all arrestees for medical/mental illness using a form approved by the Office of Clinical Services and Inmate Health (OCSIH). Information shall be entered into the Electronic Medical Record (EMR) when possible and OCSIH approved paper form will be completed when EMR is not available.
      b. Intake Screening shall be conducted within 2 hours of admission for any inmate being admitted from the community or for any inmate

being transferred from another facility who has not been so screened.

2. Intake Screening shall be conducted as an individual and confidential interview for both medical and mental health issues and shall include the following:
   a. Measurement and documentation of vital signs including:
      i. A blood pressure measurement using a wrist cuff in the event that handcuffs cannot be removed,
      ii. Temperature,
      iii. Pulse,
      iv. Respirations,
      v. A finger-stick glucose reading on all known or suspected persons with diabetes,
      vi. A pulse-ox measurement and a peak flow rate measurement when there is an indication or suspicion of respiratory problems
      vii. A pregnancy test on all females of child-bearing age (ages 12 through 65) entering the facility.
   b. Nurse will question the arrestee/detainee/inmate regarding the presence of any known chronic or acute health conditions and will determine if any medications are currently being used.
      i. Nurse will document any report of disease, medical or mental health condition. Any accompanying records shall immediately be given to medical personnel conducting the intake processing and those records shall immediately be placed in the arrestee/detainee/inmate's medical record
      ii. Arrestee/detainee/inmate reporting or determined to have active acute, chronic medical, mental health, substance abuse, or other conditions requiring immediate medical care shall be referred to an appropriate clinician for physical examination and treatment or referred to community

emergency medical services as medically indicated within two hours of admission to the intake area

iii. Nurse will document any report of current medications whether prescriptive, over-the-counter, or street drugs.

iv. Medications brought into a facility may be turned over to custody to be placed in Property. Any medications disposed of shall be done so in accordance with the Pharmacy Services Manual and applicable State laws and regulations.

v. Arrestees may be told that medications may be administered to inmates once they are seen by a clinician and medications are ordered, and that any current physician prescribed drugs can be offered. No drugs from containers or blister packs brought by the inmate or arresting officers to the facility shall be administered to the arrestee unless verified as packaged from a recognized correctional facility or detention center or a contract pharmacy.

vi. Nurse will initiate the Continuity of Care form completing those sections regarding medical conditions and medications currently in use as well as any demographic information available.

3. Once the initial screening questionnaire is completed, the Intake team consisting of the Nurse, the Mid-Level Provider/Physician's observations, visual inspection and/or patient response findings will be documented on appropriate forms electronically, if equipment is available, noting medical and mental health conditions, or on an OCSIH approved form if the equipment is not available.
    a. Observation shall include, at a minimum:
        i. Behavior, which includes but not limited to state of consciousness, mental status, appearance, conduct, tremors and sweating.

    ii. Body deformities, ease of movement, durable medical equipment needs, brace, prosthesis.
    iii. Condition of visible skin, including trauma markings, bruises, sores, ulcerations, jaundice, rashes and infestations, needle marks or other indications of drug abuse.

b. Individuals requiring immediate attention or referral for more focused attention will be referred immediately (within the hour of admission) to the appropriate clinician or special care provider. These include, but are not limited to, individuals who have evidence of:
    i. Potential withdrawal syndromes secondary to alcohol, substance abuse, use of barbiturates, or opiates,
    ii. Suicide risk,
    iii. Serious illness or injury previously un-noted that may require triage to community hospitals
    iv. Acute or serious psychiatric conditions,
    v. Communicable diseases,
    vi. Urgent and emergent medical problems,
    vii. Age group issues that may indicate the need for special treatment (i.e. juveniles and aged individuals),
    viii. Education/DPSCS Student Information for Inmates must be completed for all inmates under the age of 22,
    ix. Mental or physical disabilities requiring special attention.

c. An opportunity for new arrestees, detainees, and inmates to articulate their need for medical or mental health treatment will be provided.

d. Ectoparasite assessment shall be completed within the limits of discussion and visibility of hair and skin during this initial examination.
    i. Those inmates appropriate for empiric treatment for lice infestation shall receive such treatment within the first 24

hours of admission. (Pregnant inmates will receive alternative treatment as ordered by the clinician).

e. An examination of the mouth and teeth shall be done to determine if there are any dental problems requiring immediate referral.

f. Individuals eligible for methadone detoxification or methadone continuation shall be referred to substance abuse specialists and enrolled in those programs in accordance with established procedures. Enrollment shall occur within twenty-four (24) hours of initial intake screening.

g. Individuals eligible for alcohol withdrawal treatment shall be immediately referred for this treatment and appropriate placement.

h. PPD placement will be completed within 72 hours of acceptance into a facility. The result will be read between 48 and 72 hours of placement and available for review during the Comprehensive Physical Examination that shall occur within seven days of that acceptance.

    i. A chest x ray for positive PPDs will be completed within five days of the positive reading and documented in the inmate health record.

    ii. Persons with positive readings shall be isolated until clearance for the disease is verified.

4. Initial mental health screening shall be completed as part of IMMS. The nurse or higher level provider completing the IMMS process provides a brief screening using the approved questionnaire. Arrestees/detainees/ Inmates who present with symptoms of psychosis, unstable mood, suicidal thought or behaviors, severe agitation considered not to be related to substance abuse or who exhibit other symptoms suggestive of danger to themselves or others shall be referred immediately to a qualified mental health professional for further evaluation and initiation of a treatment plan.

    a. Mental Health personnel will provide training for medical personnel to assure a consistent approach to these issues prior to any

attempt to make observations regarding symptoms of psychosis, unstable mood, suicidal thought or behavior, or non-substance abuse related agitation.

b. All newly admitted detainees/ inmates/retakes parole violators entering intake facilities from the community shall receive a suicide risk assessment by a qualified Mental Health Professional within 24 hours of admission. (This is in addition to the brief screening done upon entry by the nurse.)

c. Individuals conducting mental health screening and suicide risk assessments shall follow the appropriate DPSCS protocol in doing so and in taking subsequent actions.

d. All individuals conducting mental health screenings shall receive training, at least annually, on the conduct of such screening by qualified mental health professional. Training shall include didactic information and standardized instructions for completing the screening form and suicide assessment.

e. A complete mental health assessment will be completed for all arrestees/ detainees/inmates within seven days of incarceration using OCSIH approved Intake Mental Health Screening Form.

C. Medication Administration may be necessary to initiate or continue therapies begun prior to arrest.

1. Nursing staff will collect all known data regarding prescription or other medications during the screening process including a signed release of information that may be used to verify current medications, as well as other health information required for making decisions regarding patient care management including any recent hospitalizations or treatments in progress prior to arrest.

    a. The release of Information signature may also be used to obtain pertinent medical records as necessary for continuity of care from the community into DPSCS.

   b. The Release shall be placed into the patient's hard copy record for use in the event that additional medical problems are revealed later in the admissions process.
   c. The Release of Information is valid for one year from the date it is signed.
   d. All efforts made to obtain information from external sources and the outcomes of those efforts will be recorded in the patient's medical record.
2. Arrestees with special medications related to special needs such as organ transplant, HCV, HIV, Chemotherapy, dialysis and other chronic or acute conditions will be allowed to continue those medications once verified by medical staff.
   a. Verification attempts for all medications shall be initiated by medical staff during the IMMS process in the booking area.
   b. Documentation of all attempts to verify medications and the outcome of those attempts shall be documented in the patient's medical record.
   c. The medical/psychiatric provider, as appropriate, shall be notified of the outcome of the verification attempt within four (4) hours of the receipt of a response from the community or within eight (8) hours of initiation of the process if no response is received.
3. Regardless of the outcome of verification attempts, arrestees will be maintained on pre-incarceration treatment regimens as reported by an arrestee or a pharmacologically equivalent substitute for medical and mental health conditions whenever possible, i.e., the clinician can identify the need for those treatment regimens. Decisions to medicate or to withhold medications and rationale for the decision shall be documented in the patient medical record.
   a. Persons requiring continuation of mental health medications will be referred immediately by the nurse following the initial intake screening and attempts at medication verification (either via EPHR

or community contact) to a psychiatry provider for bridge orders to enable immediate availability of mental health medications.

b. Once the RN has apprised the psychiatry provider of the situation for persons with mental health conditions needing medications, the psychiatry provider shall write orders if on-site, or give verbal orders to the RN who shall document the orders and initiate the first dose of medication as indicated. If psychiatric bridge order is denied the nurse will forward the detainee's name to the mental health vendor's scheduler who will schedule the detainee to be seen by a psychiatrist or psychiatric nurse practitioner within 24 hours of denial of medication.

c. Somatic medication needs will be referred to the mid-level or physician responsible for the area for orders to enable immediate availability of those medications.

d. Medical and psychiatric providers shall prescribe and initiate medication for chronic medical and mental health diseases (such as HIV+, Diabetes, Hypertension, Bi-Polar Disease, Depression, et al) using DPSCS formulary medications as appropriate for the disease and in keeping with community standards and safe medical practice in the event that the arrestee is unable to provide names or doses of medication, and the provider is able to determine a need for medication based on his or her examination, patient history, and related signs/symptoms.

e. Medication ordered shall be initiated within twenty-four (24) hours of initial intake screening.

4. Stock medication will be used to initiate dosing on the same day the detainee is admitted.

    a. All medication administration, whether somatic, psychiatric, or single dose, from stock or non-stock shall be documented on the Medication Administration Record (MAR) following OCSIH policy and procedure.

b. All stock medication shall also be documented on the stock card to assure the medication can be refilled when necessary.

5. Formulary substitution may be necessary and only with the facility physician's or psychiatrist's order and only after approval from the respective clinicians' Medical or Psychiatric Director.
6. The mid-level clinician or physician initiating the medication shall order the medication using the accepted ordering process for patient specific medications. This bridge order shall be for seven days for somatic medications and up to 14 days for mental health medications. That medication shall be dispensed per dosing orders immediately upon receipt. (I.E., if the dose is to be at 10 a.m. and 10 p.m., the first ordered dose shall be given as close to the 12 hours following the initial dose as possible).
7. In the event that a medical or mental health provider is not on site at the time of the admission, the screening nurse shall contact the on-call clinician to receive orders regarding continuation of medication or other treatments deemed necessary as a result of the initial screening.

D. Special housing requirements may be necessary for certain arrestees. Urgent onsite referrals to medical/mental health triage team for items on screening questionnaire that require immediate intervention for special housing include:

1. An onsite referral to the mental health triage team for mental health items on initial screening questionnaire that require immediate interventions.
2. Isolation for arrestees with signs and symptoms of tuberculosis or any suspected communicable disease to prevent infection of others.
3. Arrestees with alcohol withdrawal syndrome are housed in designated cells for monitoring and follow-up.

E. Heat Stratification is required on all admissions to an Intake facility and periodically as conditions affecting any change in that status arises.

1. All arrestees, male and female will be assigned a heat risk category upon entry and at the Comprehensive Intake physical Examination and housing assignment process, and throughout the year.

2. All male arrestees shall be designated for H1 housing by the receiving/screening nurse while at BCBIC (air conditioned housing) until they are reevaluated by a clinician and heat risk is reclassified based upon the initial chronic medical conditions or medications prescribed as per DPSCS heat stratification policy.
3. Clinical findings and medications prescribed at the intake examination will determine the final heat risk stratification.
4. Any detainee who is prematurely moved prior to receiving a Comprehensive intake Physical or is placed into a non-air-conditioned facility as part of the transfer screening process, prior to receipt of a final heat stratification assignment will receive on his or her Intake Comprehensive Intake Physical and a final heat stratification.
    a. The H-1 assignment will remain until the intake physical is completed and an alternative risk is assigned.
    b. Female arrestees will receive heat stratification upon entry to BCBIC and upon their Comprehensive Intake physical at WDC per protocol.
    c. Final heat stratification shall be by medical doctor and shall be documented on the Electronic Medical Record (MAR) Patient Problem list as “Heat Risk Stratification” category H-1 H-2 or H-3 and the Electronic Medical Record (EMR) classification template located on the home page.
    d. A weekly data report of H-1 and H-2 detainees will be maintained and submitted to classification and to the OCSIH as an electronic file from May 1 through September 30th each calendar year from both medical and mental health contractors. Included in the file shall be, at a minimum:
        i. The inmate’s name,
        ii. Date of birth,
        iii. DOC number,
        iv. Heat stratification code

v. Facility and

vi. Any code changes.

e. There shall be a notification on the individual problem lists for patients requiring a heat stratification code change, specifically the original heat stratification on the problem list will be recorded as resolved and the new Heat Stratification will be entered as the current "problem" on that list. The process will be repeated every time there is a Heat Stratification change.

5. If the clinician recommends housing other than general population related to heat such as infirmary or air-conditioned dormitory, staff will be responsible for coordinating the transfer of information regarding that order notifying custody of special housing needs or special needs and only by using the designated classification and housing form.

F. Arrestees at detention with positive response(s) to the Initial Medical/mental health Screening Questionnaire will have an orange wristband placed on the right wrist by the Triage team and a disposition made.

1. Arrestees/detainees identified as alcohol withdrawal problems will have a yellow wrist band placed on the left wrist by the triage team.
2. Arrestees who require immediate intervention will be directed or escorted to see the Medical Treatment Team and/or Mental Health Team as soon as the IMMS disposition is completed.
3. The Medical/Mental health treatment team will perform a targeted patient evaluation focusing on the immediate medical/mental health issue(s) and provide intervention(s) accordingly.

a. Arrestees with an Orange wristband and identified to have a medical condition and/or mental health problem, but are determined to be stable while being triaged will be evaluated sequentially along with the booking process.

b. Arrestees with an orange wristband will be given priority during the booking process.

c. Arrestees with a yellow wristband will be monitored and evaluated for signs and symptoms of withdrawal and maybe given priority during the booking process.

d. A daily log will be created and maintained to schedule medical evaluation of arrestees. The patient log created for the day will be communicated among the team leaders (Physician, Psychiatrists, Psychologist, PA, CRNP) of each shift to plan the follow-up and provision of services. A log of arrestees not seen/shift will be reconciled every 12 hours to reflect completed screenings and submitted for review to the ACOM daily.

G. Inmate Transfer/Releases require additional attention by medical/nursing staff.

1. Within 12 hours of being notified by custody that an inmate is to be released or transferred, the inmate's medical records shall be reviewed by nursing staff at the intake facility and a Transfer Screening Form shall be completed.
2. Inmates with risk stratification of M-1 and M-2 shall have their medical records envelopes labeled M-1 and M-2 as appropriate.
3. All persons admitted through facilities other than detention shall follow transfer screening policies as patients are moved from facility to facility.
   a. The initial Intake is done only once per admission.
   b. Once completed, the transfer screening shall accompany the patient to his or her next facility and policies for transfer shall be followed.
   c. Concurrently, the continuation of the Intake Process (Medical Evaluation Manual Chapter 1, Section 2) shall be continued if it has not been completed as described in Intake Part I and II.

III. Rescission:

DCD 130-100, Section 110 Medical Intake Evaluation, dated March 1, 1996

OPS Manual or Medical Evaluations Chapter Three (Accept/Reject)

IV. Date Issued: July 15, 2007/Revised July 2008/ Revised April 2009

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 1
MEDICAL INTAKE

Section B
Medical Intake Process: Part II

I. Policy: All inmates newly admitted to DPSCS facilities shall receive a medical intake evaluation immediately upon the inmate's entrance from the community that will: Identify and address any urgent medical/mental health/dental health needs of those arrestees/detainees/inmates admitted to any DPSCS facility and/or are transferred from a pretrial facility to Patuxent Institution or a Division of Correction facility. Identify and triage arrestees/detainees/inmates with known or easily identifiable chronic health needs that require medical intervention. Identify and isolate arrestees/detainees/inmates who appear potentially contagious or have communicable diseases. Identify and facilitate intervention for arrestees/detainees/inmates that may be at risk for suicide. Identify and facilitate intervention for arrestees who have a history of acute or persistent and serious psychiatric illness, or developmental disabilities. Identify at an earlier time arrestees/detainees/ inmates who may be at risk for heat related health issues if placed in non-air conditioned environment.

II. Procedure:

A. Physical Examinations

1. All intake physical examinations shall be conducted by a clinician utilizing the DPSCS Intake History and Physical Examination Form found in the Electronic Health Record (EHR).

a. A Consent/Refusal of Medical Treatment (See Medical Records Chapter One, and Appendix A of this policy) shall be signed upon arrival at a facility, and provides for the initial and general ongoing care of the

inmate/detainee. The inmate/detainee has the option to refuse care and sign the appropriate section of the form.

   b. Staff may read the consent form to the patient if necessary.
   c. Staff will present the consent form in a positive manner, stating that we are seeking consent to care and that blood will be drawn as required by Maryland for syphilis testing, and that the same sample can be used for HIV testing.
   d. At no time will staff present testing in the form of a question (Examples of unacceptable approaches: "do you want to be tested," "you don't want your blood drawn, do you?")
   e. While arrestees/detainees/inmates may elect not to have HIV testing, they will have to write that they want it specifically on the consent form.
   f. RPR and gonorrhea testing are not optional, and samples are to be collected no later than the seven day physical on all incoming persons.
2. All newly admitted inmates entering DPSCS facilities from the community shall receive a physical examination within seven (7) days of intake.
3. New Inmates or those called "Retakes" (such as parole violators) who have not received physical examinations within the past 12 months shall receive physical examination.
   a. Clinician will at a minimum, however review the physical examination that was completed within the last 12 months and comment upon any changes or updates and record that information in the EHR.
   b. Clinician will ask the Inmate whether or not there have been changes in his or her medical/mental health since the time of that physical as each section is reviewed.
   c. Clinician will follow the steps below (4) and do a new physical if the stated criteria above are unmet.
   d. Regardless of whether a new physical is completed or the less than 12 month old physical is used, the clinician will enter a statement into the medical record regarding any changes and sign that entry.

4. Inmates who have a documented physical examination within the last 12 months need not have a new physical examination unless:
   a. Abnormal vital signs are apparent
   b. An acute medical problem or chronic medical condition by history is present, including but not limited to:
      i. Hypertension (HTN)
      ii. Coronary Artery Disease (CAD)
      iii. Congestive Heart Failure (CHF)
      iv. Chronic Obstructive Pulmonary Disease (COPD)
      v. Asthma
      vi. Diabetes Types 1 and 2
      vii. Seizures
      viii. HIV infection
      ix. Tuberculosis infection or disease (TB)
      x. Chronic Care Needs (CC)
      xi. Cancer
      xii. Recent surgery (past 12 months)
      xiii. Recent physical trauma (past 12 months)
      xiv. Other medical conditions requiring emergent or chronic care.
      xv. Prescription medications the inmate is receiving.
      xvi. Physical disability
      xvii. Special needs

      xviii. Medical screening identifies a new medical problem that requires evaluation.

   c. The date of the last physical examination and the absence of active medical problems by history shall be documented on the Intake History and Physical Evaluation Form for all inmates who have had a physical examination within the past 12 months and for whom the physical examination has been deferred.

5. All inmates receiving a history and physical examination shall be evaluated by a provider using the Intake History and Physical Examination Form documenting the following:
   a. Medical history including but not limited to:
      i. Allergies,
      ii. Current medications,
      iii. Chronic medical conditions,
      iv. Hospitalizations,
      v. Family history,
      vi. Review of symptoms
      vii. Identification of disabilities.
      viii. Last menstrual period
      ix. Head Injuries
      x. Vaccination history for juveniles
   b. Physical examination to include evaluation of the:
      i. Head,
      ii. Ears,
      iii. Eyes,
      iv. Nose,
      v. Oropharynx,
      vi. Neck,
      vii. Lymphatics,
      viii. Skin,
      ix. Extremities,
      x. Breasts,
      xi. Lungs,
      xii. Heart,
      xiii. Abdomen,
      xiv. Genitalia,
      xv. Pelvic (females)

xvi. Digital rectal/prostate exam and inspection (as stated below in diagnostics), includes stool guaiac for inmates 40 years of age and older.

xvii. Neurological functioning cranial nerves 2-12 and reflexes and deficits.

xviii. Mouth and teeth to determine if there are any apparent dental issues requiring referral and make referrals as appropriate.

xix. Clinician will document any refusals and the reason for the refusal.

6. Time frames for conducting physical examinations for detainees and inmates entering DPSCS facilities may be expedited at the discretion of the DPSCS-CS.
7. Diagnostic and age appropriate preventive health screening tests consistent with the recommendations of the American Academy of Family Practice Physicians will be conducted and documented on the DPSCS Intake History and Physical Examination Form, as follows:
   a. STD Screening and syphilis serology (RPR with automatic FTA if RPR is positive). Blood will be drawn for the purpose of the necessary lab work at the time the PPD is planted enabling the results to be available at the time of the complete physical examination.
      i. If PPD is contraindicated the RPR will be drawn prior to the intake PE by the 5th day.
      ii. STD screening including gonorrhea, Chlamydia, Trichomonas will be done for females as part of their pelvic exam.
      iii. Symptomatic males who complain of urethral discomfort or discharge will receive screening if antibiotic treatment fails to resolve the complaint.
   b. Education and voluntary HIV testing for all sentenced and pretrial detainees/inmates in accordance with DPSCS protocol.
   c. Pap smears for all female inmates unless performed and documented within the last 12 months as normal.
   d. A review of the pregnancy test results and necessary referrals to obstetrical care following the DPSCS-CS Care of the Pregnant Inmate

Manual if pregnant. If for any reason, the pregnancy test result cannot be located a repeat test shall be completed at this time and the clinician will proceed as already stated here.

e. Clinically indicated mammograms shall be performed for detainees and inmates in a time frame consistent with American Academy of Family Physicians (AAFP) guidelines.
f. Snellen Vision Test unless performed and documented within the past 12 months and testing for near vision.
g. Audiometric screening in accordance with the following:
    i. Audiometric testing for all inmates less than and up to 21 years of age.
    ii. All persons 22 and above will have at a minimum, a tuning fork assessment (if the clinician has shown competency in its use).
    iii. Regardless of age, any person offering that he or she has some problem with hearing or with abnormal tuning fork result will be referred for a full audiometric examination, unless performed and documented within the past 12 months.
h. Electrocardiogram (ECG),
i. Blood chemistries, and urinalysis with microscopic exam
j. PPD or chest x-ray if past positive for TB
k. Sickle cell screen and other diagnostic studies shall be ordered when medically indicated so that appropriate treatment may be provided.
l. A digital prostate examination will be performed on all males beginning at age 40 or earlier if symptoms indicate a need.
    i. All males age 40 and above will be evaluated for the need to perform a PSA (Prostate Specific Antigen) test and the test will be done if deemed appropriate by the examining physician.
    ii. All males age 50 and above will have a PSA at the time of their periodic physical examination.

8. All intake diagnostic lab tests shall be completed and documented in the patient health record within 48 hours of the order with the exception of RPR

tests which must be reviewed and the review documented in the patient health record within 4 hours of receipt by the provider.

9. All inmates identified with disabilities at the time of physical examination shall have documentation of the disabilities included in the medical record utilizing the DPSCS Disabilities Assessment Form.
   a. Disabilities shall be described in functional terms only, without disclosure of related medical problems such as hypertension, diabetes, cancer or HIV infection.
   b. A copy of the form shall be forwarded to the case management manager or supervisor of the intake facility.
10. The evaluating clinician shall determine the level of medically permissible activity and medically necessary housing assignments.
    a. The clinician's recommendation shall be documented using the Medical Clearance: Program and Work Assignment Form.
    b. A copy of the form shall be forwarded to the case management manager or supervisor.

B. Treatment Plan/Risk Stratification

1. A physician shall review all inmates receiving physical examinations and shall develop an approved individual treatment plan that is documented on the Intake History and Physical Examination Form. The treatment plan shall include, but not be limited to the following:
   a. An assessment of active medical problems
   b. An enumeration of all medically indicated diagnostic studies and treatments.
   c. Recommendations for specialty referrals.
   d. Chronic Care Clinic assignment as per DPSCS protocol including the placement of the clinic flow record sheet in the medical record.
   e. Special housing assignment.
   f. Risk stratification for chronic illnesses, as follows:
      i. 0 – Healthy

ii. M-1 – Chronically ill – stable (hospitalization not anticipated during the next year)

iii. M-2 – Chronically ill – unstable (hospitalization anticipated during the next year. To include moderate to severe asthmatic individuals.

g. Final Heat Risk assignment which shall also be communicated to Custody Staff per procedure.

h. Immunization assessment (see section II. C of this document)

i. Medical Alert Assessment (see Section II. D of this document)

j. Education/Special Needs Assessment and order referrals as appropriate.

k. Instruction about exercise.

l. Adaptation to the correctional environment.

2. The reviewing physician shall ensure that all identified medical, dental and mental health problems are documented on the DPSCS problem list.

C. Immunizations

1. All inmates shall receive immunization with tetanus/diphtheria toxoid when medically indicated. Immunization shall be documented in the inmate's medical record.

2. Inmates under the age of 18 will be assessed regarding immunization needs and the contractor will provide age appropriate vaccination updates.

3. Authorization to update vaccinations by appropriate guardian will be documented in the medical record. An excel spread sheet tracking juvenile vaccination status will be maintained.

D. Medical Alert

1. All inmates shall be assigned medical alert badges if one of the following conditions applies:

a. Heart Disease (including pacemaker and internal defibrillators)

b. Diabetes (insulin dependent)

c. Seizure disorder (under treatment)

d. Asthma (moderate to severe)

e. Renal Disease (dialysis dependent)

f. Disabilities (blindness, deafness)

g. Allergies (life threatening only)
h. External medical devices (e.g. catheters, colostomy, etc.)
2. Inmates with psychiatric illnesses or infectious disease conditions shall be identified by a medical alert badge.
3. A physician shall secure a medical alert badge for an inmate by completing the Medical Alert Identification Request Form and submitting the form to the institution's Identification Unit unless otherwise specified by the Warden.
4. The same criteria and form shall be utilized for issuing alert badges in maintaining institutions for inmates newly identified with medical conditions requiring alert badges.

E. Education/Special Needs Referral.
1. All education provided to the inmate related to their disease condition or access to care must be documented in the appropriate area in the EHR.
2. All detainees or inmates requiring special needs accommodation must be referred accordingly using approved referral forms as specified in the Special Needs Manual.

III. References:
A. Standards for Health Services in Prisons, National Commission on Correctional Health Care
B. American Correctional Association: Adult Correctional Institutions, 4th edition with 2014 supplements.
C. Clinical Practice in Correctional Medicine, Michael Puisis, D. O. 1999
D. American Public Health Association APHA Standards for Health Services in Correctional Institutions – 2003
E. Public Health Behind Bars from Prison to communities, Robert B. Greifinger, 2007
F. Department of Justice MOU
G. PDSD 185-4 Heat Stratification
H. DPSCS Receiving Screening
I. DPSCS Intake Mental Health Screening
J. DPSCS Intake History and Physical Evaluation Form
K. Tuberculosis Testing Form
L. DPSCS Disabilities Assessment (DCD Form 130-100nR)
M. DPSCS Medical Clearance: Program and Work Assignment
N. Maryland State Department of Education/Correctional Education/DPSCS Student Information for Inmates under 21 years of age.
O. DPSCS/CS Manual on Care of the Pregnant Inmate

IV. Date Issued: July 15, 2007

Revised July 2008
Revised April 2009
Revised October 2009
Reviewed December 2010
Reviewed September 2011
Reviewed October, 2012.
Reviewed July 2013
Reviewed: December, 2014
Reviewed: December 2015.

Appendix A

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

CONSENT/REFUSAL OF MEDICAL TREATMENT

Patient's Name (printed) ____________________ DOC#______________ Date of Birth: _____________
I, __________________, hereby authorize the Department of Public Safety and Corrections to provide me appropriate medical care. This care may include, but is not limited to physical and mental health assessments, obtaining vital signs, weight, and specimens such as urine, blood and sputum, and age-appropriate preventive health testing. Specimens may be tested for pregnancy, STD's, medical conditions and communicable diseases including HIV. I consent to be tested for HIV unless specifically stated below:
I sign this form willingly and voluntarily with full understanding of the above and with the knowledge that it can be retracted at any time. This form does not replace any future consent forms for specific treatment and/ or interventions.

__________________________________ ___________________________
Signature of Patient Witness

__________________________________ ___________________________
Date and Time Facility

Signature of parent or person authorized to consent for patient, it patient is a minor, incompetent or unable to sign consent form. This shall be witnessed by two adults.

__________________________________ ___________________________
Signature of Parent or Guardian Witness One

__________________________________ ___________________________
Witness Two Date and Time

****NOTE: Tests for Syphilis, Tuberculosis, and Gonorrhea may NOT be refused. Pregnancy Screening for Females may NOT be refused!**

<u>REFUSAL OF SERVICES:</u>

I, _____________________, have been informed by medical personnel of the necessary medical procedures. Against medical advice at this time, I refuse to have the following done:

☐ Physical examination ____

☐Urine ____

☐ Test for HIV ____

☐ Other ____

__________________________________ ___________________________
Signature of Patient Witness One

__________________________________ ___________________________
Date and Time Facility

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 1
MEDICAL INTAKE

Section C
Transgender Detainees/Inmates

I. Policy: DPSCS will provide medical services and render hormonal support for Transgender detainees/inmates with documentation of previous evaluation and/or enrollment in a certified Transgender Program.

II. Procedure:

A. All detainees that present as transsexual by declaration and phenotypic expression will have included as a part of their 7 Day Intake Physical Examination documentation of:

1. The age of recognition of gender based dysphoria.
2. Whether male to female or female to male transition.
3. Tanner stages (see appendix I) related to hormonal influence.
4. Hormones used with their dosages as well as the source of the hormones (clinical versus street drugs).
5. Treating provider or institution.
6. Length of time on hormonal treatment.
7. Results of palpitation of the breast/liver masses, and testicular size, mass.
8. Venous system varicosities.
9. History of STD and communicable diseases.
10. For Male to female patients, the clinician will assess and document for:
    a. Evidence of feminization or hormone usage,

b. Breast development,
c. Absence of facial hair,
d. Completed or stage of completion of sexual organ surgical alterations.

11. For Female to male patients, the clinician will assess and document for:
    a. Facial hair,
    b. Male pattern head hair (short, shaved, etc.),
    c. Absence or presence of abdominal or chest hair,
    d. Presence or absence of clitoral hypertrophy,
    e. Completed or stage of completion of sexual organ surgical alterations.

B. The clinician will order a minimum:
   1. Hormonal levels for testosterone, estrodial, and serum prolactin as appropriate for the end sexual orientation of the patient.
   2. STD and/or communicable disease cultures as appropriate including, but not limited to:
      a. HIV
      b. HCV
      c. HBV
      d. RPR

C. The clinician will order old records specifically related to the transgender treatments and/or evaluations along with other records as needed for the care of this patient.

D. Treatment plans shall be developed based on the physical and reported findings of the physical examination.
   1. Incomplete surgical gender reassignment require that the patient be classified according to his or her birth sex for purposes of prison housing, regardless of how long they may have lived their life as a member of the opposite gender.
      a. These patients are usually offered protective custody.

b. Male-to-female transgender women are at greater risk of sexual violence by other male inmates if they are not placed in protective custody.

2. Completed surgical gender reassignment are generally classified and housed according to their reassigned sex.
3. Hormonal therapy evaluation should be completed.
   a. The use of hormones to maintain secondary sexual characteristics may be continued at the levels approximating those used prior to incarceration regardless of whether or not they have completed their surgical re-assignment if they can provide documentation of :
      i. Enrollment in a gender dysphoria/transgender program or
      ii. Psychological verification of the condition.
   b. Inmates who self-proclaim transgenderism and who have self-prescribed hormonal therapy without medical or psychological verification may be maintained on hormones on a case-by-case basis but will require the following:
      i. A referral for complete mental health evaluation by a consultant who specializes in or is familiar with gender dysphoric patients.
      ii. Routine follow up of liver, breast, and biochemical markers, serum prolactin, etc. as a routine part on ongoing health care needs.
   c. A suicide assessment is required if the hormonal therapy is removed.

E. Indications of sexual misconduct or violence involving this patient should be monitored by both mental health and medical staff on a routine basis upon entry into the system and such behavior reported to custody. (Routine in this case would equate to persons seen for chronic care, i.e., no less than every three months and more frequently if there are sick call needs).

III. References: American Public Health Association Standards for Health Services in Correctional Institutions 2003

Wikipedia for a copy of the Tanner Stage of Development

IV. Rescissions: None

V. Date Issued: April 30, 2011

Reviewed/revised: February 22, 2012

Reviewed: July 2013
November 2014
December 2015

Appendix I

From Wikipedia, the free encyclopedia

The **Tanner scale** (also known as the **Tanner stages**) is a scale of physical development in children, adolescents and adults. The scale defines physical measurements of development based on external primary and secondary sex characteristics, such as the size of the breasts, genitalia, and development of pubic hair, and was first identified by James Tanner, a British pediatrician and thus bears his name.[1][2][3]

Due to natural variation, individuals pass through the Tanner stages at different rates, depending in particular on the timing of puberty. In HIV treatment, the Tanner scale is used to determine which treatment regimen to follow (adult, adolescent, or pediatric).

Definitions of TannerStages

Pubic hair (both male and female)

Tanner I
: no pubic hair at all (prepubertal Dominic state) [typically age 10 and younger]

Tanner II
: small amount of long, downy hair with slight pigmentation at the base of the penis and scrotum (males) or on the labia majora (females) [10–11.5]

Tanner III
: hair becomes more coarse and curly, and begins to extend laterally [11.5–13]

Tanner IV
: adult-like hair quality, extending across pubis but sparing medial thighs [13–15]

Tanner V
: hair extends to medial surface of the thighs [15+]

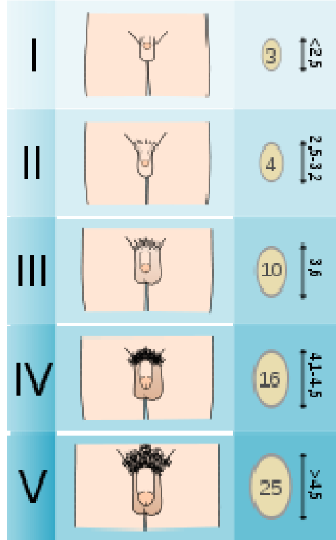

Illustration of the Tanner scale for males.

Genitals (male)

Tanner I

prepubertal (testicular volume less than 1.5 ml; small penis of 3 cm or less) [typically age 9 and younger]

Tanner II

testicular volume between 1.6 and 6 ml; skin on scrotum thins, reddens and enlarges; penis length unchanged [9-11]

Tanner III

testicular volume between 6 and 12 ml; scrotum enlarges further; penis begins to lengthen to about 6 cm [11-12.5]

Tanner IV

testicular volume between 12 and 20 ml; scrotum enlarges further and darkens; penis increases in length to 10 cm and circumference [12.5-14]

Tanner V

testicular volume greater than 20 ml; adult scrotum and penis of 15 cm in length [14+]

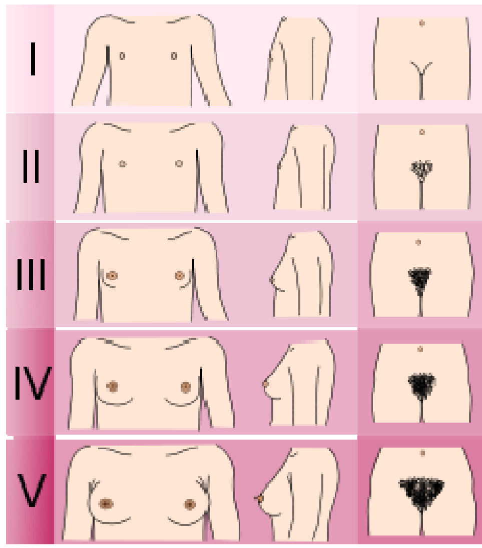

Illustration of the Tanner scale for females.

Breasts (female)

Tanner I

no glandular tissue: areola follows the skin contours of the chest (prepubertal) [typically age 10 and younger]

Tanner II

breast bud forms, with small area of surrounding glandular tissue; areola begins to widen [10-11.5]

Tanner III

breast begins to become more elevated, and extends beyond the borders of the areola, which continues to widen but remains in contour with surrounding breast [11.5-13]

Tanner IV

increased breast size and elevation; areola and papilla form a secondary mound projecting from the contour of the surrounding breast [13-15]

Tanner V

breast reaches final adult size; areola returns to contour of the surrounding breast, with a projecting central papilla. [15+]

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICE/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 1
MEDICAL INTAKE

Section D
Heat Stratification

I. Policy: DPSCS Clinical Services shall have specific procedures for recognition, prevention, reporting and care of inmates at risk for complications of heat related to medical and mental health issues as referenced in the departments mediation agreement under the Duval consent.

II. Procedure:

A. This policy/procedure requires the inclusion of definitions:

1. Dehydration means a physiologic condition of a deficit of body fluids necessary to maintain normal body functions and health which commonly occurs due to inadequate fluid intake, excessive perspiration, medications, physical activity, etc. and easily occurs during periods of high environmental temperature.
2. Features of Dehydration include a range from mild to severe symptom including dry mucous membranes, fatigue, weakness, rapid pulse, and low blood pressure.
3. Heat Risk Code means a code for designating heat risk within three levels: H1- Highest risk, H2 – Intermediate and H3 – low risk. [See Appendix 1].
4. Heat Respite- Temporary relief placement of a detainee to a climate controlled environment of 87 degrees or lower for a minimum of two hours per day as specified in the Heat Code Stratification scheme of H1, H2 or H3 under the heat consent.

5. Heat Exhaustion means a clinical condition resulting from prolonged exposure to high environmental temperature and which requires urgent emergency intervention. Symptoms include fainting, vomiting, sweating profusely, weakness, with weak pulse and cold clammy skin.
6. Heat Respite Period means a designated period of time which may be modified by the Warden for any identified security and public safety issues, which will involve increased opportunities for additional fluid replacement, increased showering frequency and modification of work and outdoor activity considerations as contained in published guidelines from the CDC and local authorities.
7. Heat Stroke means a medical emergency for a condition where the body is unable to cool itself because body temperature is elevated (greater than 105 degrees) with dry skin, rapid pulse and altered consciousness.
8. Non -Seasonal Heat Alert means a heat alert notifications outside of the seasonal heat alert window governed by the DPSCS Chief Medical Officer / designee under the conditions of seven day forecast of temperatures exceeding 90 degrees Fahrenheit, or 88 degrees Fahrenheit with a 35% humidity index, as the daytime temperature measured between 12:00 noon and 6:00 PM.
9. Seasonal Heat Alert [SHA] means an administrative reporting and activity status that invokes a specific protocol to be followed by medical and custody staff. Seasonally this is the period from April 30 through September 30.

B. Medical Responsibilities in assuring that Heat Stratification measures are applied include:
   1. During routine health screening done on arrival at a Sally port, or other Intake portal, medical staff will assign an initial heat stratification code (Heat Risk Codes H1, H2 and H3) listed in the “DPSCS Placement in Permanent Air-Conditioned Housing Criteria” [Appendix 1]
   2. This initial heat risk code category assigned shall be documented on the Initial Medical Mental Health Screening Form (IMMS). [Appendix 2]. Detainees at BCBIC will be considered H1 status by default until the Intake

Physical Exam and Heat Risk Coding is completed (done by day seven of detention).

3. A final heat code assignment shall be assigned by a licensed medical provider {mid-level provider or higher] at the intake physical completion.
    a. Heat code determinations during intake physical shall be recorded in the EMR within the Medical Classification Box of the "CHM Home page" (using the Next Gen product).
    b. It shall also be documented as the "heat risk code" on the physical exam form, the Medical Clearance Form, and the Work Assignment Form [MD DC FORM 130-100} and submitted as part of the medical clearance process to the Classification Office.
    c. This shall be done within 7 days of reception and
    d. Shall be communicated to custody for use in housing assignment and heat respite management.
4. The heat risk code assignments shall be solely on the basis of the medical provider's best judgment and the elements contained in the Heat Policy.
5. During the intake process, detainees will receive informational material addressing personal heat risks and its prevention.
6. Medical department will receive a fax of scheduled transfers from BCBIC to BCDC using the "BCBIC Inmate Transfer to BCDC" Form including the Number of Vacant air conditioned beds available, twice daily during shifts A & B from Custody. [Post Order – Appendix 3].
    a. BCBIC Medical Record Department will transfer the Heat code of each detainee from the medical record to the specified column on the "BCBIC Inmate Transfer to BCDC listing".
    b. When the Number of Potential H1 transfers exceeds the number of air conditioned bed vacancies the lead medical provider at BCBIC dispensary will be contacted by Custody to identify those H1 coded detainees most in need of the bed vacancies. Priority amongst similarly coded H1 detainees will be determined by age, current medical problems, acuity and review of the clinical record.

i. Priority may be given to H-1 seniors (60 years or greater);
ii. Morbidly obese inmates {350lbs or higher};
iii. Mentally ill inmates who may be on combinations of drugs that severely compromise adjustments to heat;
iv. Endocrine conditions {thyroid, insulin dependent diabetes etc.} and steroid dependent respiratory problems.

c. The Completed "BCBIC Inmate Transfer to BCDC" list with Heat stratification and prioritization will be faxed to BCDC traffic. [Post order – Appendix 4].

C. The Mental Health Contractor has specific responsibilities regarding heat stratification in for persons with mental health conditions.

1. Mental Health Contractor will develop and distribute to patients an educational handout providing information of the risks involved when their medication is taken under conditions that contribute to dehydration.
   a. Documentation of this education and
   b. The plan of action regarding movement and or heat respite as well as additional fluids/hydration opportunity consistent with the DPSCS heat policy will occur at the initial mental health Intake process.
2. Mental Health staff shall generate a list of inmates who are on psychotropic medications that will impact them adversely under condition of extreme heat.
   a. This shall be completed weekly and will be done in cooperation with the Pharmacy Vendor.
   b. A review of the heat code assignment for the inmate to determine if the heat code is consistent with the mental health designated category code for heat will be completed at least weekly following the development of the list.
   c. Post review of the list, any changes in assignment of heat code will comport with the process for heat code reassignment.
   d. Mental Health Clinician shall update the Heat Stratification Code following the process above in II B 3 a. (Heat code determinations during intake

physical shall be recorded in the EMR within the Medical Classification Box of the “CHM Home page”, {using the Next Gen product}.

3. When an inmate who has not been prescribed a medication for mental health condition previously is prescribed a psychotropic drug, the new order may place that inmate in a different heat stratification code, and the Mental Health provider will follow the procedure to change the heat stratification category as appropriate.
4. Reassignments of the Heat Code made by Mental Health staff shall be consistent with the policy category [Appendix 1]. All reassignments shall include:
   a. Completion of a change in housing assignment on the “Transfer of Housing Assignment Form [DPDS 0121-03]” [Appendix 4] which is then sent to traffic to reflect the need for air conditioned housing and or heat respite.
   b. A copy of the change in housing assignment form shall be maintained in a folder on site.
   c. Generation of a weekly a listing of inmates that specifies whose heat category have been modified secondary to mental health drugs prescribed or mental health diagnosis change for DPSCS and the ACOM office.
5. Mental Health provider will maintain a roster of mental health inmates who are currently verified to be on psychotropic medications as determined by mental health screening.
   a. Unstable mental health inmates will be triaged using the on- call psychiatrist and placed in the air-conditioned mental health unit (IMHU).
   b. Subsequent management and disposition will be determined through mental health protocol.

D. Custody has a role in the heat stratification process and that role is defined in DPDS 100.0007 currently in DPSCS draft update. Essentially their responsibilities include:

1. Traffic shall use the received “heat code” for each Detainee for housing assignment.

2. Traffic shall assure that air conditioned bed vacancies will be filled promptly.
3. Traffic shall forward a Heat Code Tracking sheet to Central Region designee for court report.
4. Traffic will keep the Heat code of all detainees on a Heat Stratification Log, for future use when needed, e.g. Dorm to dorm transfer, seasonal or non-seasonal Heat Alert period.
5. Custody compiles report and forwards to Attorney General Designee weekly so that Attorney General's Office can incorporates report into documents for Court review.
6. Custody has specific housing they can use to accommodate patients with heat related health needs.
   a. These beds will be restricted to stable H1 detainees whose medical or mental health problems do not require infirmary care or constant nursing or medical support.
   b. In addition, this type of housing shall be restricted to inmates whose security level and public safety risk qualify them for such housing.
   c. Detainees with H1 code but are ineligible for air conditioned housing secondary to security or mental health placement will be communicated to medical for frequent evaluation and care.
   d. Additionally, all Detainees with heat risk code of H1 and housed in non-air conditioned housing will receive intermittent respite and daily Nursing rounds to inquire about the detainees current medical status.
      i. Detainees with complaint of heat related symptoms shall be referred to medical triage.
      ii. Documentation of these rounds and received complaints will be maintained on site.
   e. Heat respite for H1 and H2 inmates not housed in air- conditioned areas will be conducted by custody daily and fluids or ice will be provided as directed in DPDS.100.0007 and documentation will be maintained on site.
   f. All beds in designated air conditioned dormitories shall be occupied or assigned for occupancy at all times.

E. Reassignment of Heat Codes can be made at any time. Following protocol stated throughout this policy.
   1. During clinical encounters, Medical and Mental Health providers shall review and update detainees heat risk code with the revision recorded on the CHM Home page of Next Gen with the date of revision.
   2. Medical and Mental Health staff will document the revised Heat Risk Code on the Transfer of Housing Assignment Form" [DPDS 0121-03] and send to traffic to initiate the housing reassignment or heat respite.
   3. Medical /Mental Health vendor will maintain a copy of the change in Transfer of Housing Assignment Form in a folder on site.
   4. A weekly summary of those inmates identified by medical staff as H-1 will be generated from NextGen by the medical vendor and electronically submitted to the DPSCS compliance officer and the ACOM for documentation purposes to be retained.
F. CQI audits/responsibilities related to Heat Policy Compliance shall be routinely completed by Medical and Mental Health Vendors.
   1. An audit of the Heat Code assignment process shall be completed for the months of May through September and submitted to the ACOM and DPSCS designated staff by the 20th of each month. The audits shall be completed using a Clinical Services approved audit tool.
   2. Medical and mental health staff will conduct review of this policy and procedures each year and submit a completed report on the review with suggestions/edits/corrections by October 30 each year. DPSCS Clinical Services will make the sole determination regarding any changes with this input.
   3. A computer generated listing of heat stratification shall be provided from the EMR to traffic before May 1st for the current residents of BCDC to traffic/ classification office to assist in housing assignment.
   4. Inmates in the resting population designated H-1 will be identified prior to May 1st for consideration of housing in permanent air conditioning in J-I.
G. Utilization Management Reporting shall include:

1. Any incident of heat related complaints that generate any offsite trip for management /care must be documented and communicated to UM as a heat related occurrence on the “ER report form” for tracking.
2. Any transfers of inmates for care to alternative infirmaries related to heat issues must be documented on the transfer form and faxed to UM for tracking purposes from May 1st to September 30th.

H. Medical Vendor shall be responsible for heat index tracking.
   1. Medical staff will determine if a heat risk inmate is suffering from a medical condition related to excessive heat exposure.
   2. A Heat Incident Log will be generated which should identify the inmate, the complaint and the treatment to include relocation, hydration, medication review and change, transport out of the facility [Appendix 6].
   3. This log will be part of the weekly dash report and sent weekly to the ACOM office for review.

I. Orientation for New Medical and Mental Health Vendor Staff Related to Heat Consent shall be a part of all new hire education.
   1. All medical supervisory staff shall insure that heat alert policies and procedures are part of the orientation of all staff and that subordinate staffs are trained and familiar with the policy and procedure within the first weeks of orientation.
   2. This will include a signed document of the in service as well as a copy distributed to each staff member of the heat consent policy and processes.
   3. Documentation of this education/orientation shall be maintained in the vendor personnel records.

J. Education and Information related to heat conditions shall be mandatory.
   1. Signs and symptoms of heat exhaustion , dehydration etc. shall be distributed and posted where inmates and medical staff interact, including day rooms , sick call, chronic care clinics, booking, Reception Screening area, segregation units.
   2. This shall be done annually prior to the beginning of the seasonal heat period.

3. Custody Staff shall be included in educational programs regarding heat related medical/mental health problems prior to May 1.
    a. Training shall include recognition of heat related conditions.
    b. Training shall be offered annually.

III. References:

A. DPDS.100.0007 Heat Stratification Protocol 1/11/2011
B. DPSCS DRAFT 100.0007 Heat Stratification Protocol
C. ACA Standard 4-ALDF-4C-22

IV. Rescissions: None

V. Date Issued: May 15, 2012
October 2012
July 2013

VI. Reviewed: December 2014
Reviewed: December 2015

Appendix 1: Heat Stratification/"DPSCS Placement in Permanent Air Conditioned Housing Criteria"

Appendix 2: Initial Medical Mental Health Screening Form (IMMS).

Appendix 3: Medical Record Policy Heat Stratification For BIBIC– Post Order

Appendix 4: Transfer of Housing Assignment Form [DPDS 0121-03]

Appendix 5: Division of Pretrial Detention and Services Heat Stratification Tracking Log

Appendix 6: Heat Incident Tracking Log

Appendix 1

DPSCS HEAT STRATIFICATION/PLACEMENT IN PERMANENT AIR CONDITIONED HOUSING CRITERIA:

H-1: Medical Conditions:
Dehydration
Alcohol and Drug Withdrawal
Heart Disease
Uncontrolled Hypertension/CHF
Insulin Dependent Diabetics, Type II
Inflammatory Bowel Disease
Renal Disease, Thyroid Disease
Third Trimester Pregnancy
High Risk Pregnancy complicated by chronic disease.
Asthma, Moderate to Severe (steroid dependent, PERF < 80%, and Wheezing), other respiratory conditions including COPD
Seizure, with more than one anti-convulsant medication
Complicated HIV/AIDS
Age > 60 years, weight > 250lbs.
Extensive Psoriasis, (open lesions)
Extensive Burn
Collagen Vascular Disease
Any other condition determined to place an inmate at risk as assessed through sound medical judgment.

H-2 Medical conditions
Mild Hypertension without diuretic treatment
Mild History of Asthma, requiring no inhaler utilization past 4 months
Uncomplicated Seizure Disorder with no other co-existing conditions.
Stable First and Second Trimester Pregnancy, without Chronic Disease.
Type II Diabetes, without other Chronic Disease.

H-3 Medical Conditions
Stable HIV Positive, with CD4 >500 and no history of opportunistic infection
Stable Thyroid Condition,
Stable asthma no documented asthma attack for 1 year

MENTAL HEALTH CONDITIONS:

H-1 Mental Health
Any Mental Health Condition that is not stable and/or causes increased agitation, overexertion, and the inability to self-hydrate. (Air conditioning Infirmary designated housing observation required)
Medications solo or in combinations
Neuroleptic, Mood Stabilizers,
Lithium, Tegretrol, Valproic Acid,
Haldol, Mellaril, Stelazine,
Thorazine, Prolixin, Cogentin,
Risperdal, Benadryl, Vistaril, etc.)
Anticholonergic, antihistamine and Anti- Parkinson medications.
Neuroleptic with unstable medical (any of the above + a chronic disease or age 60 years.
Street Drug or Alcohol Withdrawal. (Cocaine, Heroin, PCP, etc)

H-2 Mental Health
Single Neuroleptic, Tricyclic, (Doxepin, Elavil, Pamelor, Triavil, etc.)

H-3 Mental Health
SSRI's (Selective Serotonin Reuptake Inhibitors) eg Prozac, Effexor, Paxil etc.

Appendix 2 MARYLAND DEPARTMENT OF PUBLIC HEALTH AND CORRECTIONAL SERVICES

INITIAL MEDICAL MENTAL SCREENING QUESTIONAIRE

Offender Name: DOB:

Booking ID:

BP mmhg	Pulse /min	*RR /min*	Temp F	Pulse Ox %
If Diabetic document random fingerstick glucose:				
If Asthmatic document peak flow rate:				

Observations *These items require immediate intervention by the appropriate triage team		
*Does the offender appear to exhibit bizarre or unusual behaviors suggestive of mental health disorders such as being violent, unusually loud, confused or incoherent?	*☐ Yes	☐ No
*Does the offender appear to be disoriented or not alert?	*☐ Yes	☐ No
Is the offender sweating or suffering from tremors?	☐ Yes	☐ No
Does the offender have skin conditions such as open wounds, jaundice, rashes?	☐ Yes	☐ No
Does the offender have observable deformities or exhibit difficulty of movement?. Blindness, deafness, uses wheelchair?	☐ Yes	☐ No
*Does the offender appear to be under the influence of, or withdrawing from drugs or alcohol?	*☐ Yes	☐ No
*Does the offender's behavior or physical appearance suggest the risk of suicide or assault on others? [e.g. Tearful, anxious, threatening etc]	*☐ Yes	☐ No
Medical *These items require immediate intervention by the appropriate triage team		
*Do you have a history of tuberculosis or have you ever been treated for tuberculosis?	*☐ Yes	☐ No
*Do you have a frequent cough with phlegm or blood?	*☐ Yes	☐ No
*Do you suffer from frequent fevers or night sweats?	*☐ Yes	☐ No
*Are you bleeding or do you have pain, cuts, bruises, open sores, broken bones or gross oral abnormalities?	*☐ Yes	☐ No
Are you currently prescribed medications for a medical condition?	☐ Yes	☐ No
Do you currently have allergies?	☐ Yes	☐ No
Do you have medical problems such as a rash, infection, hepatitis, VD or seizures or Diabetes?	☐ Yes	☐ No
Have you used any alcohol or drugs such as cocaine, heroin, PCP, LSD or Xanax in the past 72 hours? If yes ask next four questions and refer to triage team if any one	☐ Yes	☐ No

or more of the four questions answered as Yes.		
Are you currently experiencing withdrawal? If yes from what substance:	☐ Yes	☐ No
Have you had withdrawal problems, seizures, or blackouts from alcohol or drugs?	☐ Yes	☐ No
Do you drink alcohol or take drugs regularly and have never stopped?	☐ Yes	☐ No

Appendix 3

MEDICAL RECORD DEPARTMENTS

EFFECTIVE DATE: 01/01/2008
REVIEW/REVISE DATE: 06/10/2009

APPROVED BY:STATEWIDE DIRECTOR OF MEDICAL RECORDS

TITLE: HEAT STRATIFICATION FOR BCBIC – POST ORDER

PURPOSE: To ensure that the "BCBIC Inmate Transfer to BCDC" for inmates and arrestees transported from BCBIC (males only) to BCDC (males only) columns are checked for the correct Heat Stratification code, with immediate communications on findings to the BCDC Classification Division. This policy applies only to MALE INMATES transferred from BCBIC to BCDC. (Female inmates at BCBIC transferred to BCDC – Women, not applicable).

RESPONSIBILITY: BCBIC Medical Records Department staff (only).

<u>From BCDC Traffic Division to BCBIC Medical Record</u>

a) Daily, the BCDC Traffic Division will fax the "BCBIC Inmate Transfer to BCDC" listings to BCBIC Medical Record Department @ 410-783-5271.

   List will be faxed between 12 noon and 6 p.m. each day, including weekends. See sample "BCBIC Inmate Transfer to BCDC" form.

b) BCBIC Medical records clerk must on receipt:

   1) Immediately fax "BCBIC Inmate Transfer to BCDC" to BCBIC Dispensary at 410-539-7176.

   2) Contact BCBIC Dispensary to inform clinical staff of list sent, and confirm receipt.

   3) On back page of the "BCBIC Inmate Transfer to BCDC" write: date and time "BCBIC Inmate Transfer to BCDC" faxed to BCBIC dispensary, the name of the

clinical person notified in BCBIC Dispensary, followed by clerk's initial performing this task.

c) Obtain the inmate's Heat Stratification code from one of the following areas, but in this sequence:

The Heat Stratification code will be written or circled as H-1, H-2, or H-3.

1) Nextgen: go to "History", then "MD Chm Home", then the "Classification" column (upper left hand of screen).

2) Medical Clearance Form (middle of form) filed in the Health Chart.

3) SallyPort folder on the "Medical and Mental Health Questionnaire" (bottom of form).

d) Check the appropriate Heat Stratification Code column against the inmate(s) listed on the "BCBIC Inmate Transfer to BCDC" form.

e) **Note:** The Lead Medical Provider or Lead Physician Assistant in the BCBIC Dispensary must be contacted whenever:

1) The NextGen inmate profile, the Medical Clearance Form, or "Medical and Mental Health Questionnaire" is without an inmate's Heat Stratification Code.

2) The number of bed vacancies listed on the top page of the "BCBIC Inmate Transfer to BCDC" form is **less than the number of "H1's" checked.**

3) Provider will be responsible for identifying and writing-in the missing Health Stratification code, and/or identify and check against the inmate's name that is most suitable for the bed-vacancies.

From BCBIC Medical Record Department to BCDC Traffic Division

On completion of the T-4 checks for the Heat Stratifications:

a) Fax completed list to: 410-209-4278, attention Traffic Officer.

b) Staple fax confirmation sheet to back of List.

c) Pull, Prepare and Package Health records for transfer.

d) File the T-4 log sheet in binder, latest date on top.

Appendix 4

DIVISION OF PRETRIAL DETENTION AND SERVICES
TRANSFER OF HOUSING ASSIGNMENT

BCBIC BCDC

DETAINEE NAME: _______________ ID#: ______________

FROM (CURRENT LOCATION): _______________ ____________ _____________

SECTION BED # MATTRESS #

REQUEST MADE BY: _____________ DATE: _________ TIME: _________AM/PM

(Printed Staff Name &Title)

****

<u>REASON FOR TRANSFER</u>: JOB REMOVAL COURT DISPOSITION

X OTHER (Explain):____

____

X H- 1 H-2 H-3 _______________ / __________________________________

(Medical Staff Printed Name) (Medical Staff Signature)

<u>RECOMMENDED TYPE OF HOUSING:</u>

PROTECTIVE CUSTODY SEGREGATION JUVENILE GENERAL POPULATION

TOWER/BUILDING SUPV. SIGNATURE OF REVIEW: ____________________________________

SHIFT COMMANDER APPROVAL: ____

(Form VOID unless signed by Shift Commander or Operations Captain, when applicable)

****

TRAFFIC OFFICE HOUSING ASSIGNMENT:

TO (NEW LOCATION): _____________ _________ _____________ _____________________

SECTION BED # MATTRESS # DIETARY CLEAR DATE

AUTHORIZED:____

(Traffic Officer Signature)

HOUSING UNIT OFFICER VERIFICATION:

***OFFICER SIGNATURE:____**

(Signature verifies that detainee has been received and assigned to appropriate cell/bed as indicated above)

1. Form MUST be signed by medical staff for any Detainee transferred for Heat Stratification purposes.
2. Completed form MUST be delivered to Traffic Officer prior to end of shift.

DPDS #0121-03(rev. 06/10)

Transfer to BCDC

INMATE NAME	ID NUMBER	FROM	TO	STRATIFICATION			REASON FOR NON-TRANSFER	CLASSIFICATION / BIRTHDATE	
				H-1	H-2	H-3	(C/R) COURT REL. (B/R) BAIL REL. (MED) MEDICAL (O/J) OTHER JURISDICTION (P/C) PROTECTIVE CUSTODY (W/C) WORKING MAN		
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

Appendix 5

Division of Pretrial Detention & Services
Heat Stratification Tracking Log

RESIDENT	BCBIC SCREENING	BCDC ARRIVAL	BCDC HOUSING PLACEMENT

	ID Number	Last Name/First	Status	MM/DD	Time (mil.)	H-1	H-2	H-3	MM/DD	Time (mil.)	MM/DD	Time (mil.)	AC Bed #	non-AC #
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
	Status Code:	R - Released prior to transfer W - Writ X - Weekender		Medical Screener's Signature:					Escort Off's Signature:		Duty Capt's/Designee's Signature:			
	COMMENTS (Please, sign and date all remarks)													

Apppendix 6:
Heat Incidence Tracking Log

Contractor: **Month:** ______________________

Date	Region	Site	Inmate Name	Medications	HCP Triage Encounter (urgent,emergent,sick)	Provider level	Heat Symptoms	Predisposing Factors	ER	Inf	Treatment	Disposition
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										
	Baltimore Pre-trial	MDC										

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 10
PRIVATE MEDICAL/PSYCHIATRIC/PSYCHOLOGICAL PROFESSIONAL EXAMINATION OF INMATE

I. Policy: The Department of Public Safety and Correctional Services (DPSCS) will permit the admission of private physicians, psychiatrists, and/or psychologists into its facilities under certain conditions, but because the Department contracts full medical services for its inmates, the expense will be borne by the inmate.

II. Procedure:

A. Examinations of inmates by private medical, psychiatric, and psychological professionals which pertain to areas involving issues or events not related to the DPSCS system mandated responsibilities will be permitted on an individual basis.

1. This will be permitted only after the Department receives documentation that sufficiently justifies the request.
2. The examination will be permitted only for the purpose of evaluation and diagnosis.

B. Any examination by the above named professional for any other purpose must be initiated by Court Order or cleared by the Office of the Attorney General through established Departmental policies and procedures.

C. Any expenses attendant to any of the examinations whether inmate initiated or Court Ordered will be borne by the inmate.

III. References: None

IV. Rescissions: DCR 130-30 (Issued September 1, 1979)

V. Date Issued: October 15, 2007
Reviewed/Revised: September 17, 2009
November 29, 2010
October 3, 2012(no changes)

July 11, 2013
December 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 11
ORAL HEALTH PROGRAM

I. Policy: Oral health care will be provided to the inmate population in the State's correctional system and will be based on the severity of oral disease, the medical status of the inmate, and the projected length of time of incarceration. Dental sick call services will be provided.

II. Procedure:

A. Each inmate treated in a Department of Public Safety and Correctional Services (DPSCS) dental facility will be informed of the status of his/her oral health and of the appropriate procedures to access care. Diagnostic and treatment recommendations will be forwarded with the inmate to any other assigned institution.

B. Inmates will be placed into one of the following Oral Health Classification at the institution where dental care is sought. Minimally, all inmates who seek routine dental care will be maintained at a Class II classification.

1. Class I patients:

a. Will have scheduling priority over other classes of treatment; and

b. Shall be provided care immediately, require emergency dental treatment for conditions such as acute oral infections (abscesses, periodontitis), fractured bones, traumatic injury of soft tissues, fractured tooth with vital pulpal exposure, severe pain, suspected neoplasm, or swelling.

2. Class II patients:

   a. Will have the second highest scheduling priority.

   b. Require treatment for conditions such as extensive or advanced caries, severe periodontal disease, asymptomatic pulpal or apical infections, or have a dental status that affects the individual's ability to obtain adequate nutrition.

3. Class III patients:

   a. Will have the third highest scheduling priority.

   b. Require treatment that is not of an urgent nature. Dental conditions in this class include moderate periodontal disease, caries not affecting the pulp, and multiple missing teeth.

4. Class IV patients:

   a. Require no dental other than preventive care.

   b. If their classification changes, care will be provided using the established priorities as noted above.

C. The maintaining facility to which the inmate is assigned will be responsible for providing oral care under the following Oral Care Criteria:

1. Twenty-four hour emergency care shall be provided to all Class I inmates in all facilities.

a. If indicated, hospital-based emergency care will be provided.

b. Telephone triage by a dentist will be available to the medical and nursing staff at times when the dentist is not in the facility.

2. Oral self-care education will be provided to as many inmates as resources allow by dental personnel of the maintaining facility.

3. An oral screening will be conducted by health care personnel at the time of reception into the Division.

   a. The purpose of this screening will be to determine if there are acute dental needs and referral for care if acute problems are identified.

   b. If resources allow, an examination will be completed on all inmates within three months after assignment to a facility.

   c. Each patient will be classified according to the priority of his/her dental needs and care will be provided, if needed, under the established priority guidelines.

4. Routine treatment for Class II, III, and IV inmates may include all necessary examinations, radiographs, diagnostic tests, periodontal scaling and root planning procedures, amalgam and composite restorations, limited endodontic treatment (see criteria below), extractions, pre-prosthetic surgery, and full and removable partial dentures.

   a. Priority on scheduling for routine treatment will be given to those inmates whose remaining sentences are more than 12 months.

   b. Routine dental care will be provided to medically compromised patients, regardless of the length of

incarceration, to preclude dental disease as a complication in the overall health status of the patient.

c. This care, however, shall be appropriate for the health status of the individual and will control foci of infection or other pathological processes that may negatively affect the patient's overall health.

d. The extent of routine caries will be dictated by patient responsiveness and interest in their oral health, and the availability of dental personnel.

e. Services will be provided to ensure the patient a healthy oral status that is care free, periodontally stable, and with enough teeth for adequate mastication.

D. There are necessary limitations of care as described below:

1. Endodontic care will not be routinely provided and will be limited to structurally and periodontally sound anterior or bicuspid teeth that are critical to the overall oral health of the patient. Since endodontic treatment requires a significant commitment of dental time, treatment planning, and administrative management, endodontic procedures will be monitored to ensure efficiency and conserve resources.

2. Treatment of Periodontal Class II or III cases will be limited to the removal of supra and sub gingival calculus and augmentation with self care.

3. No cast restorations (crowns, inlays and bridges) will be provided.

4. Full dentures will be provided for those patients who need but do not have dentures at the time of incarceration.

   a. Denture relines (lab or chair-side) will be provided where indicated.

b. Full dentures will not be provided more often than once every six years and reline procedures will not be provided more often than once every two years (regardless of intercurrent release and reincarceration).
c. Partial dentures will be all acrylic, with or without wrought clasps, and will only be provided where the minimal level of periodontal health has been achieved and all caries have been eliminated.
d. Replacement of missing teeth for cosmetic reasons will not be performed.
e. Partial dentures will only be provided to establish a minimal functional occlusion. Minimal functional occlusion shall consist of the presence of posterior masticatory function, functional guidance, and incisal function.
    i. Posterior masticatory function consists of at least four posterior teeth in each arch in a positive stable occlusion.
    ii. Functional guidance consists of bilateral cuspid lift or bilateral cuspid/bicuspid group function or any combination there of. Incisal function consists of an adequate number of opposing incisors in each arch to incise food.
    iii. Third molars are excluded from this definition.
    iv. Partial dentures will not be replaced more often than once every six years (regardless of intercurrent release and reincarceration).
f. In the event of a lost or broken appliance, a replacement will be completed.

i. However, laboratory and material costs for replacements shall be paid by the inmate.

Ii Dental time priority will be given to inmates requiring initial prosthodontic appliance fabrication.

E. There are exceptions to the Limitations of Care under the conditions described below:

1. The scope of treatment in the Oral Health Care Program is intended to be limited to those services provided in the general practice of dentistry and as outlined in this program description.
2. All exceptions to this limitation of care shall be approved by the regional director and dental contract administrators before initiating care.
3. The Agency Contract Operations Managers (ACOMS) have the authority to provide a final disposition if conflicts arise. DPSCS dental consultants have the authority to direct the contractor to provide referrals or additional care to inmates on a case-by-case basis.

F. Accessory treatment includes orthodontic tooth movement, fixed prosthetics, dental implants, edentulous ridge augmentations, orthographic surgery, TMJ appliances or surgery, or any other elective procedure requiring outside hospitalization or treatment by a dental specialist. Accessory treatment services will not be authorized services.

G. Quality assurance/inmate oral health care services will be evaluated using the DPSCS Oral Health Care Quality Assurance Program.

H. In the event dental sick-call backlogs to the equivalent of more than one month, the contractor upon the request of the ACOM in consultation with the DPSCS dental consultants will make arrangements to come into compliance within 30 days of the request.

I. Documentation

1. All oral health care shall be documented in accordance with the oral health care treatment form.
2. All inmates shall consent to and authorize dental treatment and/or oral surgery in accordance with DPSCS policies and procedures

III. References: DCDs 130-2, 130-4

IV. Rescissions: DCD: 130-500 Oral Health Care Program Description (issued 1995)

V. Date issued: October 15, 2007
Reviewed/Revised: September 17, 2009
January 6, 2011
September, 27, 2011
Reviewed October 2012
July 11, 2013
December 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 12
CLEARANCE FOR INMATES TO WORK

I. Policy: Inmates will be placed in jobs within the prison system only after medical clearance according to DPSCS established procedures and in compliance with applicable laws and regulations. If mental health clearance is also needed, the inmate will be referred to mental health or additional information to be added to the clearance form.
Note: Food Handler Clearance is covered individually under the Infection Control Manual.

II. Procedure:
   A. All inmates identified as eligible and targeted for a specific job within the prison system shall be medically cleared by a licensed health care provider in the institution where the inmate will work prior to beginning that job and whenever there is a medical issue raised regarding the infectious disease status of the inmate.
      1. Inmates with the following suspected or confirmed food borne illnesses or other potential food borne illnesses will not be cleared for food service (as stated in the Food Handlers' Clearance Policy in the Infection Control Manual):
         a. Hepatitis A
         b. Salmonellosis
         c. Shigella infection

d. Campylobacteriosis
e. Ambiasis
f. Vibrio species infection
g. Giardiasis
h. Viral gastroenteritis
i. Other enteric infections and/or non-specific diarrhea
j. Staphylococcal skin infections/or any open sores or draining wounds, MRSA
k. Streptococcal skin infections
l. Streptococcal (Group A, beta-hemolytic) pharyngitis
m. Trichinosis
n. Typhoid fever

2. Persons expecting to be assigned to non-food handling jobs are subject to scrutiny of the same infectious diseases in their clearance process, and the medical director for the Service Delivery Area/designee will have the final decision as to whether an individual with a disease in the list above can be placed into a specific job after taking into consideration the contact with others a job will require and the physical constraints that might be necessary to assure the medical well-being of the inmate or those with whom she/he may come into contact.
3. Clearance results from a medical assessment which shall include a chart review, physical inspection and a brief history to identify any potential infectious diseases. Some inmate work assignments require that a mental health assessment be completed before the final clearance is made.
4. Results of findings shall be documented in the medical record (EMR) and on Clearance to Work form.
5. Workers involved in any job that involves contact with others shall be provided education on personal hygiene and a demonstration of proper hand washing by the health care provider. Documentation of the education shall be placed in the individual's EMR or medical record if the EMR is unavailable.

a. If the clinician approves the inmate for a job, a copy of the Clearance to Work form shall be forwarded to the case management department of the DOC.
b. If the clinician approves the inmate for a job pending mental health approval, the Clearance to Work Form shall be passed to the mental health specialist assigned to the area for the additional screening and completion of the form. The mental health specialist shall forward the complete form to the medical staff for inclusion in the file and forward to the case management department.
c. If the clinician disapproves an inmate for a job, a medical referral shall be made to a physician for further evaluation and appropriate action.

B. An inmate with suspected or confirmed diagnoses that impact on their work assignments or those individuals who are in routine contact with (e.g. shigella, Salmonella, Hepatitis A etc.) will be referred immediately to the site Infection Control Coordinator and the medical provider or the mental health specialist as appropriate.
   1. The inmate will be medically treated for the indicated infection and medically cleared once again for the job after the clinician feels the inmate is safe to return to work.
   2. The inmate will receive the necessary treatment for his mental health disorder and communication between the mental health and somatic clinicians will determine the final outcome regarding clearance for work.

C. An inmate with a psychiatric history or behaviors that might impact a specific job for which he or she has shown interest (such as suicide prevention companion) will be referred to mental health for additional clearance before the inmate may initiate service for that job regardless of the current status of the mental health disorder.

III. References:

A. DCD 130-200: Infection Control Manual, Section-Prevention (Food Services Control and Sanitation)" Section-Reporting
B. COMAR 10.06.01 – Communicable Diseases (reviewed date—2007)
C. COMAR 10.16.01.09 – Foodborne and Waterborne Diseases

D. DCD 160-9, Food Services Handler Sanitation and General Orientation.
E. Maryland Commission on Correctional Standards C-3, C-4, C-5, C-8.
F. Federal Bureau of Prison OPI: HSD/FDS 4700.05 Food Service Manual (June 2006)

IV. Rescission: None

V. Date Issued: October 15, 2007

Reviewed/revised: September 13, 2009
January 6, 2011
September 27, 2011
October 31, 2012
July 2013
December 2014
December 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 13

SEXUAL ASSAULT ON AN INMATE

I. Policy: Detainees/inmates reporting to have been sexually assaulted while in DPSCS custody shall be managed using guidelines consistent with the Prison Rape Elimination Act (PREA). An initial medical evaluation and subsequent intervention focused solely upon injury or trauma sustained during the assault shall be conducted. DPSCS medical vendors will not participate in or conduct a forensic examination. All specimen collection for forensic examinations will be done after the patient is transferred to an approved off site medical facility for assessment by an independent provider or nurse who conducts forensic examinations.

II. Procedures:

A. Any contractor or state psychology staff who becomes aware of or receives report of sexual assault on an inmate/detainee shall notify Custody without sharing medical details, and shall notify other vendor staffs, facility PREA compliance manager, medical vendor's Regional Administrator and additional authorities following PREA National Standards CFR 115.61(a-e). All notifications must be documented in the victim's medical records.

B. Following any report by an inmate concerning sexual assault, the inmate will be brought to medical for an examination to address any immediate medical needs.

C. The clinician will identify and triage detainees/inmates that require medical intervention, and provide treatment (First Aide type, ice bandages etc.) necessary to stabilize the inmate prior to and during transfer to a facility for forensic examination. No attempt to wash blood, semen or any other

body fluids off of the inmate, clean or remove clothing or potential evidence shall be done.

1. If the reported sexual assault incident occurred beyond 72 hours from the date of presentation to medical, unless there is rectal tear or associated trauma, an ER visit or assessment by a Sexual Abuse Forensic Examiner (SAFE)/Sexual Abuse Nurse Examiner (SANE) would not be indicated as there is no data to support that forensic evidence would still be recoverable beyond 72 hours of a sexual assault incident. The notifications to the mental health psychology staff, social work and PREA coordinator will be done irrespective.
2. If the event is within the 72 hours guideline regarding the sexual assault allegation and the provider believes the event is indicative of one that would yield forensic information if testing occurred then the decision to refer the inmate offsite for evaluation can be made by the clinician.
3. The clinician will make the call to the local ER and discuss the indications regarding a PREA incident and any pertinent medical or mental health information including disabilities (hearing, intellectually challenged, blind, etc.). Any noted disability should be documented.
4. Fondling, kissing, external rubbing of genitalia without skin to skin contact, buttocks patting, does not usually warrant off site referrals but do require referrals to licensed mental health professionals, state psychologist, notification to the PREA coordinator, medical vendor's Regional Administrator, and custody staff and documentation of referrals in the electronic medical record and the completion of an incident report (SEIR).

D. If no clinician is available on site to make a determination regarding off site assessment by SAFE/SANE, the following will occur:

1. The nurse will contact the on call clinician to make a determination regarding the need for offsite transport for forensic evaluation and to notify the local ER of the allegations of sexual assault.
2. The nurse will document all measures taken in the patient's medical record.
3. All facts regarding injuries as reported by the patient will be included in the medical record including any disabilities.
4. If the alleged sexual assault precipitates a determination that the event necessitates an offsite forensic examination or there are medical indications or concerns that an examination should be performed, where possible, inmates will be taken to an offsite medical facility that has a SAFE or SANE to conduct the forensic examination related to the sexual assault allegation. If this expertise is not available then an external provider/nurse who has training regarding forensic examination related to sexual assault can be substituted by the community facility.
5. The medical vendor staff will notify the mental health contractor, state psychology, state social work and the facility PREA compliance manager of the allegations of a PREA incident as soon as possible and will document the notifications in the electronic health record within the shift.
6. The medical vendor will complete a Serious Event Incident Report—PREA using the contractor's Serious Event Incident Report (SEIR) form and fax it within 12 hours to the designated DPSCS Clinical Services contact person and copy Psychology, Social Work and Mental Health staff, of the facility. Hot line allegations of PREA related incidents notifications should follow the same alert route.

E. No forensics activity will be performed by the DPSCS Medical Contractors including but not limited to nail scrapings, cultures, smears, in-depth genital examinations (except as needed to perform "first-aid").

F. The nurse in the examination area shall make arrangements for transfer of the patient to a community hospital where all forensic evidence will be collected and a thorough examination of the patient will be completed.

1. The clinician will call the Emergency Room to which the patient is being transported to inform the receiving facility of the event and the patient's observed condition.
2. A copy of the clinician's findings of the initial history and cursory examination shall accompany the patient to the hospital.
3. The contractor nurse will contact the facility PREA compliance manager to let them know the patient has been seen, stabilized and sent to the hospital within one hour of the transfer.
4. Nurse will make a referral to the mental health vendor for follow up of the patient upon his or her return to the facility along with state psychology.
5. Within 4 (four) hours of return to the DPSCS facility, a clinician will review the emergency room notes, and write appropriate orders for care in the patient's medical record. If the provider is off site the ER protocol for review will be conducted and the disposition of care executed.
6. All inmates shall be seen for medical follow-up within the first 24 hours following the initial offsite medical visit regarding the allegations of sexual assault.
7. All follow-up testing related to Sexually Transmitted Infections (STI), pregnancy, HBV, RPR shall be reviewed with the inmate within 5 business days, including any additional testing or required treatment.
8. All of the PREA related post assault follow-up clinical activities for medical, and mental health care must be completed whether or not an off-site visit was indicated including testing and prophylactic treatment for STIs and pregnancy (if female).

9. If pregnancy results from the sexual abuse the detainee or inmate shall receive timely and comprehensive information about access to all pregnancy related medical services including abortion, as outlined in the DPSCS Clinical Service Pregnancy Management Manual along with a referral to Mental Health/Social Work.
10. If custody indicates an inmate should not be transported offsite for care, the contractor regional and statewide medical directors must be notified ASAP by the staff to confer and make recommendations. The DPSCS Medical Director must be notified if there is an inability to resolve the issue of the dispositions.

G. Juvenile offenders who report allegations of sexual assault or coercion shall be separated from the other offenders.
   1. Medical staff, custody staff or any other vendor staff, (Mental Health, Dental, Etc.) shall develop a process to report and respond to any PREA related incidents that are identified via Hot Line or Department of Juvenile Services or Social Services reporting number. The incident, name and facility location and return number shall be documented in the inmates/detainee record.
   2. A Serious Incident Report (SEIR) should be generated using the contractor SEIR form and DPSCS ACOM notification of the allegations or assault should be done with copies to DPSCS Clinical Services contact person, psychology, mental health, and social work staff of the facility.

H. A Mental Health Professional will see the patient within 24 (twenty-four) hours of his or her return to evaluate for any treatment needs, and document findings in the patient's medical record.

I. If the patient's situation did not generate the need to have an off-site hospital visit, a mental health professional shall conduct a mental health evaluation within 24 hours of initial report of incident and document disposition and follow-up needs as indicated.

J. Upon repeated, recurrent allegations of Sexual Assault by offenders facility staff shall convene at the direction of the DPSCS statewide Medical/Mental Health Directors, and /or Jail Administrator or Warden of a facility, a multidisciplinary clinical/custody team to review offenders who have repeated allegations of sexual threat, assault or conduct to glaring evidence of an environment that precludes the possibility of a sexual infraction occurring. A plan of action for these cases will be reviewed and supported by the team with documentation of the disposition placed within the inmates' record.

   Offenders who are not in general population but are separated from other offenders and are within sight and sound of custody staff, who repeatedly report incidences of sexual misconduct in an environment that is not accessible to other inmates *may on a case by case basis* post review and recommendation of the multidisciplinary committee, <u>not be transported for evaluation off site</u>. Medical and Mental Health staff will case manage his or her complaints, and document that the environment the inmate resides in is safe.

K. The alleged abuser shall be offered mental health evaluation by a mental health professional within 30-60 days of the alleged assault or abuse.

L. The alleged abuser shall be offered testing related to STIs within 5 business days.

M. The patient and alleged abuser shall be offered follow-up STI testing within 60-90 days of initial testing to include HIV, HCV, and syphilis serology.

N. If the patient or alleged abuser refuses the offered testing, the DPSCS procedure for refusal of care shall be followed.

O. All treatment services shall be provided to both parties (the victim, and the alleged abuser) without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

P. The Contractor shall comply with any standards adopted by the Attorney General of the United States in conjunction with the Prison Rape Elimination Act (PREA). Training of Clinicians and Healthcare Professionals on identification of evidence of unreported sexual assault and appropriate referral processes for possible sexual assault cases shall be entered into the Contractor's database confirming that the training has been provided within 90 days of staff hire and in accordance with the DPSCS zero-tolerance policy.

Q. A query of documented DPSCS PREA incidents from Clinical Services will be sent to the Health contractors to review for compliance with PREA standards. The contractor shall conduct PREA compliance audits on a monthly basis; and will submit audit results and a trending report by region and facility on the DPSCS NetDocs site. The contractor shall submit a corrective action plan for non-compliant areas.

R. The contractor shall present PREA findings and trending reports at the monthly/quarterly MAC meetings.

III. References

NCCHC Standards for Health Services in Jails J-B-05
NCCHC Standards for Health Services in Prisons P-B-05
ACA Correctional Health Care 1-HC-3A-13
Prison Rape Elimination Act – Part 115 National Standards
Medical RFP
DPSCS Inmate on Inmate Sexual Conduct-Prohibited (COS.200.0004)
DPSCS Pregnancy Management Manual

IV. Rescissions: None

Date Issued: March 29, 2011
Date Reviewed: September 27, 2011
Date Reviewed: February 12, 2012
Date Revised: October 12, 2013
Date Revised: February 28, 2014
Date Reviewed: December, 2014
Date Reviewed: December, 2015

DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SYSTEMS

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 2
PERIODIC MEDICAL EVALUATIONS

I. Policy: It is the policy of the Department of Public Safety and Correctional Services that periodic medical examinations are offered to all inmates in correctional institutions annually for inmates 50 years of age and older, and every four years for inmates under 50 years of age. In addition, age and gender appropriate preventive health screening will be conducted as suggested by the American Academy of Family Physicians.

II. Procedure:

A. Periodic medical evaluations shall include:

1. Physical Examinations – Physical examinations shall be performed utilizing the DPSCS Period Physical Examination form and will include the following at a minimum:
    a. Vital signs and weight
    b. Peak flow, pulse ox where indicated and random finger stick for glucose per policy
    c. TB screening results
    d. Full examination of the head, ears, eyes, nose and throat
    e. Examination and documentation for umbilical or inguinal hernias
    f. Neck, lymphatics, skin, extremities, breasts, lungs, heart, abdomen, genitalia, pelvic exam (females), PAP smear examination.
    g. Neurological (cranial nerve exams) systems examination.
2. Diagnostic and age appropriate preventive health screening tests consistent with the recommendations of the American Academy of Family Practice Physicians will be conducted and documented on the DPSCS Intake History and Physical Examination Form, as follows:

a. Urinalysis dipstick for protein, red/white cells/glucose
b. Complete Blood Count (CBC)
c. Electrocardiogram and interpretation at age 50 as a baseline study and at any age when medically indicated
d. Snellen vision test
e. Audiometric screening with tuning fork for inmates 22 years of age or older and with bell-tone audiometer for inmates 21 years of age or younger
f. Blood sugar test
g. Other diagnostic test when clinically indicated
h. Stool for occult blood x3 and an assessment for colorectal abnormality including digital rectal exam and consideration for colonoscopy per community standards
i. A digital prostate examination will be performed on all males beginning at age 40 or earlier if symptoms indicate a need.
    i. All males age 40 and above will be evaluated for the need to perform a PSA (Prostate Specific Antigen) test and the test will be done if deemed appropriate by the examining physician.
    ii. All males age 50 and above will have a PSA at the time of their periodic physical examination

3. Breast screening include:
    a. Breast examinations and mammograms shall be performed on female inmates beginning at the end of the inmate’s first year of incarceration in accordance with the following guidelines and timetable
    b. Breast examination annually for inmates 35 to 39 years of age and mammogram x 1 at age 39 unless exam is abnormal then a clinically warranted
    c. Breast examination annually and mammogram every two years for females 40 to 49 years of age with a negative family history of breast cancer and negative breast exam

d. Breast examination and mammogram annually for females 40 to 49 years of age with a family history of breast cancer, or previously abnormal mammogram
e. Breast examination and mammogram annually for females 50 years of age or older regardless of family history
f. Mammograms may be ordered at any time when medically indicated, e.g., symptoms of breast cancer, personal history or breast cancer of the breast exam is abnormal.

4. Cervical/uterine cancer screening includes pelvic examinations and PAP smears to be performed with the following frequency from the date of intake:
   a. Every two years for females under 40 years of age unless otherwise clinically warranted
   b. Annually for females 40 years of age or older
   c. Abnormal PAP smear are to be repeated and a referral made to a GYN specialist for evaluation and colonoscopy exam when medically indicated
5. All inmates with a negative or unknown history of a positive PPD shall receive annual tuberculin skin testing with results documented in the inmate medical record, utilizing the DPSCS Tuberculosis Testing Form
6. All inmates seen for a periodic examination will be offered an opportunity to have a test for HIV/AIDS. The offer and resulting response of the inmate will be documented in the patient EPHR.

B. If an inmate refuses any part of the Annual or Quadrennial Periodic Physical then a Release of Responsibility form signed by the inmate listing sections refused must be placed in the medical records.

C. Any new diagnoses resulting from periodic medical evaluations shall be recorded on the problem list in the EMR.
   1. Abnormal test will be discussed with the inmate within 14 working days of the result and documented in the EPHR that the inmate has been informed.
   2. A treatment plan will be developed and documented in the EPHR and discussed with the inmate.

D. Documentation of exams and testing results shall be done in the medical record.

III. References:

   A. ACA Standard 3-4348, Periodic Examinations

   B. MCCS Standard .02, Periodic Health Examinations

   C. DPSCSD 130-110, Medical Intake Evaluation

   D. DPSCSD 130-207, Medical Management of Tuberculosis

IV. Rescissions: DCD 130-100, Section 112, Periodic Medical Evaluations

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Chapter 3
BCBIC DISPENSARY OBSERVATION

I. Policy: To optimize the use of resources and secure public safety personnel transportation of pre-trial patients with non-emergent medical conditions, patients with medical conditions requiring close observation will be observed in the BCBIC dispensary for a period of time while they await available shuttles to local community hospitals so long as their medical condition is stable and transportation by custody or regular ambulance is considered prudent by licensed medical providers. Patients with emergent medical condition and/or serious jeopardy to their health, serious impairment of bodily function or dysfunction shall be referred to emergency room via 911.

II. Procedure:

A. The following definitions shall apply for the purposes of this policy:

1. Medical observation—Medical observation is monitoring and observing medical urgent/non-emergent patients in the dispensary until a final disposition is made or effected within a 12-24 hours period of time. It is not for holding emergencies.
2. Observation Cell- The room designated to treat and observe relatively stable medical patients until a final disposition is made {i.e. Room 2S51—at BCBIC}.
3. Non-Urgent Condition – a medical condition in which a patient's vital signs, wound, or other medical complaint do not present immediate danger or further harm to the patient in the opinion of a licensed medical practitioner.
4. Urgent Condition— a medical condition that is able to wait for intervention for at least 12-24 hours without requiring specialized medical attention in the opinion of a licensed medical practitioner.

5. Emergent Condition – a medical condition that requires immediate intervention secondary to the fact that the condition would cause significant morbidity, further harm, or death with any delay in care.
6. Transportation shuttle- designated vans that drop off and pick up detainees requiring urgent or non-emergent care 7 days per week with the following frequency: 7:30 am, 11:30 am, 7:30 pm and 11:30 pm

B. Triage of all medical complaints shall be completed by a Registered Nurse or higher level to determine non-urgent, urgent, or emergent status of the complaint.
   1. If one of the categories requiring further medical attention is necessary, the nurse shall consult with on site or on-call provide to determine mode of transportation and whether the complaint can be held in observation or immediate transportation is necessary.
   2. Nurse shall record the outcome of this consultation in the patient's medical record: the EMR if one has been activated on the detainee or the hard copy file if one has not yet been activated. Documentation into the EMR shall be completed using the "unscheduled visit template" for both nursing and provider encounters
   3. No patient shall be admitted to the observation area until this consultation is complete.

C. All persons admitted to the observation area shall be evaluated face-to-face by a medical provider before or immediately after admission to an observation room.
   1. An admission to the observation room requires a working diagnosis, reason for observation, plan of care and monitoring parameters and these shall be determined by the admitting provider.
   2. Monitoring Parameters shall be defined and ordered with immediate notification values. (For example: "inform MD or PA/NP for BP<90 mm/hg" or "Contact clinician with changes in orientation to time place person").

D. Nursing staff shall document all monitored and observed parameters in EMR (Next-Gen). The parameters should include but not be limited to, vital signs, (temp, pulse, BP, respiration Pulse-ox), and a finger stick for blood sugar on admission and also as ordered.

1. Nursing assessment and its documentation must be completed by a registered nurse every 4 hours and as ordered by a provider.
2. On-site providers must make patient rounds of the observation area every 4 hours and as needed.
    a. A medical disposition of a patient's condition shall be made on all patients who are observed while waiting for transportation.
    b. Patients who require more than12 hours of observation should either be sent to the infirmary (MTC & WDC), or to an outside hospital based upon the clinical situation as assessed by a provider and agreed to by the regional medical director/designee.

E. All discharges from the observation room shall be documented with follow-up treatment plan.

F. All orders and treatment plans received from an on-call provide shall be entered into EMR as a telephone order by the nurse receiving the order.

1. All telephone orders shall be tasked to the providers review and completion shall occur within 24 hours of making the phone order.

G. Tracking of patients placed in observation shall be logged and there shall be documentation of each observation to include but not be limited to:

1. Logistical information including date, item entered, observation area, time of observation.
2. The patient's appearance (state of consciousness, visible exudates, color, demeanor, indications of plan, etc.).
3. Vital signs results.
4. Verbal complaints.
5. Any unusual findings seen or heard.

H. Utilization management notifications process shall be completed for any off site care including the requests for authorization, completions of any necessary forms and follow through with collegial reviews of each case.

III. Reference: None

IV. Rescissions: None

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Chapter 4
EMERGENCY SERVICES

Section A
EMERGENCY SERVICES

I. Policy: All DPSCS inmates and detainees requiring emergency health care shall receive timely treatment from appropriately trained personnel and emergency care organizations in accordance with established procedures and the DPSCS Utilization Management Procedure and Protocol Manual.

II. Procedure:

   A. Emergency health care services shall be provided in DPSCS institutions in accordance with the following parameters:

      1. All DPSCS institutions shall have 24-hour "on-call" somatic and psychiatric physician coverage documented on a monthly roster distributed and posted for the staff and facility personnel.
      2. All DPSCS institutions shall have access to community emergency medical services (EMS) including, but not limited to:
         a. Emergency Department/Community Hospital
         b. Regional Trauma Center
         c. Regional Burn Center
         d. Poison Control Center
      3. Listings of emergency resources shall be posted in medical areas designated by the Regional Medical Director and in administrative areas designated by the managing officer. These lists shall include emergency addresses and telephone numbers.
      4. The Regional Medical Director/designee shall coordinate "911" emergency services with appropriate local emergency health care providers who provide

ambulance “911” response operations. The Utilization Management contractor policy and procedure regarding emergency notifications shall be followed. The process shall include the following:

a. Expedient evacuation of inmates requiring emergency medical treatment, following assessment by a Registered Nurse or higher.
b. Uninhibited facility access for community emergency vehicles, equipment and personnel.

5. Any problems or delays in providing community “911” emergency service responses shall be reported to the contractor managing officer, the Regional Medical Director, Agency Contract Operations Manager (ACOM) and the DPSCS Medical Director.
6. All DPSCS detainees who suffer medical emergencies shall be provided first-aid and Basic Life Support (BLS) services by trained medical staff, civilian staff and custody staff. Visitors who experience medical emergencies shall be triaged and managed by contractor health staff until community emergency services arrive.

B. All clinicians, nursing staff, dentists, mental health staff, vendor administrators/support staff and correctional officers working in DPSCS institutions shall be certified in BLS or American Heart Association (AHA) emergency medical care and re-certified per perspective organizations in accordance with applicable directives. All medical healthcare personnel shall have Automated External Defibrillator (AED) training and competency documented in their personnel record.

1. Documentation of BLS/AHA/AED training and/or certification shall be readily available in the medical administrator’s office on site and shall be documented and updated as needed in the DPSCS credentialing and training folders repository. BLS certification includes familiarization with the operation of the AED.
2. No less than annually, the Regional Medical Director / designee shall ensure that designated clinicians and nursing staff in all DPSCS institutions receive

in-service training on the provision of emergency medical care. Training shall include the following:

a. Review of the usage and location of stock emergency medications, supplies, and equipment, and
b. Basic first aid training

C. All DPSCS institutions (dispensaries and infirmaries) shall maintain emergency medications, supplies, and equipment according to established lists that have been approved and maintained by the Regional Medical Director.

1. All DPSCS dispensaries, and infirmaries, designated by the DPSCS Medical Director, shall maintain an AED. This device will be tested weekly at a minimum, and testing results will be recorded on a log as part of "crash cart" checks. A monthly AED utilization report shall be submitted as part of the CQI monthly meeting agenda.
2. The emergency "crash cart" and other emergency supplies shall be stocked, at a minimum, with the items listed in Appendix 1 found at the end of this Chapter.
3. The emergency "crash cart" shall be sealed without compromising emergency access. Seals will be checked for breakage each shift by the nursing staff.
4. Emergency "crash cart" contents, and other emergency supplies, shall be replaced as necessary. The emergency "crash cart" will be inventoried immediately following utilization. Weekly inspections shall be conducted by the medical contractor staff to ensure that supplies are available according to protocol and to ensure that no medications have expired.

D. First Aid Kits shall be made available in all DPSCS institutions, and in designated DPSCS motor vehicles. They shall be contained in areas that provide security, yet allow ready accessibility to necessary emergency supplies.

1. Locations of first-aid kits shall be determined by the managing officer, in conjunction with the Regional Medical Director. First aid kits shall be maintained in accordance with the guidelines outlined in the Department's approved pharmacy manual.

2. First-aid kits shall contain, at a minimum, those emergency supplies listed on the First-Aid Kit Stock List as seen in Appendix II found at the end of this Chapter.
3. First-aid kits shall be compact and manually transportable.
4. An inventory of supplies shall be listed in all DPSCS facility first-aid kits. This inventory of institutional First-Aid kits shall be reviewed monthly by the designated Charge Nurse.
   a. Outdated inventory shall be replaced and missing medication documented per pharmacy policy and procedure.
   b. A summary of the outdated inventory shall be submitted as part of the contractor pharmacy audit report submission to DPSCS.
5. All supplies will be kept individually wrapped and dry in order to maintained cleanliness. Supplies should remain organized insuring ready accessibility.
6. The inventory of First-Aid Kits in DPSCS motor vehicles shall be completed by designated officers and medical staff as appropriate to ensure that adequate supplies are maintained.

E. Medical staff shall participate in all disaster drills conducted by DPSCS personnel.

F. Emergency drills – the Regional Medical Director / designee shall conduct emergency drills no less than semi-annually for all DPSCS facilities and maintain documentation of the drills and training components of the drills.

III. References:

A. NCCHC – Correctional Health Care – Prison Standards, 2003
B. DCD 110-24, Emergency Operations Plan
C. DCD 130-100; Section 140 – Emergency Services Protocol – 140A Automatic External Defibrillator – Jan. 2002

IV. Rescissions: DPSCS 130-100-140 Emergency Services

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Chapter 4
EMERGENCY SERVICES

Section B
AUTOMATED EXTERNAL DEFIBRILLATOR (AED)

I. Policy: All licensed medical and mental health providers contracted for the department and designated as first responders shall be trained in the use and maintenance of the Automated External Defibrillator (AED) for utilization as an adjunct in providing emergency Basic Life Services (BLS) to inmates, employees and visitors.

II. Procedure:

A. The Heartstart FR2 AED Trainer and Training Tool Kit will be used by a licensed BLS or ACLS instructor to train all health care providers in the use of the AED.

1. Training for all healthcare staff will be conducted in conjunction with CPR re-certification.
2. Additionally, self-learning packets will be accomplished at least every 6 months.
3. All newly hired healthcare providers will be trained in the proper use of the AED within one month of employment.
4. Training shall include a review of operation, troubleshooting AED problems, changing the battery and performing a battery check in addition to the use of the apparatus in an emergency.

B. The AED will be located in designated Clinical areas within the Infirmary and the dispensary areas. It will be stored and be readily available with other emergency equipment.

1. The User Manual will be clearly labeled and kept in the AED carrying case.

2. A copy of the Required Equipment List will be placed on each AED carrying case.

C. The progress note should reflect the use of the AED on the patient during the emergency situation and why its usage was clinically indicated.

D. The AED will be maintained in good working condition.

1. A Safety Inspection Log will be completed by the charge nurse or designated nurse every shift at each location where an AED is kept.
2. The safety inspection log will consist of:
   a. An inspection of the carrying case
   b. A charged battery check of the hourglass status indicator and
   c. A visual count of all equipment in the carrying case.
3. Any/all discrepancies will be corrected by performing the appropriate trouble shooting. The nurse will:
   a. Record discrepancies on the daily safety inspection log.
   b. Report discrepancies to the DON or designated nurse manager accordingly.

E. All supplies depleted from the use of the equipment will be replaced immediately following use. The same will apply to replenishing expired supplies.

F. Considerations/Precautions to be taken include:

1. Avoidance of the use of radio transmissions within 6 feet of the patient.
2. Avoidance of placing defibrillation pads over implanted pacemakers or defibrillators.
3. Removing any medication patches from the patient's chest and wiping the area clean.

G. A monthly State wide report on AED utilization shall be submitted by the contractor to the Department of Public Safety and Correctional Services: Office of Clinical Services/Inmate Health.

III. References: DPSCS, Office of Clinical Services/Inmate Health, Medical Evaluations Manual, Chapter 4, Emergency Services.

IV. Rescissions: DPSCS Directive 130-100-140A (AED)

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Chapter 5
CONSULTATIONS

I. Policy: All Maryland DPSCS detainees and inmates shall have timely access to medical to medical, surgical, mental health and dental consultations when medically indicated. Consultations will be conducted pursuant to the DPSCS approved Utilization Management contractor protocols and procedure manual. Telemedical conducted consultations are the preferred process.

II. Procedure:

   A. Contractors shall abide by the Agency approved comprehensive Utilization Management (UM) Protocol and Procedure Manual.

   B. On a minimum of a weekly basis the facility patient care committee will review the disposition of Consultations awaiting approval from the Utilization Management Medical Director and document in the electronic record the ongoing options disposition/treatment of the inmate.

   C. The primary provider upon submission of a formal consult to UM shall receive information regarding approval or denial within 5 working days of submission of consultation.

      1. However priority considerations for tele medical approved consultations are a priority. Specialty consultations that can be completed via telemedical technology will be documented as the default preference. Accordingly, pre-certification process includes but is not limited to:

         a. Outpatient procedures and consultation
         b. Specialty diagnosis, imaging services
         c. Surgeries
         d. Twenty-three (23) hours admission requests

e. Urgent/ER admissions
f. Inpatient hospitalizations (non emergent)

D. All DPSCS medical consultations shall have a written order in the medical record by a physician, midlevel provider, psychologist, psychiatrists or dentist.
E. The medical indication for all consultations shall be documented in the EMR as an On-Site Consultation request using the On-Site Consultation request in the EMR.
F. The medical contractor provider shall discuss the reasons for the consultation with the site Medical Director who will agree or disagree with the request. If the site Medical Director disagrees, he or she will discuss alternative plan with the provider and document such in the EMR. If the site Medical Director agrees with the request, he or she will forward the request to the Regional Medical Director who will participate in the Utilization Management collegial review process as referenced in the Utilization Review Manual.
G. The Regional Medical Director will document the outcome of the collegial review in the EMR on the same date of the review.
H. The medical contractor shall submit a Consultation Summary report to the ACOM on a weekly basis to include all consults requested by providers with dispositions. The DPSCS Chief Medical Officer will be copied on all consultation appeals within 24 hours of the appeal via e-mail.
I. All appropriate staff shall receive in-service training on the consultation process. Documentation of the in-service including a list of persons attending the training shall be forwarded to the DPSCS Agency Contract Operations Manager.
J. The copy of consultation template shall be forwarded to nursing and/or medical records staff. Consultations shall be scheduled in accordance with institutional procedures.
K. Medical record staff shall document the consultation type and location, order date, scheduled appointment date, completed consultation date, utilization review request and approval or denial date on a Consultation Log.
L. The time period for scheduling and completion of the routine consultation will follow the UM contractor guidelines.

1. Consultations exceeding an eight-week time frame shall be reviewed by the regional health care manager and the contractor's medical director or physician designee. A monthly report of the consultations that exceeded the time lines shall be submitted to the ACOM for review.
2. The reason for delay shall be documented in the EMR and communicated to the patient.
3. If there has been a "missed appointment" related to scheduling or transport, the contractor is to document such in the EMR and submit on a monthly basis, a "missed appointment" listing and a completed appointment listing as part of the specialty consultation log submission to the ACOM region.
4. The log shall identify the rescheduled date.
5. The contractor shall incorporate UM missed appointments in the monthly CQI agenda along with the UM approval and alternative option recommendations.

M. Telemedical consultations:
   1. By inmates name number site and consultation specialty a report of why a consultation could not be completed via telemedical will be sent electronically to the DPSCS CMO weekly for review with a copy to the Contractor director to Telemedical. It will be part of the CQI data reporting at the quarterly CQI meeting and tracked.

N. Emergent/urgent consultations shall be completed within a 24/48 hour period respectively utilizing the procedure outlined in the UM Manual.

O. All cancelled or denied consultations shall be documented by a physician in the inmate's EMR progress notes, including an explanation as to why the consultation is no longer medically indicated.
   1. These cases will be discussed during collegial review.
   2. The DPSCS Chief Medical Officer shall be advised in writing of any desire for an appeal of the UM decision by contractor's Regional Medical Director and the UM Medical Director.
   3. An audit of the denied/alternative recommendations listing shall be conducted by DPSCS CQI at least twice yearly.

P. Medical records or nursing staff shall ensure that all completed consultations are forwarded to a physician for review.

1. No completed consultations will be filed unless it is initialed and dated by the contractor physician.
2. The reviewing physician shall initial the completed consultation report and order any medically indicated diagnostic studies, evaluations, or treatments and then document the review in the EMR progress not and schedule a follow up appointment with the inmate to discuss the results within 30 days of the completed consultation.

Q. Depending upon the urgency of the consultative matter, a physician shall review the consultation results with the inmate:

1. Within 2-4 weeks after receiving the consultant's recommendations but within 5 days for more urgent conditions.
2. Document the discussion and the inmate's electronic medical record.

R. The ordering physician shall be responsible for ensuring that inmates in need of urgent consultations or major surgery are not transferred to another DPSCS facility by implementing the following procedures:

1. Urgent consultations are marked "urgent" on the consultation template.
2. Initiate a written Physician Order for "Medical Hold."
3. The institutional case management supervisor or facility administrator shall be notified that the inmate cannot be transferred without medical clearance, using the appropriate DPSCS form.
4. The form shall be marked in the Transfer/Housing Assignment section for Restricted: Medical Hold Evaluation in process, inmate should not be transferred.
5. When appropriate, the clinician will indicate length of the restriction.

S. The clinician shall lift any restriction ordered when the evaluation is completed by using the same DPSCS Form as used to make the restriction.

T. The DPSCS Medical Consultation Log will be submitted monthly to the Agency Contract Operations Manager and Utilization Management Contractor.

III. References: NCCHC P-E-12, Continuity of Care ACA, Section E: 4-4347

IV. Rescissions: DPSCS 130-100-126 Primary/Specialty Medical Services Consultations

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Chapter 6
INMATES WITH SPECIAL NEEDS

I. Policy: Inmates admitted into DPSCS facilities who demonstrate medical, physical or mental health needs that require special adjunctive support in order to secure their safety and well-being shall be identified during the initial intake receiving process and/or during other clinical encounters. Appropriate measures that include treatment and discharge planning shall be done to accommodate the inmate's disability such that continuity of care and support is maintained upon entrance and at discharge from the facility.

   Special need patients are inmates who are medically stable but cannot be housed in general population because of their physical or medical condition. These patients include, but are limited to: persons with machines for sleep apnea, persons with dialysis catheters, or those with other impairments or disabilities, vision, hearing, or chronically ill; communicable diseased; terminally ill or developmentally disabled. Mental health inmates whose conditions limit mainstreaming may be housed in special mental health units or infirmaries.

II. Procedure:

   A. All inmates upon entry into any DPSCS facility shall receive a medical and mental health receiving screening as part of the intake process within 2 hours, conducted by a clinician (at minimum a RN) and followed up utilizing the DPSCS Intake History and Physical Examination Form within 7 days.

   B. All physical examinations will be reviewed by a physician and the reviewing physician will ensure that all identified medical, dental and mental health problems are documented on the DPSCS Problem List.

C. All detainees and inmates with active acute or chronic medical conditions identified at receiving screening shall be referred immediately for clinical evaluation by a midlevel provider.

D. The initial intake examination shall identify physical and mental disabilities that require specific treatment accommodations in order for the inmate to successfully navigate the routine demands of correctional environment. The examination may require the following:

   1. Snelling Vision Test – On all DPSCS or Patuxent inmates unless one has been performed and documented with the past 12 months at local detention centers or other DPSCS facilities.
   2. Hearing Testing – Audiometric testing for DPSCS or Patuxent inmates in accordance with the following:
      a. Bell-tone audiometry for all inmates under 21 years of age,
      b. Tuning Fork Test for all inmates 21 years of age and older unless performed and documented within the past 12 months at local detention centers or other DPSCS facilities, and
      c. Identification of need for interpretive services.

E. All sentenced inmates identified with disabilities by a clinician at the time of physical examination shall have documentation of the disabilities included in the medical record on the DPSCS Disabilities Assessment Form.

F. Disabilities shall be described in functional terms only without disclosure of related medical problems such as hypertension, diabetes, cancer or HIV infection. (Example: description may include such descriptions as limited mobility of legs or visually impaired without stating the diagnosis associated with the impairment.)

   1. The evaluating clinician shall determine the level of medically permissible activity and medically necessary housing assignments for all sentenced and pretrial inmates including special consideration – to the extent reasonable possible – for sight and sound separation of juveniles from adults.
      a. At the time of admission to a special needs unit, the clinician will document in the medical record the reasons for admitting the inmate to the

special need unit, how long he is likely to remain in the special need unit and what would be required to move the inmate from special housing.

  b. Any medication given to the patient will be documented on the MAR per standard medication protocol.
  c. Where possible, a multidisciplinary team approach to the management of the needs of the patient may be done on a monthly or as needed basis.

2. Individuals requiring durable medical equipment or special assistive devices shall be allowed to maintain equipment from home. If none is available from the home, the department will provide medically approved assistive devices.
3. Special needs inmates shall be considered for work assignments consistent with the level of abilities associated with their perspective challenges.
4. The clinician's recommendations shall be documented using the Medical Clearance: Program and Work Assignment Form which shall be forwarded to the case management manager or supervisor.
5. Inmates with special needs housed in onsite special medical housing or cells will be monitored by the medical contractor staff.
   a. If an inmate's medical condition changes or becomes unstable, the clinician will provide admission orders to the infirmary. If the condition is stable but requires observation, transfer to a special needs unit if available within the facility may be done, if acute care hospital housing is not deemed necessary.
   b. The nurse or the clinician will assess the suitability of housing for an inmate in a special care unit and he/she will make the determination of the disposition for a patient housed in a special needs unit.
6. Inmates with special needs may require additional care and contracted medical staff will assess clothing, mattress, blankets, commissary, access to phone, meals and other privileges to assure that these will be similar to those of inmates housed in the general population unless otherwise ordered or restricted by the nurse, clinician, or custody staff.

G. A copy of the form shall be forwarded to the case management manager or supervisor of the intake facility for case management purposes related to housing, jobs, etc.

H. A physician will develop an individual treatment plan that is documented in the medical record on the Intake History and Physical Examination Form for all inmates with special needs.

I. Inmates admitted to the infirmary or any special medical or mental health unit, who return from the hospital or the emergency room, will have their treatment plan updated to reflect any additional findings resulting from that medical encounter.

J. A Psychiatric treatment plan, when applicable, shall be documented by a psychiatrist/mental health professional in the medical record progress notes. The treatment plan shall include, but not be limited to the following:

    1. Assessment of active medical problems.
    2. Special dietary consideration to include increased caloric needs for juveniles, renal dialysis, diabetics, etc.
    3. Enumeration of all medically indicated diagnostic studies and treatments.
    4. Nursing plan review.
    5. Recommendations for specialty referrals, durable medical equipment, wheel chairs, C-pap machines, specialized medication, chemotherapy, prosthetic support, etc.
    6. Chronic Care Clinic assignment. Special housing assignment, Infirmary, ADA, special medical tiers.
    7. Juveniles housed under conditions maintaining sight and sound separation from adults when reasonably possible.
    8. Specialty consultation.
    9. Social and psychological services.

K. Discharge Planning – Continuity of Care will include appropriate discharge planning for all inmates who are being released from the infirmary, special needs unit or housing and transferred to another jurisdiction, discharged from chronic care or discharged to the community, etc. A copy of the discharge plan utilizing

the Continuity of Care (COC) form shall be sent with the inmate, and will include, at a minimum:

1. Problem List.
2. A written assessment of the inmate's active medical problems.
3. A list of current medications/ allergies.
4. Treatments and pending consultations.
5. Follow-up appointment.
6. Activity and housing needs.

III. References: None
IV. Rescissions: None
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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

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Chapter 7
INMATE TRANSFER SCREENING
Includes Local Intakes (Persons from County Detentions to DPSCS)

I. Policy: The contracted medical vendor will assure that continuity of care is maintained when an inmate is transferred and will provide health screening for inmates moving from one DPSCS facility to another or from an outside hospital or another jurisdiction into a DPSCS facility, or from a DPSCS facility to another jurisdiction.

II. Procedure:

1. For the persons transferring within DPSCS, a medical professional at both the sending and receiving DPSCS facilities will review the medical record and complete the transfer screening using the “Health Services Transfer Screening” template in the electronic health record (EHR).
   - A. When given at least 12 hours’ notice that an inmate is being transferred to another DPSCS facility; a health care professional shall review the inmate’s paper and electronic medical record and complete the transfer/sending screening in EHR with an alert for inmates with health care needs requiring urgent attention. The medical professional shall ensure that the transferring inmate’s medications and paper chart are packaged and delivered to Custody for transportation with the inmate according to established protocols.
   - B. Within 4 hours of transfer into the receiving facility, a medical professional shall review the medical record of the inmate and document that review in the EHR using the transfer/receiving screening template. For inmates with a medical alert, such review will occur within one hour of arrival.
   - C. The medical professional completing the review at the receiving institution will ensure that any identified necessary follow up occurs:

i. Appoint the inmate to be seen in the appropriate setting, including chronic care clinic within 30 days of arrival;
ii. Refer an inmate to the mental health provider;
iii. Refer an inmate to the Infection Control staff for any necessary follow up;
iv. Refer an inmate with a current dental need to the dental department, and
v. Ensure that current medications are continued or discontinued by clinician.

D. In those facilities that are ACA accredited, a registered nurse shall interview the inmate upon arrival and complete documentation in the EHR reflecting completion of the required face to face screening.

E. The transfer sending/receiving documentation will be completed for both permanent and temporary housing transfers including but not limited to court appearances or surgical procedures scheduled in a location distant from the maintaining facility.

2. For persons transferring as a Local Intake from a County Detention Center, the facility's DON/Designee will contact his or her counterpart at the sending facility to obtain the following:
   A. Medical information regarding the individual and request a transfer of medical records to DPSCS with the patient.
   B. A list of medications and request that all on hand is sent with the patient to the receiving facility to prevent interruption in medication administration.
   C. Information regarding any special needs of the transferring patient (diet, ambulatory status, hearing or vision deficits, etc.), and request that any necessary existing medical equipment be transferred with the patient.
3. All persons returning to a DPSCS facility after an outside hospital or health care facility inpatient stay shall be transported by custody to the designated infirmary unit for evaluation and clearance for housing.
4. All individuals returning from an outpatient visit shall be transported by custody to the designated medical dispensary for evaluation and clearance prior to housing.
5. When an inmate is transferred from a DPSCS facility to another jurisdiction for a period of time greater than one day, a health care professional will provide to the facility's Case Management Department a written assessment of the inmate's

active medical problems, including a list of current medications and treatment. A copy of this assessment will be provided to the facility's representative of the Office of Programs and Services/Clinical Services.

III. Reference: None

IV. Rescissions: DPSCS 130-100-122

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 8

OPTOMETRIC AND OPHTHALMOLOGIC SERVICES

I. Policy: To provide standardized guidelines for early and periodic screening, diagnosis, and treatment of vision needs of Department of Public Safety and Correctional Services (DPSCS) inmates. All inmates received in DPSCS facilities shall receive at the Initial Intake physical an initial visual screen examination including, assessment of near/far vision but not limited to, the Snellen chart (far vision) and at each periodic medical examination and Chronic Care Clinic dilated exams consistent with DPSCS policy where indicated.

II. Optometric and/or ophthalmologic evaluations, including vision and corrective prescriptions, shall be provided within a time frame consistent with acceptable medical practice but not to exceed 45 days.

III. Procedure:

   A. Inmates found to have visual acuity worse than 20/50 in either eye by Snellen exam shall be referred for optometric evaluation by the provider/ nurse.

   B. The optometric evaluation shall occur within 30 calendar days of the initial examination, and documented in the patient's medical record.

   C. If the optometric examination confirms visual acuity worse than 20/50 in either eye and the optometrist/ophthalmologist deems corrective lenses necessary, then eyeglasses shall be prescribed by the consultant and processed by the Optometry vendor.

   D. Within 30 days of the writing of a medically necessary prescription for eyeglasses, the optometrist shall properly fit, the correctly filled prescription, for the inmate for whom the prescription was written.

1. If the prescription glasses ordered are delayed beyond 45 days the inmate and the Agency Contract Operations Manager (ACOM) shall be notified in writing with the reason(s). The department reserves the right to order a change of supplier and/or any other changes they deem necessary in order to provide services in the time-frames specified above if there is consistent documented delays in receipt of eye glasses.
2. Contact lenses shall not be prescribed solely for cosmetic purposes. If a recent incarcerated inmate is admitted to a DPSCS facility with contact lenses that are not related to eye disease i.e. cosmetic, the inmate can keep the contact lenses until he/she is provided regularly prescribed glasses by the department. At that time, the inmate must surrender his/her contact lenses. Unless there is a specific diagnostic eye problem that can only be supported with contact lenses e.g. keratoconus.
3. The medical contractor must supply the necessary medical supplies for the maintenance of the contact lenses during the time period when the inmate has retained the contact lenses contact solutions maybe purchased in the commissary by the inmate as well.
4. Eyeglasses shall be distributed to the inmates by nursing staff on site. The inmate shall sign a receipt form (DPSCS Form OTS 130-251-2. Rev. 1/31/2014) when eyeglasses are issued. The actual fitting of the eyewear should be done by the Optometrist /ophthalmologist.
5. Frequency of replacement/repairs of broken eyeglasses shall be reasonable and conform to community standards. Each inmate shall be provided eyeglasses on an every two year basis provided that the inmate's vision status requires a new prescription. Broken eyeglasses shall be replaced/repaired within a 60 day time period following the inmate's request. If there is a pattern of loss or destroyed glasses by an inmate the department may have the cost of the glasses replacement be taken from the inmate's account.

E. All inmates over the age of 40 will have an optometric examination and tonometry to be performed biannually. Those sixty and over will receive tonometry screening annually.
F. If the tonometry screen is abnormal with intraocular pressure above 21mm/Hg, the optometry vendor shall conduct a retinal imaging prior to referral to the Ophthalmologist for assessment and treatment
G. All inmates with a suspected or confirmed diagnosis of diabetes, diabetic retinopathy, glaucoma, severe vascular hypertensive or lipid disorders shall have retinal image taken at least annually by the optometrist and referred for ophthalmologic services.
H. Referral or consult to ophthalmology shall be generated by the optometry vendor in the electronic patient health record (EPHR) and tasked to the Primary Care Physician who will present the patient to collegial for approval.
I. Retinal images shall be taken by trained optometry staff. At the request of the ophthalmologist, additional retinal images may be taken by the Optometry staff.
J. All retinal images shall be stored in a network folder accessible to all care providers including consultants and providers shall be notified of availability of image through the alert section in the EPHR.
K. All retinal images shall be reviewed by the ophthalmologist within four weeks of completion and documentation of patient evaluation and plan of care shall be documented in the EPHR.
L. The medical vendor shall immediately evaluate an inmate in an event of an eye emergency, other visual loss, infection or pain and if medically indicated, make a referral to an ophthalmologist within twenty four (24) hours for a follow up assessment. The eye evaluation should include a description of the injury, visual fields and a vision check. If slit lamp exam is available that information should also be documented as part of the referral information for the Ophthalmologist.
M. The medical vendor shall treat and manage glaucoma, cataracts and other diseases or disorders which impact vision with an Optometry /ophthalmology specialist utilizing established ophthalmological national guidelines approved by the Department's Chief Medical Officer.

N. Self-referrals for eye examination shall not be more frequent than one examination every two years unless there are specific symptoms associated with visual difficulty. Any inmate who submits a request for eye examination more frequently than every two years shall be evaluated by a physician to determine the medical necessity for such an examination prior to referral to the eye doctor.

O. Self-referrals for vision examination by the inmate must be submitted on a Sick Call Request.

P. The inmate shall be evaluated by an optometrist or ophthalmologist within 30 calendar days of referral for non-emergent care. The medical record shall contain complete documentation of all optometric and ophthalmologic care including evaluations and prescriptions, and the provision and receipt of eyeglasses.

Q. All clinical data related to eye services belong to DPSCS and cannot be duplicated, published or presented without the departments expressed permission.

R. The eye contractor/subcontractor shall submit clinical data regarding eye care in the form and format dictated by the DPSCS Chief Medical Officer to be submitted monthly with quarterly/yearly summary.

IV. References:

A. DPSCS 130-11, Sections 112 and 114

B. Secretary's Directive 07-94

V. Rescissions: Form DPSCS 130-233aR
Form DPSCS 130-251aR (Revised 1/92)
DPSCS 13-100-130 issued 5/2007

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DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES

OFFICE OF CLINICAL SERVICES/INMATE HEALTH

MEDICAL EVALUATIONS MANUAL

Chapter 9

LABORATORY AND RADIOLOGY SERVICES

I. Policy: DPSCS vendors will provide and record the outcomes of laboratory and radiology services necessary for the diagnosis and care of arrestees/inmates/detainees in a timely manner. Laboratory/radiology processes will be completed as follows except where specifically stated otherwise in another policy:

II. Procedure:

   A. Laboratory tests for diagnosis and/or the care and treatment of patients shall be initiated by a Maryland licensed clinician.

      1. Test requests shall be entered into the patient's EMR (Electronic Medical Record) as an order.
      2. Ordering clinician shall "task" the order to the nurse or a phlebotomist who shall in turn perform the requested test or assure that it is completed.
         a. All tests drawn or collected shall be appropriately labeled with the patient's name, DPSCS number, date, time and site/facility.
         b. A completed laboratory request form matching the clinician's orders shall be attached to collected specimens.
         c. Specimens shall be placed in the designated collection area for shipment to the appropriate laboratory.
      3. Charge nurses shall be responsible for checking task lists daily to assure all have been addressed within a twenty-four (24) hour period.
      4. Laboratory results are electronically sent to the EMR desktop of the ordering clinician for review and signature.
         a. These results must be reviewed, documented within the electronic health record with action/no action indicated and electronically signed and dated

within 48 hours of receipt on the desktop (excluding weekends and holidays).

   b. After clinician review and disposition, orders for treatment if necessary, will be written by the clinician and tasked to the nurse.
   c. Orders shall be carried out by nursing staff and recorded as such in the EMR with any outcomes resulting from the orders carried out.
   d. Charge nurses shall assure these tasks have been accepted and carried through within a twenty-four (24) hour period.

5. Hard copies of test reports (non-electronic format) will be reviewed, signed and dated by the reviewing clinician within 48 hours of receipt of the report (excluding weekends and holidays).
   a. Signed and dated hard copies of test reports will be filed in the designated section of the medical chart hard copy file.
   b. Initials and date on the report will indicate that the clinician has reviewed the report.
   c. In addition to the hard copy initial, the clinician shall also place a note in the EMR progress note reflecting his or her findings regarding that report.

B. Radiological test for diagnosis and/or the care and treatment of patients shall be initiated by a Maryland licensed clinician.

1. Test requests shall be entered into the patient's EMR (Electronic Medical Record) as an order.
2. Ordering clinician shall "task" the order to the nurse or an x-ray technician who shall in turn perform the requested test or assure that it is completed. Only persons licensed and/or certified to perform specific tests shall be permitted to do so for DPSCS patients.
3. An appropriate radiological test request form shall be completed and sent to the testing site.
4. Charge nurses shall be responsible for checking task lists daily to assure all have been addressed within a twenty-four (24) hour period.
5. Radiological test results are sent to the ordering clinician for review and signature.

a. The results must be reviewed, documented within the electronic health record and action /no action indicated and electronically signed and dated within 48 hours of receipt on the desktop (excluding weekends and holidays).
b. After clinician review and disposition, orders for treatment if necessary, will be written by the clinician and tasked to the nurse.
c. Orders shall be carried out by nursing staff and recorded as such in the EMR with any outcomes resulting from the orders carried out.
d. Signed and dated hard copies of test reports will be filed in the designated section of the medial chart hard copy file.

C. All test results ordered as "STAT" will be called-in/faxed to the facility by the laboratory conducting the test within 4 hours.
1. If the ordering clinician is not at the facility, the charge nurse/designee will call the on-call clinician with the results.
2. Nurse will accept phone orders for additional care and/or treatment resulting from the call, and the clinician will sign those orders within twenty-four (24) hours of providing them.

D. Labs will also call in critical laboratory values.
1. These values must be reported to the ordering or covering clinician within four (4) hours.
2. Notification of the report to the provider by the nurse shall be placed in a progress note in the electronic health record.
3. Documentation of any actions taken must be provided in the medical records within 24 hours of receipt of the result by the clinician or by the nurse if telephonic order is given.

E. All routine, non emergent lab work and all x-rays will be completed within 48 hours of the order, excluding specialty services (MRI, CT, etc.) appointment.
1. Documentation of the reason for any missed appointment must be entered into EMR.
2. Patient shall be rescheduled for the next available clinic.

3. If a patient misses two consecutive appointments, the patient shall be seen by the clinician for counseling and further education regarding the importance of the missed test or conversely decide together that the test is no longer necessary. The outcome of that patient/clinician session shall be recorded in the EMR progress note.

F. The State's medical vendor will apply for certification or waiver from the Centers for Medicare and Medicaid Services (CMS) in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements.

III. References: Maryland Medical and Mental Health Contracts

IV. Rescissions: None

V. Date Issued: December 2010
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