
STANDARDS FOR HEALTH
SERVICES IN JUVENILE
DETENTION AND
CONFINEMENT
FACILITIES

NATIONAL *COMMISSION ON*
CORRECTIONAL HEALTH CARE



1995

ALAN P. TEZAK
1755 TEMBY DRIVE
HERSHEY, PA 17033

STANDARDS FOR HEALTH SERVICES IN JUVENILE DETENTION AND CONFINEMENT FACILITIES

1995

These standards represent the official position of the National Commission on Correctional Health Care with respect to minimum requirements for health services in juvenile detention and confinement facilities. They do not necessarily represent the position of individuals represented on the Board of Directors or of any supporting organization of the National Commission on Correctional Health Care.



National Commission on Correctional Health Care
2105 N. Southport, Chicago, IL 60614-4017
(312) 528-0818

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Many individuals have contributed to this, the fourth revision of the *Standards for Health Services in Juvenile Detention and Confinement Facilities*. The National Commission on Correctional Health Care (NCCHC) appreciates the efforts of all who have been involved. It was particularly gratifying to receive a large number of suggestions and comments in response to a mail survey of correctional health professionals, correctional administrators working in juvenile facilities, and national associations in the health, corrections, and legal fields. Consideration of these comments, through many hours of discussion by members of a special task force appointed in October 1994 to recommend revisions to these standards, was essential to the publication of this revised standards manual. Members of this special task force were

James W. M. Owens, MD, CCHP (Chair), Medical Director, Washington Department of Juvenile Rehabilitation, Seattle, Washington

Charles J. Baker, MD, Medical Director, Los Angeles County Health Services Department, Juvenile Court Health Services, Los Angeles, California

Robert T. Brown, MD, Medical Director, Children's Hospital Adolescent Health Center, Columbus, Ohio

Kurt C. Friedenauer, Administrative Director, Idaho Department of Health and Welfare, Youth Services Center, St. Anthony, Idaho

Ronald J. Gagne, MD, Manchester Family Health Center, Manchester, New Hampshire

Krista R. Johns, JD, Director of Curriculum Development, National Council of Juvenile and Family Court Judges, National College of Juvenile and Family Law, Reno, Nevada

Lynn Maskel, MD, Director of Forensic Psychiatry, Loyola University Medical Center, Maywood, Illinois

David W. Roush, PhD, National Juvenile Detention Center, Marshall, Michigan

Gary Shostak, MPH, Director of Health Services, Massachusetts Department of Youth Services, Boston, Massachusetts

Jerome P. Rosenthal, PhD (Staff Liaison), Director of Accreditation, National Commission on Correctional Health Care, Chicago, Illinois

In addition to the important work of this task force, the revision of the juvenile standards also benefitted from the special efforts of several organizations and individuals. Diane Miles, MS, RD, LD recommended changes to the dietary standard (Y-53), and the American Dietetic Association provided an updated food guide pyramid for Appendix E. Also, the dental form in Appendix B was submitted by Wendell Page, DDS, the Dental Director of Juvenile Court Health Services under Charles Baker, MD for the Los Angeles County Department of Health Services.

Finally, NCCHC's Policy and Standards Committee reviewed and edited the Standards. Members were Carl Bell, MD, Chair; B. Jaye Anno, PhD, CCHP-A; Samuel Eichold, MD; Gerald P. Ellsworth, MPH, CCHP; John M. Vargo, DO, CCHP; Henry C. Weinstein, MD, CCHP; and Jonathan B. Weisbuch, MD. Many others on the NCCHC Board of Directors, and with special assistance from staff members Jacqueline M. Moore, PhD, CCHP and Carolyn E. Weiland, also provided important contributions to the revision of these standards. The National Commission on Correctional Health Care is grateful for all these efforts, since the result promises to promote improved health services for youth in our nation's juvenile detention and confinement facilities.

Edward A. Harrison, CCHP
President

PREFACE

Standards for Health Services in Juvenile Detention and Confinement Facilities represents a revision of standards first published by the American Medical Association in 1979 and subsequently revised in 1984 and 1992 by National Commission on Correctional Health Care. NCCHC is a not-for-profit, 501(c)(3) organization working toward improving health services provided in our nation's jails, prisons, and juvenile detention and confinement facilities. NCCHC's Board of Directors is comprised of individuals named by the following supporting organizations:

American Academy of Child and Adolescent Psychiatry	American Health Information Management Association
American Academy of Family Physicians	American Jail Association
American Academy of Pediatrics	American Medical Association
American Academy of Physician Assistants	American Nurses Association
American Academy of Psychiatry and the Law	American Osteopathic Association
American Association of Physician Specialists	American Pharmaceutical Association
American Association of Public Health Physicians	American Psychiatric Association
American Bar Association	American Psychological Association
American College of Emergency Physicians	American Public Health Association
American College of Healthcare Executives	American Society of Addiction Medicine
American College of Neuropsychiatrists	John Howard Association
American College of Physicians	National Association of Counties
American Correctional Health Services Association	National Association of County Health Officials
American Counseling Association	National Council of Juvenile and Family Court Judges
American Dental Association	National District Attorneys Association
American Diabetes Association	National Juvenile Detention Association
American Dietetic Association	National Medical Association
	National Sheriffs' Association
	The Society for Adolescent Medicine

HOW TO USE THIS BOOK

These standards represent NCCHC's recommended minimum requirements for juvenile health services. They are intended for use as guidelines for short term facilities (such as detention centers) and long term facilities (such as residential treatment centers and training schools). Larger group homes and halfway houses may find the standards helpful for directing their operations. Facilities or governments that contract with community or private agencies for health services may find the standards useful for specifying contract expectations and evaluating contract performance. Once implemented, the standards can lead to: (1) increased efficiency of health services delivery; (2) greater organizational effectiveness; (3) better overall health protection for confined juveniles; (4) reduced risk of liability related to health services; and (5) NCCHC health care accreditation.

There are sixty-six (66) standards, grouped under six general areas, included in this manual. The general areas are: Administration (11 standards); Managing a Safe and Healthy Environment (6 standards); Personnel (9 standards); Care and Treatment (32 standards); Health Records (4 standards); and Medical/Legal Issues (4 standards). Each standard is accompanied by a discussion section that elaborates on the intent of the standard, provides alternative approaches for achieving compliance, or defines key terms included in the standard. The discussion is not part of the standard itself.

Following the number and name of each standard (youth standards are distinguished from the jail and prison standards with the "Y" designation) is an identification of the standard as either "essential" or "important," representing categories used in the National Commission's accreditation program for juvenile facilities. Accredited juvenile facilities are expected to be in compliance with all of the applicable essential standards and with eighty-five percent of the applicable important standards.

CHANGES MADE SINCE THE LAST STANDARDS WERE PUBLISHED

The 1995 edition of the juvenile standards reflects four types of changes: a standard that has been re-classified from important to essential; a new standard; refinements to existing standards; and a new order of the standards.

One new standard has been re-classified from important to essential:

Y-25 Communication on Special Needs Patients (page 23)

One new standard has been added:

Y-11 Grievance Mechanism (important) (page 9)

A number of the existing standards were changed to clarify the intent of the standard. For example, Y-02 Medical Autonomy formerly referred to physicians and dentists and has been

expanded to include all health professionals. As another example, Y-27 Initial Health Screening was expanded to include a discussion of performing a violence risk assessment upon intake. The other standards that were modified are Y-03 Policies and Procedures; Y-33 Health Appraisal; Y-36 Skilled Nursing and Infirmary Care; Y-38 Pregnant Juveniles; Y- 15 Ectoparasite Control; Y-16 Infection Control Program; and Y-54 Dental Care.

Finally, the order of the standards was rearranged, and an additional section — Managing a Safe and Healthy Environment — was created in order to make the standards more accessible.

In addition to the standards, NCCHC has periodically adopted “position statements” on important topics in the correctional health care field. Among the topics for which position statements have been adopted are

Administrative Management of HIV in Corrections*

Administrative Management of Tuberculosis in Correctional Facilities

Correctional Health Care and the Prevention of Violence*

Competency for Execution

DNA Analysis

Drug Testing for Correctional Staff

Health Care Funding for Incarcerated Youth

Mental Health Services in Correctional Settings

Third Party Reimbursement for Correctional Health Care

Women’s Health Care in Correctional Settings*

* is reprinted in Appendix F

For clarification on any of the standards, or for an evaluation of facility compliance, please contact:

National Commission on Correctional Health Care
2105 N. Southport
Chicago, Illinois 60614

Phone (3 12) 528-0818
Fax (312) 528-4915

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Y-01 Responsible Health Authority (essential)

The facility has a designated *health authority* with *local responsibility* for *health care* services pursuant to a written agreement, contract, or job description. The health authority may be a physician, *health administrator*, or agency. When this authority is other than a physician, final medical judgments rest with a single designated *responsible physician* licensed in the state.

Discussion

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

The *health authority's* responsibilities include arranging for all levels of health care and ensuring quality and accessibility for all health services provided to juveniles. It may be necessary for the facility to enter into written agreements with outside providers and facilities in order to meet all levels of care. A *health administrator* is a person who by education (e.g., RN, MPH, MHA, or a related discipline) is capable of assuming responsibility for arranging for all levels of health care and ensuring quality and accessibility of all services provided to juveniles. The designation of CCHP (Certified Correctional Health Professional) is highly desirable.

A *responsible physician* is required in all instances; s/he makes the final medical judgments regarding the care provided to juveniles at a specific facility. This includes reviewing the recommendations for treatment made by health care providers in the community. In most situations, the responsible physician will be the health authority. In many instances, the responsible physician also provides primary care.

Local responsibility means that the health authority must be someone who is on-site at least part-time. Even in a state system where policies are established from a central office, there must be a designated health authority at the local level to ensure that policies are carried out.

Y-02 Medical Autonomy (essential)

Matters of health care are the sole provinces of the responsible physician and other health professionals. However, security regulations applicable to facility personnel also apply to health personnel.

Discussion

The provision of health care is a joint effort of administrators and health professionals and can be achieved only through mutual trust and cooperation. The health authority arranges for the availability and monitoring of health care services; the official responsible for the facility provides the administrative support for accessibility of health services to juveniles.

The term *health care* as used throughout these standards is intended to include alcohol and other drug treatment and psychiatric services, which are a part of the medical program. The primary responsibility for psychiatric services rests with the physician. Other health professionals (such as nurses, social workers, and psychologists) can provide psychiatric services under a physician's supervision.

Y-03 Policies and Procedures (essential)

There is a manual of written policies and defined procedures approved by the health authority that includes a statement regarding each standard listed in the table of contents of this document. Each policy, procedure, and program in the health care delivery system is reviewed at least annually and revised as necessary under the direction of the health authority. Each document bears the date of the most recent review or revision and signature of the reviewer(s) in the front of the manual.

Discussion

The importance of a manual that specifies the health care policies and procedures at a given juvenile facility cannot be over stressed. Such a document serves as an important reference for existing health care staff and as an excellent training tool for orienting new health care staff to the facility. A sample system for developing policies and procedures is included in this document in Appendix A.

It is not expected that each policy and procedure in the original manual be signed by the health authority. Instead, a declaration paragraph should be contained at the beginning of the manual outlining the fact that the entire manual has been reviewed and approved, followed by the proper signature. When changes to specific policies are made in the manual, they must be initialed by the health authority.

Annual review of policies, procedures, and programs is considered good management practice. This process allows the various changes made during the year to be formally incorporated into the agency manual instead of accumulating in a series of scattered

documents. More important, the process of annual review facilitates decision-making regarding previously discussed but unresolved matters.

Y-04 Administrative Meetings and Reports (essential)

Health services (including psychiatric) are discussed at least quarterly at documented *administrative meetings* between the health authority and the official legally responsible for the facility, or their designees. There is, at a minimum, an *annual statistical report* outlining the types of health care rendered and their frequency.

Discussion

Administrative meetings held at least quarterly are essential for successful programs in any field. Problems are identified and solutions sought. Health care staff is also encouraged to attend other staff meetings of the facility to promote a good working relationship among all staff.

Regular staff meetings that involve the health authority and the official legally responsible for the facility and include discussions of health care services meet compliance if documentation exists (e. g . , if minutes or a report of such meetings are kept).

If administrative and/or regular staff meetings are held but not documented, the health authority needs to submit a quarterly report to the facility administrator that includes the effectiveness of the health care system, description of any health environment factors that need improvement, changes effected since the last reporting period, and, if necessary, recommended corrective actions. Health environment factors that are of the greatest concern are those in which there are life-threatening situations (e.g., a high incidence of suicides and/or physical assaults and severe overcrowding that affects juveniles' physical and mental well being).

The annual statistical report should include, but not be limited to, the number of juveniles receiving health services by category of care, as well as other pertinent information (e. g . , operative procedures, referrals to specialists, and ambulance services). The annual statistical report should be given to the facility administrator, the responsible physician, and where, applicable (e.g., detention centers), the juvenile court judge.

Reports made more frequently than annually or quarterly also satisfy compliance guidelines.

Y-05 Internal Quality Assurance (essential)

Written policy defines the internal *quality assurance program* utilized by the facility. The program specifies the type of health services review that occurs, who conducts the review, and the frequency. The responsible physician (or a *quality assurance committee*) monitors the care rendered by health providers quarterly.

Discussion

Quality assurance programs consist of formalized methods of ensuring the quality and consistency of the health services provided. There are many ways to accomplish this goal. The usual method employed is to review a sample of patient health records on a fixed schedule (e. g . , weekly, semi-monthly, or monthly) to ensure that health care delivery is occurring according to established policies. Health records can be selected on a random basis (e.g., every tenth health record), a temporal basis (e.g., health records of patients seen in the last week), a diagnostic basis (e.g., all health records of current diabetic patients), or practitioner basis (e.g., all patients treated by certain practitioners).

The elements (i.e., “markers” or “indicators”) to be monitored in the review of health records may include, but need not be limited to:

- the adequacy of treatment plans initiated by health providers;
- the extent to which physicians’ and dentists’ orders have been carried out;
- the completeness and the legibility of the health record;
- the sufficiency of pharmaceutical matters (e.g., the types of medication ordered and notations regarding their administration); and
- the appropriate implementation and countersigning of standing orders, when utilized.

A *quality assurance committee* is a group of health providers working at the facility who meets on a fixed schedule to conduct health record reviews and/or to discuss the results of such reviews. In addition to the responsible physician, such committees usually include representatives of other health services and departments such as nursing, pharmacy, medical records, dentistry, and psychiatry. The number of individuals serving on such a committee and the services and departments represented will vary with the size of the staff and the types of health care provided on-site. In a small facility without separate health services departments, the responsible physician may carry out the quality assurance activities.

It should be noted that external peer review and/or periodic reviews by outside groups (e.g., grand juries, public health departments, and county medical societies) do not meet compliance. While reviews by legally entitled outside groups are to be encouraged as additional checks on the quality of care provided, they do not take the place of a systematic internal quality assurance program.

Y-06 Disaster Plan (essential)

Written policy and defined procedures require that the health aspects of the facility's disaster plan be approved by the responsible health authority and the facility administrator. The disaster plan is drilled at least annually.

Discussion

Policy and procedures for health care services in the event of a man-made or natural disaster, internal disaster (e. g . , riots), or external disaster (e.g., mass arrests) must be incorporated in the institution's plan and made known to all facility personnel. Health aspects of the disaster plan should include but not be limited to the following: the triaging process, outlining where care will be provided; notification of ambulance and hospital evacuation of patients from the facility; specific roles of health care personnel; and laying out a backup plan. In case injuries must be treated on-site, separate disaster supplies should be planned, stored, and regularly checked. Routine fire drills or drills which do not involve a mobilization of health staff do not meet compliance.

The need to drill the disaster plan cannot be overemphasized. Drilling the disaster plan helps to identify weaknesses in it that might otherwise remain uncorrected. All staff members need to practice their roles, so they will respond appropriately in the event of an actual disaster. In addition, it is suggested in large facilities with more health staff that each shift of health care workers perform a disaster drill annually.

Y-07 Support Services (important)

If health services are delivered in the facility, adequate staff, space, equipment, supplies, materials, and publications, as determined by the health authority, are provided for the performance of health care delivery.

Discussion

The type of space and equipment for the examination and treatment area will depend upon the level of health care provided in the facility and the capabilities and desires of

health care providers. In all facilities, space should be provided where the juvenile may be examined and treated in private.

Basic equipment generally includes the following: thermometers; blood pressure cuff; stethoscope; ophthalmoscope; otoscope; percussion hammer; scale; examining table; gooseneck light; sink with hot and cold water; transportation equipment (e.g., wheelchair and litter); bathroom; sharp containers; refrigerator for supplies; current medical reference textbooks and drug information, such as the *Physician's Desk Reference*, *AMA Drug Evaluations*, *Nursing Drug Handbook*, *Drug Facts and Comparisons*, and *Red Book*; a text on adolescent medicine; and a medical dictionary.

If female juveniles receive medical services in the facility, equipment appropriate for pelvic examinations and gynecological reference books should be available. If psychiatric services are provided in the juvenile facility, a private interviewing space, a desk, two chairs, a lockable file, and a copy of the DSM IV also should be available.

Y-OS Sharing of Information (important)

Written policy requires that the physician or his/her designee has access to information contained in the juvenile's confinement record when the physician believes such information may be relevant to the juvenile's health and course of treatment. In accordance with state statutes, facility staff members are apprised of certain medical conditions of juveniles, so they will be able to respond appropriately.

Discussion

Arrested persons frequently are in a state of high anxiety and forget details of their lives that may be important from a health standpoint. A review of the record regarding previous drug and alcohol arrests, condition at the time of arrest, and possession of medication may be important to the physician in determining the juvenile's health status. In addition, particularly in states that have decriminalized public inebriation, information on previous alcohol usage, diagnosis, and treatment should be reviewed.

While facility personnel shall not have access to juveniles' medical records, including psychotherapy records, it is important that information on juveniles' medical conditions be shared. The staff should be told about juveniles with chronic conditions (e.g., diabetes and epilepsy), those with mental instabilities (e.g., psychoses; suicidal ideation) or physical limitations, and those on medication with potential side effects. Such information will alert child care workers to potential medical crises and help them respond appropriately should a crisis occur.

Y-09 Access to Diagnostic Services (important)

Written policy and defined procedures require the outlining of access to laboratory and diagnostic services utilized by facility provider.

Discussion

Specific resources for the studies and services required to support the level of care provided to juveniles in the facility (e.g., private laboratories, hospital departments of radiology, and public health agencies) are important aspects of a comprehensive health care system, and need to be identified with specific procedures outlined for their use.

Y-10 Notification of Next of Kin (important)

Written policy and defined procedures require notification of the juvenile's next of kin or legal guardian in case of serious illness, injury, or death.

Discussion

The facility should have a set procedure for notifying a juvenile's next of kin. Disclosure of confidential information (e.g., sexual abuse or positive HIV status) should be done in accordance with state statute. The written policy should specify when such notification must occur (e.g., "any illness or injury resulting in hospitalization and in all cases of death") and who has the responsibility for such notification.

Y-11 Grievance Mechanism (important)

Written policy and procedures define, and actual practice evidences, a grievance mechanism to address juveniles' complaints about health services. The policy addresses the time frame for response to the grievance and the process for appeal.

Discussion

Each facility should have a mechanism in place to allow juveniles to express their complaints regarding health services. Some centers include health complaints in their formal grievance process. In others, juveniles are told to write to the responsible physician or health authority. Regardless of the means selected, juveniles should be told soon after they are admitted what the procedures are. Also, if someone other than a member of the medical staff responds to juveniles' grievances, medical staff input should be solicited prior to responding to a juvenile's complaint.

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

SECTION B - MANAGING A SAFE AND HEALTHY ENVIRONMENT

Important Standards

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Y-12 First-Aid Kits (important)

First-aid kits are available in designated areas of the facility. The health authority approves the contents, number, location, and procedures for monthly inspection of the kits.

Discussion

Examples of content for first-aid kits include roller gauze, sponges, triangle bandages, adhesive tape, and bandages. The first-aid kits should not routinely include emergency drugs.

Kits can be either purchased or improvised from assembled materials. All kits, whether purchased or assembled, meet compliance if:

- The kit is large enough and has the proper contents for the place where it is to be used.
- The contents are arranged, so that needed items can be found quickly without unpacking the entire contents of the kit.
- Materials are wrapped, so unused portions do not become dirty through handling.
- Any materials with expiration dates are checked to ensure they have not expired.

Y-13 Use of Tobacco (important)

Written policy prohibits the use of tobacco in any form by juveniles at the facility.

Discussion

Recognizing the evidence that tobacco products, smoking, and second-hand smoke are dangerous to health, and the fact that most state laws prohibit the sale of tobacco products to minors, the use of tobacco products in juvenile facilities should be prohibited.

Y-14 Health Promotion and Disease Prevention (important)

Written policy and defined procedures require that *medical preventive maintenance* be provided to juveniles in the facility.

Discussion

Medical preventive maintenance includes health education and medical services (such as inoculations and immunizations) provided to take advance measures against disease, and instruction in self-care for chronic conditions. *Self-care* is defined as care for a condition that can be treated by the juvenile and may include over-the-counter type medication.

Subjects for health education include personal hygiene and nutrition; sexually transmitted diseases (STDs), including HIV/AIDS; tuberculosis and other communicable diseases; the effects of smoking; self-examination for testicular and breast cancer; dental hygiene; drug use and the danger of self-medication; family planning, including, as appropriate, both services and referrals; physical fitness; and chronic diseases and disabilities.

Y-15 Ectoparasite Control (important)

Written policy approved by the responsible physician defines *ectoparasite* control procedures used in the facility. A means is available for the disinfection of bedding and clothing. Treatment must be carried out on an individual basis, after determining that no contraindicating condition exists.

Discussion

Ectoparasites such as pediculosis and scabies are skin infestations. They are communicable and may lead to secondary infections. Screening for ectoparasites should occur at admission.

Y-16 Infection Control Prow-am (important)

A written program specifying policies and procedures for the control of infection is adopted for the facility. The program is approved by the responsible health authority. The infection control program includes, but is not limited to, concurrent surveillance of patients and staff, prevention techniques, strict adherence to universal precautions, and treatment and reporting of infections.

Discussion

The facility should have an infection control committee that meets on a quarterly basis to review and to discuss infection control policies and procedures, surveillance, cleaning and disinfection techniques, and other matters related to infection control. The

committee should include the responsible physician or a designated medical representative, the director of nursing or a designated nursing representative, and other professional personnel involved in infection control. Minutes or records of committee activities should be maintained. Health staff should strictly adhere to the universal precautions as developed by Centers for Disease Control.

Y-17 Communicable Disease and Isolation (important)

There are written policies and procedures regarding the care of juveniles with communicable disease, including provision for isolation if medically indicated. Juveniles who have or are suspected of having a reportable communicable disease are isolated.

Discussion

Isolation procedures for juveniles with a communicable disease should meet the following requirements:

Where possible, the juvenile is placed in a room without a roommate. The room should be equipped with a private toilet, hand washing facility, dispenser of soap, and single-service towels.

Procedural techniques include hand washing upon entering and leaving, proper handling and disposal of infectious materials, procedures for providing proper isolation techniques, instructions provided to the juvenile and to visitors, proper handling of food utensils and dishes, proper handling of patient care equipment, and cleaning and disinfection of isolation accommodations.

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Y-18 Credentialing (essential)

State licensure, certification or registration requirements, and restrictions apply to qualified health care personnel who provide services to juveniles. *Verification* of current credentials is on file and made available for examination.

Discussion

Verification may consist of copies of current credentials or letters from the state licensing or certifying bodies regarding the status of credentials for current personnel.

Some states do not require licensure of persons working in government agencies or institutions. To promote the highest possible quality of health care, institutional health workers must be licensed if licensure would be required in a similar position in the community.

Y-19 Job Descriptions (essential)

Written job descriptions define the specific duties and responsibilities of personnel who provide services in the facility's health care system. These are approved by the health authority, reviewed at least annually and updated as needed.

Discussion

The job descriptions required by this standard are more detailed than standard civil service job classifications. They must be specific to the facility and to the position held. For example, a nurse working the evening shift who is assigned to the infirmary should have a job description for "Infirmary Nurse, Evening Shift" that specifies the responsibilities associated with that position.

Y-20 Liaison Staff (essential)

In facilities without any full-time *qualified health personnel*, written policy and defined procedures require that a *health-trained staff member* coordinate the health delivery services in the facility under the joint supervision of the responsible physician and the facility administrator.

Discussion

Valuable services may be rendered by a health-trained child care worker or social worker who may, full- or part-time, review receiving screening forms for follow-up attention, facilitate sick call by having juveniles and records available for the health provider, and help to carry out physicians' orders regarding such matters as diet, housing, and work assignments.

Qualified health personnel includes physicians, dentists, psychologists, and other professional and technical workers who, by state law, engage in activities that support, complement, or supplement the functions of physicians and/or dentists and who are licensed, registered, or certified as appropriate to their qualifications to practice; further, they practice only within their license, certification, or registration.

Health-trained staff may include child care workers and other personnel without health care licenses who are trained in the use of protocols, collecting health related information, and in other limited aspects of health care as determined by the responsible physician.

Y-21 Health Staff Orientation and Inservice Training (essential)

A written plan approved by the health authority provides for all health services personnel to participate in initial orientation and subsequent in-service training appropriate to their health care delivery activities. It outlines the frequency and number of hours of continuing training for each category of health care staff. A minimum of 12 hours of training is required annually for full-time health care providers. *Documentation* of all training is maintained.

Discussion

Providing health services in a juvenile detention/confinement facility is a unique task that requires special orientation for new personnel. These needs should be formally addressed by the health authority based on the requirements of the institution. This training should include (1) an explanation of the mission of the institution, (2) an introduction to the juvenile justice environment, (3) a tour of the facility, (4) instructions concerning applicable security procedures, and (5) information specific to health services operations.

In addition, appropriate policies and procedures should be taught to health care personnel, both initially during orientation, and as policies or procedures are revised or added.

All levels of health care staff also require regular, continuing staff development and training in order to provide the highest quality of care. Proper initial orientation and continuing training may serve to decelerate burn-out of health providers and to help to reemphasize the goals and philosophy of the health care system.

Y-22 Basic Training of Child Care Workers (essential)

Written policy and a training program established or approved by the responsible health authority in cooperation with the facility administrator should ensure that all child care workers who have direct responsibility for juveniles are trained in the following:

- types of action required for potential emergency situations;
- signs and symptoms of an emergency;
- administration of first aid, with training to have occurred, within the past three years;
- methods of obtaining emergency care;
- procedures for transferring patients to appropriate medical facilities or health care providers;
- signs and symptoms of mental illness, retardation, emotional disturbance, potential suicide, and chemical dependency; and
- signs and symptoms of suspected child abuse (including sexual abuse).

Further, all child care workers who have direct responsibility for juveniles are currently certified in cardio-pulmonary resuscitation (CPR) and trained to recognize symptoms of the illnesses most common to juveniles.

Discussion

It is imperative that facility personnel be made aware of potential emergency situations, what they should do in facing life-threatening situations, and their responsibility for the early detection of illness and injury. The intent of this standard is to ensure that juveniles are within sight or sound of health-trained child care workers at all times.

Current first-aid and CPR certification must be from an approved body, such as the American Red Cross; a hospital; a fire or police department; a clinic; a training academy

or any other approved agency; or from an individual possessing a current instructor's certificate from an approved body.

Y-23 Medication Administration Training (essential)

Written policy and defined procedures guide the training of personnel (e.g., child care workers or nurses) who administer medication, and require training from or approval by the responsible physician and the facility administrator or their designees regarding accountability for administering medications in a timely manner according to physicians' orders, and recording the administration of medications in a manner and on a form approved by the health authority.

Discussion

Training from the responsible physician encompasses the medical aspects of administering medications, including common side effects of specific drugs. Training from the facility administrator encompasses security matters inherent in distributing medications in a detention/confinement facility. The concept of distributing medications according to orders includes performance in a timely manner. (Please refer to standard Y-42 for the definition of distribution of medications).

Y-24 Juvenile Workers (essential)

Written policy prohibits juveniles from being used as health care workers in any capacity.

Discussion

Understaffed detention/confinement institutions are inevitably tempted to use juveniles to perform health care delivery services for which civilian personnel are not available. Their use frequently violates state laws, invites litigation, brings discredit to the correctional health care field, and gives them unwarranted power over their peers. If juveniles are used to clean the health services area, they must be supervised at all times.

This standard is not meant to prohibit peer education programs for the purposes of health education.

Y-25 Communication on Special Needs Patients (essential)

Written policy requires consultation between the facility administrator and the responsible physician or their designees prior to the following actions being taken regarding patients who are diagnosed as having significant medical or psychiatric illnesses: housing assignments; program assignments; disciplinary measures; and admissions to and transfers from institutions.

Discussion

Maximum cooperation between custody personnel and health care providers is essential, so both groups are made aware of movements and decisions regarding special problem patients. Medical or psychiatric problems may complicate work assignments. Medications may have to be adjusted for safety at the work assignment or prior to transfer.

Other aspects to consider in transferring medical or psychiatric patients may include:

- . suitability for travel based on medical evaluation;
- . preparation of a summary or copy of pertinent health record information medication or other therapy required en route; and
- . instructions to transporting personnel regarding medication or other special treatment.

Y-26 Food Service Workers: Health and Hygiene Requirements (important)

Written policy and defined procedures require that (a) all residents and other persons working in food service are free from diarrhea, skin infections, and other illnesses transmissible by food or utensils, and (b) workers are monitored each day for health and cleanliness by the director of food services or his/her designee.

Discussion

Laws and regulations governing food service workers often differ by state. An administrator of the facility should know what is required in that jurisdiction with respect to pre-service examinations. If they are not required in that state or locality, it is not necessary to conduct pre-service physical examinations for food service workers. It is more important that workers be checked and that they follow hygienic practices. For example, workers should be told to wash their hands upon reporting to duty, after

touching contaminated surfaces, before preparing food, and after using the toilet. Also, the use of hair nets or caps and plastic gloves should be considered for those working in food preparation or serving areas.

If the facility's food services are provided by an outside agency or individual, the facility should have written verification that the outside provider complies with the local and state regulations regarding food service workers.

SECTION D - CARE AND TREATMENT

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Y-27 Initial Health Screening (essential)

Written policy and defined procedures require *initial health screening* to be performed by health-trained or qualified health care personnel on all juveniles (including transfers) immediately upon arrival at the facility. The initial health screening findings are recorded on a printed form approved by the health authority (see sample form, Appendix B). At a minimum, the screening process includes the following:

Inquiry into :

- current illness and health problems, including mental, dental, and communicable diseases;
- medications taken and special health requirements;
- use of alcohol and other drugs, including types, methods, amounts, frequency, date or time of last use, and a history of problems that may have occurred after ceasing use (e. g . , convulsions);

immunization status;

other health problems, as designated by the responsible physician, such as a history of violence as determined by a *violence risk assessment* and

where appropriate, a history of gynecological problems and pregnancies.

Observation of:

- behavior, which includes state of consciousness, mental status (including suicidal ideation), appearance, conduct, tremors, and sweating;
- physical deformities and ease of movement; and
condition of skin, including trauma markings, bruises, lesions, jaundice, rashes, infestations, needle marks or other indications of drug use.

Disposition, such as:

- referral to an appropriate health care service on an emergency basis;
- placement in the general juvenile population and later referral to an appropriate health care service; or
- placement in the general juvenile population.

Discussion

Initial health screening is a system of structured inquiry and observation to determine a juvenile's health status on admission. This screening can be performed by health personnel or health-trained child care workers.

It must occur immediately upon the juvenile's admission to the facility and must be performed on all new arrivals. The only exceptions are juveniles who are transferred from other institutions and are accompanied by their initial health screening forms and a summary of their medical record information from the transferring institution. In this case, a new initial screening need not be conducted, but the medical information must still be reviewed and verified to ensure continuity of care.

Some studies indicate that suicide is the number one cause of death in detention facilities. Second is "cold turkey" withdrawal from alcohol and other drugs. Hence, it is extremely important for screeners to explore fully the juvenile's suicide and withdrawal potential. Reviewing with a juvenile any history of suicidal behavior and visually observing the juvenile's behavior (delusions, hallucinations, communication difficulties, speech and posture, impaired level of consciousness, disorganization, memory defects, depression, or evidence of self-mutilation), are recommended. Facilities following this approach, coupled with the training of all staff regarding mental health and chemical dependency aspects, should be able to prevent all or most suicides and "cold-turkey" withdrawals.

Particular attention should also be paid to careful descriptions of signs of trauma. All staff members should be reminded of their responsibility for reporting suspected abuse of juveniles to the appropriate authorities.

Finally, a *violence risk assessment* consisting of questions to determine if a juvenile has a violent history should be obtained from each juvenile upon intake. Such questions would include child and domestic abuse, sexual abuse, and any personal victimization. All juveniles with violent histories, including those who exhibit violent behaviors that place the safety of themselves or others in jeopardy, should be referred to treatment by appropriately trained health care providers. Treatment should not consist of only placing the juvenile on medication, but should take a balanced biopsychosocial approach to the treatment of violence (See Appendix F).

Y-28 Access to Treatment (essential)

Written policy and defined procedures require that information about access to health care services be communicated orally and in writing to juveniles upon their arrival at the facility.

Discussion

The facility should follow the policy of orally explaining to all juveniles the procedures for gaining access to medical, dental, and mental health services. This notification should take place at the time of initial screening or upon arrival at a new facility. Special procedures should be developed to ensure that juveniles who have difficulty communicating (e.g., those who are developmentally disabled, illiterate, mentally ill, or deaf) have access to health services. Where the facility frequently has non-English-speaking juveniles, procedures should be written in their language(s) as well as in English, in the form of a handbook, a handout, or signs in the juveniles' housing areas.

Y-29 Intoxication and Withdrawal (essential)

The responsible physician has approved written policy, procedures, and specific protocols for juveniles under the influence of alcohol or other drugs or undergoing withdrawal. Juveniles experiencing severe, life-threatening intoxication (overdose) or withdrawal are immediately transferred to a licensed acute care facility. Established guidelines for the treatment of individuals manifesting mild or moderate symptoms of intoxication or withdrawal from alcohol and other drugs are developed and followed. Individuals at risk for progression to more severe levels of intoxication or withdrawal are kept under constant observation by qualified health professionals or health-trained staff. *Detoxification* is done only under medical supervision in accordance with local, state, and federal laws.

Discussion

A significant percentage of juveniles admitted to facilities have a history of alcohol and/or other drug use. Newly incarcerated individuals may enter intoxicated or develop symptoms of alcohol or drug withdrawal. Alcohol withdrawal is the abstinence syndrome with the highest mortality rate, although opiate and tranquilizer withdrawal are, on occasion, life-threatening. Barbiturate withdrawal, while rare in confinement settings, is also often life-threatening. Severe withdrawal syndromes should never be managed in the non-hospital setting.

With the exception of methadone detoxification, the treatment of most non-life-threatening withdrawal consists of the amelioration of symptoms and can be managed in the convalescent or out-patient setting. Abstinence syndromes in juveniles require special attention.

Detoxification refers to the process by which an individual is gradually withdrawn from a drug by the administration of decreasing doses of the drug upon which the person is physiologically dependent, one that is cross-tolerant (antagonistic) to it, or one that has

been demonstrated to be effective on the basis of medical research. Detoxification in alcohol-dependent individuals does not involve administering decreasing doses of alcohol; it involves administering decreasing doses of drugs that are cross-tolerant to it.

Y-30 Medical Clearance (essential)

Written policies and defined procedures require that juveniles who are unconscious, semi-conscious, bleeding, or otherwise obviously in need of immediate medical attention are referred to a community hospital. Their admission or return to the juvenile facility is predicated upon written medical clearance.

Discussion

The intent of medical clearance is to prevent newly arrived juveniles who pose a health or safety threat to themselves or others from being admitted to the facility's general population and to obtain immediate medical care.

Y-31 Daily Handling of Medical Requests (essential)

Written policy and defined procedures require that juveniles' health requests be *documented* and processed at least daily as follows: they are solicited daily and acted upon by health-trained personnel, and followed by appropriate triage and treatment by qualified health personnel where indicated.

Discussion

Some facilities note on the request slip the action taken regarding triaging and file such slips in the juvenile's medical record; others use a medical log. These are examples of health requests being *documented*. All subsequent health encounters are documented in the patient's chart.

Y-32 Sick Call (essential)

Written policy and defined procedures require that *sick call* be conducted by a physician and/or other qualified health personnel and available to each juvenile according to the following schedule:

- In small facilities of fewer than 25 juveniles, sick call is held once per week, at a minimum.

In medium-sized facilities of from 25 to 100 juveniles, sick call is held at least three days per week.

Facilities with over 100 juveniles hold sick call a minimum of five days per week.

If a juvenile's custody status precludes attendance at sick call, arrangements are made to provide sick call services at the place of the juvenile's detention.

Discussion

Some people refer to "sick call" as a "clinic visit." Clinic care or *sick call* is care for ambulatory juveniles with health care requests that are evaluated and treated at a particular point in time. It is the system through which each juvenile reports for and receives appropriate medical services for non-emergency illness or injury.

The size of the facility is determined by the yearly average daily population, rather than by rated capacity.

Y-33 Health Appraisal (essential)

Written policy and defined procedures require the following:

A full *health appraisal* is completed for each juvenile within seven days after the juvenile arrives at the facility, and includes:

- review of the initial health screening results;
- collection of additional data to complete the medical, dental and psychiatric histories; laboratory and/or diagnostic tests (as determined by the responsible physician with recommendations from the local public health authority) to detect communicable disease, including sexually transmitted diseases (STDs) and tuberculosis;
- recording of height, weight, pulse, blood pressure, and temperature;
- other tests and examinations as appropriate;
- medical examination (including gynecological assessment of females), with comments about mental and dental status;
- review of the results of the medical examination and tests, and identification of problems by a physician and/or his/her designee when the law allows such; and initiation of treatment when appropriate.

The collection and recording of health appraisal data are handled as follows: The forms are approved by the health authority. Health history, vital signs, and any history of violence are collected by health-trained or qualified health personnel. Collection of all other health appraisal data is performed only by qualified health personnel. (Please refer to standard Y-20 for definitions of the terms “health-trained” and “qualified health personnel. ”)

In the case of a re-admitted juvenile who has received a documented health appraisal within the previous six months, the prior results are reviewed and tests, examinations, etc. updated as needed. Full health appraisals are repeated annually for juveniles staying that length of time.

Discussion

The *health appraisal* is the process of evaluating the health status of an individual. The extent of the health appraisal, including medical examinations, is defined by the responsible physician, but should include the steps listed above. When appropriate, additional investigation should be carried out regarding:

- . the use of alcohol and/or drugs, including the type(s) of substance used, mode(s) of use, amounts used, frequency of use and date or time of last use;
- . current or previous treatment for alcohol or drug use, including, when and where treatment was provided;
- . whether the juvenile is taking any medication for an alcohol or drug use problem;
- . any history of violence, including child and domestic abuse, sexual abuse, and any personal victimization. All juveniles with violent histories, including those who exhibit violent behaviors that place the safety and welfare of themselves or others in jeopardy should be referred to treatment by appropriately trained health care providers. Treatment should take a balanced psychosocial approach to the violence, rather than consisting of solely placing the juvenile on medication (see Appendix F).
- . current or past illnesses and health problems related to substance use, such as hepatitis, seizures, traumatic injuries, infections, and liver diseases; and
- . whether the juvenile is taking medication for a psychiatric disorder and, if so, what drug(s) and for what disorder.

Further assessment of psychiatric problems identified at the initial health screening or after admission should be provided by either the medical staff or the psychiatric services staff within seven days. In many facilities, it can be expected that such assessment will be done by a general practitioner or family practitioner. Psychiatric services staff can

include psychiatrists, family physicians with psychiatric orientation, psychologists, psychiatric nurses, or social workers.

Regarding waiver of laboratory tests for tuberculosis and STDs, a letter from the public health authority citing the incidence of the disease at issue in that locality and the justification for not conducting such tests on all juveniles is required for consideration of 'waiver.

Y-34 Emergency Services (essential)

Written policy and defined procedures require that the facility provide 24-hour *emergency medical and dental care*, as outlined in a written plan that includes arrangements for:

emergency evacuation of the juvenile from the facility;

use of an emergency medical vehicle;

use of one or more designated hospital emergency department(s) or other appropriate health facilities;

emergency on-call physician and dentist services when the emergency health facility is not located nearby; and

security procedures that provide for the immediate transfer of juveniles when appropriate.

Discussion

Emergency medical and dental care is care for an acute illness or an unexpected health need that cannot be deferred until the next scheduled sick call or clinic.

It is desirable that health personnel be trained in advanced cardiac life support services or the use of a defibrillator. If neither is available at the facility, the nearest health care facility with that support should be identified and listed in the written plan.

Y-35 Direct Orders (essential)

Treatment by health-trained or qualified health personnel other than physicians and dentists is performed pursuant to direct orders written and signed by personnel authorized by law to give such orders.

Discussion

Medical and other practice acts differ in various states as to the issuance of direct orders for treatment; therefore, laws in each state need to be studied for implementation of this standard.

Y-36 Skilled Nursing and Infirmary Care (essential)

Written policy and defined procedures guide *skilled nursing* or *infirmary care* and require: (1) a designated infirmary; (2) a definition of the scope of skilled nursing care provided at the facility, (3) a physician on call 24 hours a day; (4) *supervision* of the infirmary by a registered nurse who is there daily; (5) health care personnel on duty 24 hours per day; (6) all juvenile patients being within sight or sound of a staff person; (7) a manual of nursing care procedures; and (8) a separate and complete medical record for each juvenile.

Discussion

An infirmary is an area established within the confinement facility in which organized bed care facilities and services are maintained and operated to accommodate two or more juveniles for a period of 24 hours or more, and is operated for the express or implied purpose of providing skilled nursing care for persons who are not in need of hospitalization.

Skilled nursing or *infirmary care* is defined as in-patient bed care by or under the supervision of a registered nurse for an illness or diagnosis that requires limited observation and/or management and does not require admission to a licensed hospital. *Supervision* is defined as the overseeing of the accomplishment of a function of activity.

Advancement of the quality of care in this type of medical area begins with the assignment of responsibility to one physician. Depending upon the size of the infirmary, the physician may be employed part- or full-time.

Nursing care policies and procedures should be consistent with professionally recognized standards of nursing practice and in accordance with the nurse practice act of the state. Policies and procedures should be developed on the basis of current scientific knowledge and take into account new equipment and current practices.

Y-37 Suicide Prevention (essential)

The facility has a written plan for identifying and responding to suicidal individuals.

Discussion

While juveniles may become suicidal at any point during their stay, high-risk periods include:

- the time immediately upon admission to a facility;
- after adjudication, when the juvenile is returned to a facility from court;
- following receipt of bad news regarding self or family (e.g., serious illness or loss of a loved one) or after suffering some type of humiliation or rejection;
- segregation; and
- prolonged stays in juvenile detention facilities.

The facility's plan for suicide prevention should include the following elements:

Identification. The initial health screening form should include observation and interview items related to each juvenile's potential suicide risk (see the sample screening forms in Appendix B).

Training. All staff who work with juveniles should be trained to recognize verbal and behavioral cues and to watch for signs of vulnerability that indicate potential suicide.

Assessment. This should be conducted by a qualified mental health professional with designation of the juvenile's level of suicide risk (see sample form in Appendix D).

Monitoring. The plan should specify the facility's procedures for **monitoring** a juvenile who has been identified as potentially suicidal. Regular supervision should be maintained. (See sample protocols on suicide precaution levels, Appendix D.)

Housing. If sufficient staff is not available to provide constant supervision when needed, the juvenile should not be isolated. Rather, s/he should be housed with another resident and checked every 10-15 minutes. The room should be as suicide-proof as possible (i.e., without protrusions of any kind that would enable the juvenile to hang him/herself). It is inappropriate to place a suicidal youth in a maximum security isolation unit.

Referral. The plan should specify the procedures for referring potentially suicidal juveniles and attempted suicides to mental health providers or facilities for care.

Communication. Procedures for communication between health care staff and child care workers should exist to provide clear and current information regarding the status of the child.

Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide. The facility administrators and the health authority should receive reports about attempted and completed suicides.

Notification. Procedures for notifying facility administrators, outside authorities and family members of potential, attempted, and/or completed suicides should be in place.

Review. The plan should specify a review process if a suicide does occur.

Y-38 Pregnant Juveniles (essential)

In recognition of the high-risk nature of adolescent pregnancy, juveniles remaining in the facility after pregnancy has been diagnosed receive regular pre-natal and post-natal care, including medical examinations, appropriate activity levels, safety precautions, nutrition, guidance, and counseling.

Discussion

Pregnant juveniles remaining in the facility must have regular pre-natal care provided by qualified health care professionals including physicians having obstetrical privileges at the hospital where the delivery is likely to take place.

Y-39 Health Evaluation: Juveniles in Segregation (essential)

The health authority and facility administrator should collaborate on and authorize the institution's segregation policies. Both should receive monthly reports on the frequency of use of segregation. Written policies and defined procedures require that juveniles removed from the general population and placed in segregation because of behavior problems be evaluated daily by qualified health personnel. These encounters should be documented, and the documentation filed in the juvenile's medical record.

Discussion

Owing to the possibility of injury and depression during periods of isolation, daily health evaluation should include personal contact with the segregated juvenile, notation of bruises or other trauma markings, and comments regarding the juvenile's attitude and outlook. The juvenile should be checked daily by a health care worker. A log should be kept of all interactions with the juvenile while in segregation. These evaluations are not to replace or to preclude the checks provided by program staff. Checks by program staff should be more than visual. They should involve personal contact with the segregated youth, and should occur at least every 15 minutes.

Evaluations by qualified health personnel are more than visual checks. The segregated juvenile should be interviewed and assessed for disturbances in mental status (e.g., depression, suicidal ideation, agitation, paranoia, self-injurious behavior, evidence of bruises, or other signs of trauma). Segregation policies should state that this intervention is to be reserved for incidents in which the youth's behavior has escalated beyond the staff's ability to control the youth by counseling or disciplinary measures and presents a risk of injury to the youth or others. If special (nonresidential) rooms are used for segregation, they should be as well-illuminated as regular unit rooms and have easy access to appropriate toilet facilities. In the rare instance that a segregated youth's out of control behavior lasts 24 hours, and there appears to be a need for continued intervention, qualified health personnel should evaluate the youth directly, approve continued isolation or generate a written plan for urgent mental health assessment by a qualified mental health professional, and/or the use of alternatives to segregation (e.g., return to living units under supervision, use of medications, or transfer to a mental health facility).

Further, in recognition of the deleterious effects of prolonged segregation on juveniles, it is recommended that health care staff be involved in the development and/or review of segregation policies.

A monthly report should be given to the health authority and facility administrator about the use of segregation. This report should include information about the number of juveniles in segregation during the month, the number of days spent in segregation, and the health status of segregated juveniles.

This standard reflects a number of findings and assumptions:

Segregation is a behavioral control measure (thus subjected to administrative responsibility) which may pose medical danger (thus subject to medical responsibility). This danger increases as segregation is prolonged.

The decision to place a youth in segregation should be left to the discretion of trained program staff, but this action should precipitate a series of monitoring actions by medical personnel to protect the segregated youth from harm. The longer a youth remains in segregation, the greater the role of the medical staff should be in the decision-making process. In the beginning, health staff involvement should be confined to monitoring the juvenile's psychological state; but as the segregation period lengthens, health personnel should have increasing authority to intervene and to approve the procedure.

Prolonged segregation is defined by scientific research, community standards, regulations, statutes, and case law. Animal and human studies reveal biological, behavioral, and mental status changes under conditions of social isolation and/or sensory deprivation within 24 hours. Surveys of psychiatric facilities indicate that 24 hours is usually the upper limit for segregation. Nationwide surveys of juvenile detention/confinement facilities indicate that most have upper time limits for segregation, with a range from one hour to 15 days, and a modal limit of 24 hours or less. In cases where litigation has determined the upper limit, judges have imposed ranges of two to five hours. It is reasonable to assume from these findings and the successful experiences of juvenile detention/confinement programs that have strict, self-imposed limits on isolation, that the vast majority of segregation events can be limited to minutes or hours, and the use of segregation for a day or more is unnecessary in all but a very few cases.

Although administrators and health personnel may wish to see segregation as an exclusive administrative measure, judges have consistently declared it a medical procedure on the basis of its medical dangers. Health care personnel, therefore, are strongly encouraged to learn about the risks of segregation and appropriate safeguards against its misuse. It is the responsibility of health care personnel to inform the facility administrator about any misuse of segregation.

Y-40 Use of Restraints (essential)

If restraints are to be used in the facility, written policy and defined procedures guide the use of *fixed restraint*, and include an identification of the authorization needed, the duration, when, where, and how restraints are to be used. The health authority and facility administrator should collaborate in writing and authorizing restraint policies. Both should receive daily reports on the frequency of use of restraints.

Discussion

Fixed restraint is defined as the restraining of a youth to a bed with mechanical devices such as fleece-lined leather, canvas or soft rubber restraints, commonly referred to as "4- or 5-point restraints." This standard does not apply to handcuffs, shackles, or hard plastic straps when they are used to subdue and/or transport a juvenile. It is inappropriate to use these devices for fixed restraint. It is also inappropriate to restrain a person in an unnatural position (e.g., face down, spread eagle, hog tied), or to affix restraints to furnishings other than restraint beds. Fixed restraints, if used, should be used only in a behavior crisis in which there is danger of injury to self or others. Fixed restraints should be not used for discipline or punishment.

Medical *monitoring* of a youth in restraints by qualified or health-trained personnel should take place at least every fifteen minutes, and program staff should be in constant visual supervision of the restrained youth. Medical monitoring should consist of checks for circulation and/or nerve damage, airway obstruction, or psychological trauma. Restraining a youth for more than one hour should require the approval of qualified or health-trained personnel. Restraining a youth for more than two hours should require an evaluation by a qualified mental health professional, who should develop a plan for alternative interventions (e.g., return of the youth to the living unit under supervision, use of medications, or transfer to a mental health facility). When staff members note what they consider to be improper use of restraints, jeopardizing the health of a youth, they should communicate their concerns to the health authority or facility administrator.

This standard reflects a number of findings and assumptions:

Serious injuries and deaths, though rare, have occurred as a result of the process of applying restraints. Injuries usually occur during the restraint process, but can also be the result of nerve or artery constriction. Deaths are usually the result of airway restriction (e.g., aspiration of vomitus, gagging, or covering the mouth and/or nose of the restrained person).

When restraint practices are misused and result in litigation, judges have either forbidden their use or placed their use solely under the supervision of the medical staff. All staff who use restraints should be trained in their proper application. Medical staff should be aware of the medical risks involved and inform the facility administrator when restraints are being misused.

Many juvenile programs choose not to use fixed restraint as a behavior control measure. Other programs that do use restraints have found that carefully written policies and conscientious supervision can significantly reduce restraint time and the number of restraint incidents. For this reason, it is recommended that restraints be

kept in a central location, rather than on units, and their access be controlled by supervisory personnel.

Y-41 Immunizations (essential)

Written policy and procedures require that immunizations be updated as necessary, within legal constraints. A pregnancy test should be done on all females of childbearing age before any immunization is given.

Discussion

All 50 states require immunization for school age children. When immunizations are not up-to-date, the facility should ensure that each juvenile is fully protected. The relevant information should be obtained from parents, family physicians, schools, and other available sources.

Y-42 Pharmaceutical Services (essential)

Sufficient pharmaceutical services are provided to meet the needs of the facility and are in accordance with all legal requirements.

The facility is in compliance with all applicable state and federal regulations regarding prescribing, dispensing, distributing, administering, and procuring pharmaceuticals.

All drugs must be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Antiseptics, other drugs for external use, and disinfectants are stored separately from internal and injectable medications. Drugs requiring special conditions for storage to ensure stability -- for example, drugs requiring refrigeration -- are properly stored.

An adequate and proper supply of antidotes and other emergency drugs, and related information, are readily available to staff to meet the needs of the facility.

The facility has written policies and procedures governing the pharmaceutical services, which include but are not limited to the following:

Development and subsequent updating of a facility *formulary* or drug list for pharmaceuticals stocked by the facility. The formulary also includes the availability of non-legend medications. (The existence of a formulary does not preclude the use of unlisted drugs.)

Procurement, dispensing, distribution, accounting (i. e., monitoring), administration, and disposal of pharmaceuticals.

Maintenance of records as necessary to ensure adequate control of and accountability for all drugs.

Maximum security storage of, and accountability for *DEA-controlled substances*, needles and syringes, and other abusable items.

Automatic drug stop orders or required periodic review of all orders for DEA-controlled substances, psychotropic drugs, or any other drug that should be restricted because it lends itself to use or for any other reason dictating that patient compliance be monitored.

A system to notify the responsible practitioner of the impending expiration of a drug order, so the practitioner can determine whether the drug administration is to be continued or altered.

Administration of **drugs** only upon the order of a physician, dentist, or other authorized individual with designated privileges.

The prescribing of psychotropic medications only when clinically indicated (as one facet of a program of therapy) and not for disciplinary reasons.

All medications are under the control of the appropriate staff. Juveniles do not prepare, dispense, or administer medication.

When there is no staff pharmacist, a consulting pharmacist is used to review pharmaceutical practices at least annually.

Discussion

A *formulary* is a written list of prescription and non-prescription medications stocked in the facility. This does not restrict prescriptions of medication generated by community health care providers; however, these are still subject to review and approval by the responsible physician.

Procurement is the system for ordering medications for the facility.

Dispensing is the issuance of one or more doses of a prescribed medication in containers that are correctly labeled to indicate the name of the patient, the contents of the container, and all other vital information needed to facilitate correct drug administration.

State law controls the scope of authority of a physician or other clinicians dispensing medication.

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

Medication accounting is the act of recording, summarizing, analyzing, verifying, and reporting medication usage.

Medication administration is the act in which a single dose of an identified drug is given to a patient.

Disposal involves the destruction of medication upon the discharge of the user from the facility or the provision of the discharged juvenile with the medicine prescribed, in line with the continuity of care principle. When a facility uses the sealed, pre-packaged unit dose system, the unused portion often can be returned to the pharmacy.

DEA-controlled substances are the drugs that come under the jurisdiction of the Federal Controlled Substances Act. They are divided into five schedules (I through V). The Drug Enforcement Administration (DEA) is the leading federal law enforcement agency charged with the responsibility for combating drug use. Requirements of the Controlled Substances Act and a list of controlled drugs can be obtained from any office of the DEA.

Y-43 Special Handling: Patients with Acute Illnesses (essential)

Written policy and defined procedures require post-admission screening and referral for care of patients with acute psychiatric and other serious illnesses as defined by the health authority. Those who require health care beyond the resources available in the facility, or whose adaptation to the correctional environment is significantly impaired, are transferred or committed to a facility where such care is available. A written list of referral sources, approved by the health authority, is maintained.

Discussion

Psychiatric and other acute medical problems identified either at receiving screening or after admission must be followed up by medical staff. The urgency of the problem determines the response. Suicidal and psychotic patients are emergencies and should be held for only the minimum time necessary. Juveniles awaiting emergency evaluation

should be housed in a specifically designated area with constant supervision by health-trained staff.

The following conditions should be met if treatment is to be provided in the facility:

- safe, sanitary, humane environment as required by sanitation, safety, and health codes of the jurisdiction;
- adequate staffing and security to help inhibit suicide and assault (e.g., staff within sight or sound of all juveniles); and
- trained personnel available to provide treatment and close observation.

Y-44 Sexually Transmitted Disease and Bloodborne Disease Detection (essential)

Written policy and defined procedures require that education and counseling for and diagnosis and treatment of sexually transmitted diseases (STDs) and bloodborne diseases be made available through age appropriate materials, group education, and one-to-one counseling.

Discussion

The incarcerated youth population is at high risk for infection with STDs, including HIV and hepatitis B. Critical areas which must be addressed on-site or by referral include:

Detection. The clinical management and prognosis of STDs and bloodborne diseases is greatly affected by early recognition of symptoms and early diagnosis. Sufficient resources should be made available to detect and diagnose STDs and bloodborne diseases.

Treatment. A medical, psychological, and social support plan for the care, referral, and treatment of those testing positive for STDs and bloodborne diseases is required.

Education and Prevention. Education in this age group is crucial. The use of age appropriate brochures, comics, and videos may be part of the program. Group education and one-to-one counseling must be provided.

Public health STD clinics, Planned Parenthood Clinics, and individual physicians are examples of community resources for sexually active juveniles. HIV pre- and post-test counselling and testing are best done by one person; therefore, a juvenile whose stay is

too short to complete the entire process should be referred to the community HIV clinic or a physician treating HIV-infected people.

Y-45 Treatment Philosophy (important)

Medical procedures are performed in privacy, with a chaperon present when indicated, and in a manner designed to encourage the patient's subsequent utilization of appropriate health services. When a rectal or pelvic examination is indicated, verbal consent is obtained from the patient.

Discussion

Health care should be rendered with consideration of the patient's dignity and feelings.

Y-46 Hospital Care (important)

The facility has arrangements for providing in-patient hospital care for medical and psychiatric illnesses.

Discussion

The facility should develop a letter of agreement with each hospital it utilizes for in-patient medical and psychiatric services. This letter should indicate the willingness of the hospital to accept patients from the facility and the requirements of both parties (e.g., patient to be transferred with a summary of his/her medical record, procedures for transporting personnel to follow at the hospital, patient to be discharged with a summary of treatment received, and terms of payment).

Y-47 Special Medical Program (important)

Written policy and defined procedures guide the *special medical program* that exists for juveniles requiring close medical supervision, including *chronic care* and *convalescent care*. A written, individualized *treatment plan*, developed by a physician, exists for these patients and includes directions to health care and other personnel regarding their roles in the care and supervision of these patients.

Discussion

The *special medical program* serves a broad range of health conditions and problems, including seizure disorders, diabetes, potential suicide, pregnancy, chemical dependency, and psychosis. These are examples of some of the special medical conditions that dictate close medical supervision. In these cases, the facility must respond appropriately by providing a program directed to the individual's needs.

Chronic care is medical service rendered to a patient over a long period of time, for such conditions as diabetes, hypertension, asthma, and epilepsy. *Convalescent care* is medical service rendered to a patient to assist in the recovery from illness or injury.

A *treatment plan* is a series of written statements that specify the particular course of therapy and the roles of medical and non-medical personnel in carrying it out. It is individualized and based on assessment of the patient's needs, and it includes a statement of the short- and long-term goals as well as the methods to reach these goals. When clinically indicated, the treatment plan provides juveniles with access to a range of supportive and rehabilitative services (e. g . , individual or group counseling, and self-help groups) as the physician deems appropriate.

Special medical problems should be identified on the outside of the patient's chart. A list of chronic medications as well as any known drug allergies also may be helpful.

Y-48 Standing; Orders or Treatment Protocols (important)

Standing orders are not used by the juvenile detention/confinement facility. If *treatment protocols* exist, written policy requires that they be developed and signed by the physician and, when utilized, they be countersigned in the medical record by the physician.

Discussion

Standing orders are written orders that specify the same course of treatment for each patient suspected of having a given condition. *Treatment protocols* are written orders that specify the steps to be taken in appraising a patient's physical status. Treatment is initiated only upon the written or verbal orders of a licensed physician. Treatment protocols should not include any directions regarding dosages of prescription medications. An example of a standing order versus an acceptable treatment protocol is given in Appendix H.

The prohibition against standing orders is intended for routine cases when there is time to contact a physician, to describe the symptoms, and to obtain a direct order for

treatment. This standard does not preclude protocols for emergency situations (e.g., anaphylactic shock) when immediate action is required.

Instructions for first-aid procedures written by the responsible physician are acceptable for the identification and care of such minor ailments as would ordinarily be treated by an individual with self-care and over-the-counter medication, (e.g. mild colds and athlete's foot; minor cuts, abrasions, and burns; common headaches; and simple constipation and diarrhea). Administration of over-the-counter medication by health care personnel should be documented in the patient's record. However, it need not be countersigned by a physician unless required by the facility's own policy.

Y-49 Continuity of Care (important)

Written policy and defined procedures require continuity of care from admission to discharge from the facility, including referral to community care when indicated.

Discussion

As in the community, health providers should obtain information regarding previous care when undertaking the care of a new patient. Likewise, when the care of the patient is transferred to providers in the community, appropriate health information is shared with the new providers in accordance with consent requirements.

Juveniles identified in the facility as having long-term or potentially serious conditions should be referred to follow-up clinics, if this is medically indicated. Examples of such conditions are hypertension, diabetes, epilepsy, psychiatric disorders, urinary tract infection, chronic otitis, serious trauma, and post-operative status. Files for such patients should be marked in some fashion (e.g., color-coded) to indicate the juvenile's special medical needs.

Y-50 Chemically Dependent Juveniles (important)

Written policy and defined procedures regarding the clinical management of chemically dependent juveniles require diagnosis of *chemical dependency* by a physician or (if authorized by law) a properly qualified designee; an individualized treatment plan to be developed and implemented; and referral to specified community resources upon release, when appropriate.

Discussion

Existing community resources should be utilized if possible. The term *chemical dependency* refers to the state of physiological and/or psychological dependence on alcohol and/or other drugs.

Y-51 Care of the Physically or Mentally Disabled Juvenile (important)

Written policy and defined procedures require post-admission screening and referral for care of physically or mentally disabled juveniles whose adaptation to the detention/confinement environment is significantly impaired. A treatment plan is developed for each of these juveniles. The health authority provides a written list of specific referral resources.

Discussion

All sources of assistance for physically or mentally disabled juveniles should be identified in advance of need.

Y-52 Prostheses (important)

Written policy and defined procedures require that medical and dental prostheses be provided when the health of the juvenile would otherwise be adversely affected, as determined by the responsible physician or dentist.

Discussion

Prostheses are artificial devices to replace missing body parts. Examples include artificial limbs, an eye, or a heart valve. Orthotics are specialized mechanical devices to support or supplement weakened or abnormal joints or limbs. Examples include hip pins, braces, or eyeglasses.

Y-53 Dietary Services (important)

A nutritionally adequate diet incorporating the food guide pyramid (see Appendix E) and based on the most recent recommended dietary allowances published by the National Research Council, should be provided to all juveniles. Special medical and dental diets are served to juveniles when ordered by the treating physician and/or dentist. Regular and special meals are approved by a registered dietitian every six months.

Discussion

Nutritionally adequate diets are derived from foods in the food guide pyramid with minimum amounts provided from each segment of the food guide pyramid. (See Appendix E.)

It is recommended foods be prepared without excessive amounts of salt and that total fat in the diet should be limited. Interpretation of nutritional guidelines into menus providing specific caloric requirements requires consultation and approval by a registered dietitian due to the special nutritional needs of adolescents during different phases of growth and development.

Certain chronic conditions, for example, diabetes and obesity, as well as temporary ones such as pregnancy and post-oral surgery, require individual attention. Orders for special diets should include the type of diet, the duration of the diet, the duration for which the diet is to be provided, and any special instructions. The facility should have a procedure for ensuring that the right patient receives the diet which has been prescribed.

Y-54 Dental Care (important)

Written policy and defined procedures require that dental care be provided to each juvenile under the direction and supervision of a dentist licensed in the state as follows:

- *dental screening* within seven days of admission;
- *oral hygiene* instruction and dental health education within 14 days of admission;
- *dental examination* within one month of admission;
- dental treatment, not limited to extractions, when the health of the juvenile would otherwise be adversely affected, as determined by the dentist; and
- access to the preventive benefits of fluorides in a form considered appropriate for the needs of the individual as determined by the dentist.

In the case of a re-admitted juvenile who has received a dental examination within the past six months, a new exam is not required except as determined by the supervising dentist. Fluoride toothpaste must be available for all juveniles.

Discussion

As part of the initial health appraisal, *dental screening* is performed by a dentist or health personnel properly trained and designated by a dentist. It includes visual

observation of the teeth and gums, noting any obvious or gross abnormalities requiring immediate referral to a dentist. *Oral hygiene* instruction and dental health education should be provided by dentists, dental hygienists, or dentally trained health personnel, and should consist of measures to assist the patient in caring for his/her own oral health, such as instruction in the proper brushing and flossing of teeth.

Dental examinations and treatments are performed only by licensed dentists. The *dental examination* should include the taking or review of the patient's dental history, charting of teeth, and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination. X-rays for diagnostic purposes should be available if deemed necessary. The results of the examination are recorded on a uniform dental record system, such as the Attending Dentist's Statement, (see sample form, Appendix B). A professional dental prophylaxis should be performed as part of the treatment provided to the patients when prescribed by the dentist.

Consideration should be given to the use of topical fluorides when the dentist determines these to be needed.

Assistance should be provided for those juveniles who, because of mental, physical or other disabilities, are unable to perform daily oral hygiene techniques.

Y-55 Exercise (important)

Written policy and defined procedures outline a program of exercise and require that each juvenile be allowed a daily minimum of one hour of exercise involving *large-muscle activity*, on a *planned, supervised basis*.

Discussion

Examples of *large-muscle activity* are walking, jogging in place, basketball, ping-pong, and isometrics.

To meet compliance with exercise on a *planned, supervised basis*, the facility should provide a separate facility or room. The dayroom adjacent to the living units may be used for this purpose if planned, programmed activities are directly supervised by staff and/or trained volunteers. Otherwise, the designated hour would be no different from the rest of the day. Television and board games do not meet compliance.

Daily exercise should take place outside where possible. Regarding the use of outside yards, gymnasias and multi-purpose rooms, making available exercising opportunities (e.g., basketball, handball, jogging, running, and calisthenics) satisfies compliance even

if juveniles do not take advantage of them. While such activities may be more productive under the supervision of a recreational staff person, this is not required. For the purposes of supervision, juveniles should be within sight or sound of a staff person.

It is recommended that medical personnel advise staff about strenuous exercise during inclement environmental conditions (e.g., extreme heat or cold).

Y-56 Outside Programs (important)

Written policy and defined procedures guide outside programs such as Outward Bound or forestry camp. Recognizing the potential for health care crises in a wilderness setting, staff who accompany juveniles should be trained in first-aid and CPR.

Discussion

Activities and supplies for outside programs must be structured to take into account environmental conditions to avoid health problems such as dehydration or hypothermia. Policies and procedures should address the activity plan, supplies, and clothing for the outside programs.

Y-57 Personal Hygiene (important)

Written policy and defined procedures outline a program of personal hygiene and require that every facility that would normally expect to detain a juvenile at least 48 hours furnish bathing facilities in the form of either a tub or a shower with hot and cold running water, permit regular bathing at least every other day, permit daily bathing in hot weather in facilities without air temperature control, and make the following items available to juveniles: soap, toothbrush, fluoridated, toothpaste, comb, toilet paper, sanitary napkins and tampons when required, and laundry services at least weekly. Haircuts and implements for shaving are made available to juveniles subject to security regulations.

Y-58 Family Planning Services (important)

Written policy and defined procedures require that comprehensive family planning services, in accordance with state statutes, be available on the premises or by referral.

Discussion

Incarceration of sexually active juveniles often prevents access to appropriate family planning services. As an important aspect of health care provided in the facility, the following areas should be included:

Education regarding sexuality, pregnancy prevention, and options for those who become pregnant should be provided. Printed materials should be age-appropriate and in the main languages spoken in the community.

Counseling and Social Services regarding all aspects of sexuality should be available in the facility or by referral to appropriate community agencies. Contraceptive publications should be available for both males and females; contraceptive materials should be available upon discharge from the facility. Pregnancy detection and counseling regarding options for pregnant juveniles, including aborting or continuing the pregnancy, keeping the child or putting it up for adoption, should be included.

Liaison with Community Providers Public health family planning clinics, Planned Parenthood Foundation clinics, and individual physicians are examples of community resources for sexually active juveniles.

SECTION E - HEALTH RECORDS

Essential Standards

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Important Standards

Y-61 Transfer of Health Records and Information	56
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Y-59 Health Record Format and Contents (essential)

At a minimum, the health record file contains:

- the completed initial health screening form;
- health appraisal data forms;
- master problem list;
- all findings, diagnoses, treatments, and dispositions;
- prescribed medications and their administration;
- reports of laboratory, x-ray, and diagnostic studies;
- signature and title of each documenter;
- consent and refusal forms, when applicable;
- release of information forms, when applicable;
- place, date, and time of health encounters;
- discharge summary of hospitalizations;
- health service reports (e.g., dental, psychiatric, and other consultations); and
- specialized treatment plan, if any.

The method of recording entries in the record and the form and format of the record are approved by the health authority. A record should be maintained on every juvenile in confinement.

Discussion

The problem-oriented medical record structure is suggested. *The chart should contain a master problem list, which includes all medical, dental, or psychiatric problems, allergies, and chronic medications.* However, whatever the record structure, every effort should be made to establish uniformity of record forms and content throughout the confinement system. The record is to be completed and all findings are to be recorded, including notations concerning psychiatric, dental and other consultative services. If a juvenile is admitted more than once, existing medical records should be re-activated.

When patients are seen only at the physician's office, the record is generally kept there. However, a form for recording the visit should accompany the juvenile, so the physician can provide information regarding diagnosis, treatment, and recommended follow-up care.

Y-60 Confidentiality of the Health Record (essential)

Written policy and defined procedures that establish the principle of confidentiality of the health record require that the active health record is maintained under secure conditions,

separate from the confinement record, and that access to the health record is controlled by the health authority.

Discussion

The principle of confidentiality protects the patient from disclosure of certain confidences entrusted to a physician and other health professionals during a course of treatment. Special restrictions on disclosure under federal regulations may exist for information gathered and recorded about alcohol and drug use. On the other hand, health professionals are required in all states to report cases of suspected child abuse. The health authority should maintain a current information file on the rules and regulations covering the confidentiality of medical records and the types of information that can and cannot be shared.

The confidential relationship of doctor and patient extends to juvenile patients and their physicians. Thus, it is necessary to maintain active, secured health record files, completely separate from the juvenile's confinement record.

Y-61 Transfer of Health Records and Information (important)

Written policy and defined procedures regarding the transfer of health records and information to the outside community require that when a request for health record information is received, it is transmitted to specific and designated physicians or medical facilities in the community upon the written authorization of the juvenile.

Written policy and defined procedures regarding the transfer of health records and information require that:

Summaries or copies of the health record are routinely sent to the facility to which a juvenile is transferred either before or at the same time as the juvenile, and

Written authorization by the juvenile is necessary for the transfer of health records and information, unless otherwise provided by law or administrative regulation having the force and effect of law.

Discussion

In the event of a transfer of a juvenile within the justice system, a juvenile's health record summary addressing medical, dental, and mental health problems should accompany or precede the juvenile in order to ensure continuity of care and to prevent the duplication of tests and examinations at the receiving institution. For juveniles with

critical or chronic health problems, the files should be flagged in some fashion (e.g., with color coding) to trigger an immediate referral to medical personnel.

The transferring institution should provide a discharge summary (see sample Health Status Form in Appendix B) that includes at least these elements: medical history, date of last physical, immunization record, summary of medical problems, current health status, current level of activity, current therapy (including medications), and anticipated future health care needs.

Y-62 Record Retention (important)

Written policy and defined procedures requiring that inactive health record files are retained to legal requirements of the jurisdiction, and are re-activated if a juvenile returns to the system or facility.

Discussion

Inactive health records need to conform to legal requirements for record retention. The inactive files should be marked in such a way that juveniles can be identified as long-term care patients if they re-enter the system or facility.

SECTION F - MEDICAL-LEGAL ISSUES

Essential Standards

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Important Standards

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Y-63 Informed Consent (essential)

All examinations, treatments, and procedures governed by *informed consent* practices applicable in the jurisdiction are likewise observed for juvenile care. The informed consent of parent, guardian, or legal custodian applies when required by law.

Discussion

Informed consent is the agreement by the patient to a treatment, examination, or procedure after the patient receives the material facts regarding the nature, consequences, risks, and alternatives concerning the proposed treatment, examination, or procedure. As a general rule it is required prior to performing any invasive procedure or any treatment that has potential risks for the patient. This would include oral surgery.

The law regarding consent to the medical treatment by juveniles, and their right to refuse treatment, varies greatly from state to state. Some states allow juveniles to consent to treatment without parental consent, as long as they are mature enough to comprehend the consequences of their decision. Others require parental consent until majority, but the age of majority varies among the states. The law of the jurisdiction within which the facility is located should be reviewed by legal counsel, and, based upon counsel's written opinion, a policy regarding informed consent should be developed. In all cases, however, consent of the person to be treated is important.

Obtaining informed consent is not necessary in all cases. These exceptions to obtaining informed consent should be reviewed in the light of each state's laws, as the latter vary considerably. Examples of such situations are emergencies that require immediate medical intervention for the safety of the patient, emergency care involving patients who do not have the capacity to understand the information given, and public health matters, such as communicable disease treatment. Physicians must exercise their best medical judgment in all such cases. It is advisable that the physician document the medical record for all aspects of the patient's condition and the reasons for medical intervention. Such documentation facilitates review and provides a defense from charges of battery. In certain exceptional cases, a court order for treatment may be sought, just as it might be in the general community.

Consent is implied in a life-threatening situation or when a juvenile's judgment is impaired, rendering him/her incapable of making an informed decision. In the latter situation, parental consent may still be required.

Y-64 Right to Refuse (essential)

Juveniles have the right to refuse examinations, treatments, and procedures in accord with laws within the jurisdiction. Written policy and defined procedures should allow juveniles to refuse, in writing, medical treatment and care. Policy and procedure should guide staff in dealing with juveniles who refuse care.

Discussion

The right to refuse treatment is an extension of informed consent. Medical treatment of a juvenile without his/her consent (or without the consent of parent, guardian, or legal custodian) can result in legal complications. In other words, the decision to refuse treatment should be an informed one. The juvenile should be brought to the clinic and the benefits and risks of the proposed treatment explained. If a juvenile refuses treatment, the health authority should notify the appropriate legal custodian.

Health professionals should counsel juveniles against refusals of treatment and should continue to counsel youths who have refused a particular treatment when they believe it to be in the patient's best interest. Refusals of treatment should be made to health staff. The right to refuse does not apply when the individual exhibits an altered mental state, impaired judgment, or in life-threatening situations where consent is implied.

Y-65 Medical Research (important)

Any biomedical or behavioral research involving juveniles is done when ethical, medical, and legal standards for human research are met.

Discussion

This standard recognizes past abuses in the area of research on involuntarily confined individuals and stresses the protective measures and the interests of patient autonomy that must be considered in a decision to include such persons in clinical research. There should be adequate assurance of safety to the subject. The research should meet standards of design and control, and the juvenile must have given his/her informed consent. Federal restrictions, as well as the legal requirements of each jurisdiction, should be checked before such research is initiated. In some areas, the prior approval of a human subjects review committee is required.

When ethical, medical, and legal standards are observed, clinical trials may be an effective part of an individual treatment plan, as in the example of drug trials to treat HIV-infected individuals.

Y-66 Forensic Information (important)

Written policy and procedures prohibit the facility's health care personnel from participating in the collection of certain information for forensic purposes.

Discussion

The role of the health care staff is to serve the health needs of the juvenile patients. The position of its members as neutral, caring professionals is compromised when they are asked to collect information about juveniles that may be used against the latter.

Performing psychological evaluation of youths for use in adversarial proceedings and conducting body cavity searches for contraband are examples of inappropriate uses of a facility's health care staff. Such acts undermine credibility of these professionals with their patients, and compromise them by asking them to participate in acts that are usually done without the youth's consent. Where state laws and regulations require that such acts be performed by health care professionals, the services of outside providers should be obtained.

Body cavity searches conducted for reasons of security should be done in privacy by outside health care providers (as noted above) or by correctional personnel of the same sex as the juvenile who have been trained by a physician or other health care provider to probe body cavities (without the use of instruments) so as to cause neither injury to tissue nor infection.

In the case of sexual assault, health care professionals may gather evidence for forensic purposes with the consent of the juvenile/victim. Similarly, court-ordered laboratory tests or radiology procedures may be performed by the facility's health personnel with the consent of the juvenile.

APPENDIX A
SAMPLE POLICIES AND PROCEDURES

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DEVELOPMENT OF A MANUAL OF POLICIES AND PROCEDURES'

All organizations have policies and procedures. Such policies and procedures may not be in writing; they may not even be called by those names. They may be referred to simply as "routines" or "the way we always do things." Whatever form they take, policies and procedures are important guides to decision-making and efficient management. Standardized and consistently interpreted policies and procedures provide the staff with a clear sense of the organization's directions and provide management with a means of control. When decisions are not in accord with written policies, the decisions can be examined and brought into line with policy. If current practices turn out to be inappropriate, or different practices make more administrative sense, policies can be changed in accordance with the management's objectives. To be most effective, policies and procedures should be formally established and in written form.

Definition of Terms

A *policy* is a general statement of the goals of the organization in a specific topic area, and is a guideline for specifying and regulating operations designed to accomplish organizational objectives. It answers the question of why a certain action is favored.

A *procedure* is a specification of how a policy is to be carried out. It usually describes who will do what, when and how.

Content Issues

In the final analysis, the most important issue involved in the development of policies and procedures is the content thereof. There are certain criteria that prescribe the nature of the content of policies and procedures. For example, written procedures should clearly specify the actions required of employees. The specific questions to be answered by a procedure statement are: Who does what? When? How?

There are other questions that can be asked to test how well a policy or procedure is written. For example:

- Does the procedure address policy objectives?
- Is the procedure realistic?
- Is the procedure adequate?
- Are all relevant contractual arrangements and requirements covered?
- Are other policies and procedures compatible with this one?
- Are procedural steps in the best order?
- Is the sequence of procedural steps unnecessarily rigid?
- Can any procedural step(s) be eliminated?

⁴This section was adapted from a publication entitled The Development of Policy and Procedure Manuals for Correctional Health Care Programs (Michigan Department of Corrections, 1979).

- Does the procedure avoid bottlenecks?
- Are the procedural steps designed to operate at the lowest level of authority?
- What is the effect of proposed changes on other policies and procedures?
- Will the procedure work on all shifts?

Two other questions should be asked once the manual is complete:

- What arrangements are needed to keep manuals current?
- Who should receive copy of the manual, and how should these people be trained in its use?

Form

Clarity of the content of the policy or procedure is far more important than either its form or its format. Nevertheless, serious thought should be given to form and format, since they can contribute to clarity. The content of policies and procedures is usually typed onto official forms. Consideration should be given to providing space on the forms for the following items:

- The title of policy or procedure
- The date it goes into effect
- The date of revision
- The page number out of how many pages (e.g., page 1 of 4)
- The application: for example, when there are institutional differences in policies or procedures, this space shows the institution(s) to which this particular policy or procedure applies.
- The number of the policy or procedure
- The number of the policy or procedure it supersedes
- The signature(s) of approval and title(s) of the signer(s)
- The department, division or issuing agency and office of origin
- A reference to professional standards and state laws or administrative rules

Some of these items may appear in the body of the policy or procedure as part of the text, while others may be incorporated into the form itself. These are stylistic differences that have little consequence as long as the items are included somewhere in the written statement.

Summary

Policies and procedures need to be developed for each of the Commission's standards.

POLICY DIRECTIVE	EFFECTIVE DATE:	NUMBER:
	HEALTH SERVICES UNIT	SUPERSEDES: NO.
		DATED:
BASIC TRAINING OF CHILD CARE WORKERS		Page <u>1</u> of <u>1</u>

OBJECTIVE: To provide all child care workers with basic health training, to achieve the skills and knowledge necessary to provide first aid in emergency situations.

APPLICATION: Health Services Unit and Child Care Workers of the _____ Juvenile facility.

POLICY: Training will be provided for the child care workers in the _____ Juvenile facility to enable them to respond to health related emergency situations.

This training shall include, but not be limited to, an awareness of potential emergency situations, response to life threatening conditions, and the responsibility of early detection of illness or injury.

The first aid training course will include a certified course in CPR with periodic in-service training to maintain certification.

AUTHORITY: NCCHC Juvenile Standards
Responsible Health Authority
Juvenile Administration

REFERENCE: NCCHC Standard Y-22

APPROVED: _____ Date _____
Name, Title, Affiliation

_____ Date _____
Name, Title, Affiliation

Name of Juvenile Facility
Health Services Unit
Address
City, State Zip

PROCEDURE	EFFECTIVE DATE:	NUMBER:
	HEALTH SERVICES UNIT	SUPERSEDES: NO.
		DATED:
BASIC TRAINING OF CHILD CARE WORKERS		Page <u>1</u> of <u>3</u>

PROCEDURE:

1. A training program will be established, approved by the Health Authority and the Juvenile Administration, to provide child care workers knowledge of the following:
 - A. Types of and action required for potential emergency situations;
 - B. Signs and symptoms of an emergency;
 - C. Administration of first aid, with training to have occurred within the past three years;
 - D. Methods of obtaining emergency care;
 - E. Procedures for transferring juveniles to appropriate medical facilities or health care providers; and
 - F. Signs and symptoms of mental illness, retardation, emotional disturbance and chemical dependency.

2. The training program will be the responsibility of the senior supervisor responsible for training and personnel. It will be coordinated with the Health Administrator.

3. Training for newly hired personnel (rookie training) will be held as needed. This training includes:
 - A. Emergency medical procedures, two (2) hours;
 - B. Supervision of all juveniles, two (2) hours;
 - C. Juvenile Detention and Confinement climate, two (2) hours; and
 - D. Handling juveniles with chronic disease: epilepsy, diabetes, alcoholics, etc. two (2) hours.

4. Each child care worker will attend the correctional academy within 18 months of employment. Included in the academy classes are:
 - A. Developing communication skills and coping skills, four (4) hours;
 - B. Critical incident role playing, four (4) hours;
 - C. Medical Administration, two (2) hours;
 - D. Special classification of juveniles, two (2) hours;
 - E. Crisis intervention, eight (8) hours;
 - F. Abnormal behavior, four (4) hours;
 - G. First aid procedures, four (4) hours;
 - H. Emergency evacuation behavior, four (4) hours; and
 - I. Basics of human behavior, four (4) hours.

PROCEDURE	EFFECTIVE DATE:	NUMBER:
	HEALTH SERVICES UNIT	SUPERSEDES: NO.
		DATED:
BASIC TRAINING OF CHILD CARE WORKERS		Page. 2 of 3 .

5. Mandatory training classes will be held four (4) hours monthly including:
 - A. American Red Cross certification or equivalent:
 1. First Aid - recertification every three (3) years
 2. CPR - recertification yearly
 - B. Classes instructed by the Division of Mental Health totaling 20 hours
 1. Identification and screening of psychiatric problems
 2. Substance abuse disorders
 3. Suicide
 4. Other management problems
 5. Crisis intervention
 6. Facility procedures
 7. Interviewing and communication skills
 8. Additional training, held on a need basis, in conjunction with the mandatory training classes include review and up-dating of:
 - A. Previous training
 - B. Policies and procedures
 - C. Disaster planning
 - D. Certification in CPR and first aid for new employees
6. Child Care Workers, certified in CPR, will:
 - A. Be available to respond to any emergency situation immediately
 - B. Respond to all "man down" situations on their assigned floors:
 1. Request assistance as needed
 2. Stand by to assist Health Services personnel
7. Child Care Workers, trained in observation of signs and symptoms of life threatening situations (including psychiatric patients) will report the situations to the Health Services personnel by:
 - A. Referring juvenile to Mental Health using Form #HS-7
 - B. Referring juvenile to the medical unit by:
 1. Contacting the medical unit by phone or 2-way radio
 2. Writing a memo to be delivered to the Health Services Unit

PROCEDURE	EFFECTIVE DATE:	NUMBER:
	HEALTH SERVICES UNIT	SUPERSEDES: NO.
		DATED:
BASIC TRAINING OF CHILD CARE WORKERS		Page <u>3</u> of <u>3</u>

8. Transferring of juveniles to outside medical facilities, when the Transportation Unit is off duty, may become the responsibility of a child care worker.
- A. The Health Service Unit will notify the shift supervisor
 - B. See transportation procedure in the _____
Juvenile Policies and Procedures Manual

APPROVED: _____ Date _____
Name and Title

Name and Title Date _____

APPENDIX B
SAMPLE FORMS

Medication Administration Information - Medication Log	75
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Sick Call Slip	91

SAMPLE INITIAL HEALTH SCREENING FORM - LONG FORM

(This form is to be used when the full health appraisal is not likely to be performed within the first 48 hours of a juvenile's admission. It provides comprehensive information that may be useful to health care staff until a full health appraisal can be performed.)

Date _____

Time _____

NAME OF INSTITUTION

Juvenile's Name _____ Sex _____

Date of Birth _____ Juvenile's Number _____

Examiner's Name _____

Examiner's Observations
(where applicable, circle specific condition)

	Yes	No
1. Unconscious?	_____	_____
2. Visible signs of trauma or illness requiring immediate emergency or doctor's care?	_____	_____
Describe: _____		
3. Obvious fever, swollen lymph nodes, jaundice other evidence of infection that might spread through the facility?	_____	_____
Describe: _____		
4. Poor skin condition, vermin, rashes, or needle marks?	_____	_____
Describe: _____		
5. Under the influence of alcohol, barbiturates, or other drug(s)?	_____	_____
6. Visible signs of alcohol or drug withdrawal (extreme perspiration, pinpoint pupils, shakes, nausea, cramping, vomiting)?	_____	_____
Describe: _____		
7. Behavior suggesting risk of suicide or assault?	_____	_____
8. Carrying medication or reporting being on medication?	_____	_____
List: _____		
9. Visible Signs of Physical Deformities?	_____	_____
List: _____		

Examiner/Juvenile Questionnaire

10. Admits to the following (indicate by number and letter below):

- 1 (over one year ago)
- 2 (within past year)
- 3 (present now)

- H (hospitalized)
- M (medications, current)

- | | |
|------------------------------|---------------------------------|
| _____ allergies | _____ heart condition |
| _____ arthritis | _____ hepatitis |
| _____ asthma | _____ high blood pressure |
| _____ delirium tremens (DTs) | _____ physician-prescribed diet |
| _____ dental condition | _____ psychiatric disorder |
| _____ diabetes | _____ tuberculosis |
| _____ epilepsy | _____ ulcers |
| _____ fainting | _____ urinary tract |
| _____ venereal disease (VD) | _____ other (specify) _____ |

11. Use alcohol?

- a. How often? _____
- b. How much? _____
- c. When were you drunk last? _____
- d. When did you drink last? _____

12. Use any "street" drugs?

- a. What type(s)? _____
- b. How often? _____
- c. How much? _____
- d. When did you get high last? _____
- e. When did you take drugs last? _____

13. (For female)

- a. Are you pregnant? _____ Number of months _____
- b. Have you delivered recently? Date _____
- c. Are you on birth control pills? _____
- d. Any gynecological problems? (Specify) _____

14. Immunization history (specify dates and diseases)

Remarks (e.g., unusual behavior, special diet, type of VD, etc.)

Disposition or referral (circle appropriate response)

general population

emergency care

sick call

medical isolation

other (specify)

(A copy of this form should be included in the juvenile's medical record.)

SAMPLE INITIAL HEALTH SCREENING FORM - SHORT FORM

(This form is to be used when the full health appraisal is likely to be performed within the first 48 hours of a juvenile's admission.)

Date _____

Time: _____

NAME OF INSTITUTION

Juvenile's Name _____ Sex _____

Date of Birth _____ Juvenile's Number _____

Examiner's Name _____

Examiner's Observations
(where applicable, circle specific condition)

	<u>Yes</u>	<u>No</u>
1. Does juvenile have obvious pain or injury? Describe: _____	_____	_____
2. Is there obvious sign of infection? Describe: _____	_____	_____
3. Does juvenile appear to be under the influence of alcohol or drugs? Describe: _____	_____	_____
4. Are there visible signs of alcohol and/or drug withdrawal? Describe: _____	_____	_____
5. Does juvenile appear to be despondent?	_____	_____
6. Does juvenile appear to be irrational or crazy? Describe: _____	_____	_____
7. Is juvenile carrying medication? List: _____	_____	_____
8. Are you taking any medications?	_____	_____
9. (If female) Are you pregnant?	_____	_____
10. Is this the first time you have been detained?	_____	_____

Examiner/Juvenile Questionnaire

Yes No

11. Have you ever tried to kill yourself or done serious harm to yourself? _____

12. Do you have any serious medical or mental problems that you haven't told me about? (If yes, specify under remarks) _____

Remarks

Disposition or referral (circle appropriate response)

general population

emergency care

sick call

medical isolation

other (specify) _____

Note: Each "yes" answer requires a response. Guidelines for disposition that tell the examiner what to do or whom to call for each of the items on the form should be developed.

(A copy of this form should be included in the juvenile's medical record.)

Name & Number _____

Date: _____

Medical Confidential

Health History

HAVE YOU EVER?	YES	NO	DO YOU?	YES	NO		
Lived with anyone who had TB			Wear glasses or contact lenses				
Coughed up blood			Have vision in both eyes				
Bled excessively after injury			Wear a brace or back support				
Attempted suicide							
HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW	HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW
Asthma				Night Sweats			
Tuberculosis				Tumors, Cysts, or Growths			
Cancer or Tumor				Cramps in your Legs			
Diabetes				Rupture or Hernia			
Emphysema				Recent gain or loss of Weight			
Ear, Nose, or Throat Trouble				Frequent Indigestion			
Hearing Loss				Stomach Trouble or Ulcer			
Chronic or Frequent Colds				Hepatitis or Jaundice			
Hay Fever				Gall Bladder Trouble			
Severe Tooth or Gum Trouble				Hemorrhoids or Rectal Trouble			
Shortness of Breath				Head Injuries			
High Blood Pressure				Epilepsy or Seizures			
Pain or Pressure in Heart				Frequent or Severe Headaches			
Pounding Heart				Loss of Memory or Amnesia			
Arthritis or Bursitis				Periods of Unconsciousness			
Fractures (Broken Bones)				Paralysis, Numbness, Weakness			
Bone, Joint, or Other Deformity				Dizziness, Fainting Spells			
Painful or Trick Shoulder				Nervous Problem of Any Type			
Foot Trouble				Alcoholism			
Recurrent Back Trouble				Syphilis, Gonorrhea			
Swollen or Painful Joints				Drug Allergies			
Kidney Trouble				Lumps, Pain, Discharge on Breast			
Frequent or Painful Urination				Change in Menstrual Pattern			
Blood in Urine				Pregnancy/Abortion/Miscarriage			
Recurrent Infections				Treated for Female Disorder			
Rheumatic Fever				Thyroid Trouble			
YOUR PRESENT DOCTOR'S NAME (Address, Phone)				Have you ever been a patient or received treatment in a hospital? (surgery/injuries); state where, when, why & address			
Have you ever been treated for a mental condition? (If yes, state reason and give details)				Have you ever taken narcotics? (If yes, state what kind, when you last took it, and if you are in a treatment program)			
Highest level of education (years)				Additional Remarks: (use reverse side)			
Have you ever been incarcerated in this jail before? (if so, when?)							

Receiving Screening Form

DATE _____

TIME _____

NAME _____ SEX _____ D.O.B. _____

JUVENILE NO. _____ OFFICER OR PHYSICIAN _____

INTAKE OFFICER'S VISUAL OPINION

1. Is the juvenile conscious? YES NO
2. Does the new juvenile have obvious pain or bleeding or other symptoms suggesting need for Emergency Service? YES NO
3. Are there visible signs of trauma or illness requiring immediate Emergency or Doctor's care? YES NO
4. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection which might spread through the juvenile facility? YES NO
5. Is the skin in good condition and free of vermin? YES NO
6. Does the juvenile appear to be under the influence of alcohol? YES NO
7. Does the juvenile appear to be under the influence of barbiturates, heroin or any other drugs? YES NO
8. Are there any visible signs of Alcohol/Drug withdrawal symptoms? YES NO
9. Does the juvenile's behavior suggest the risk of suicide? YES NO
10. Does the juvenile's behavior suggest the risk of assault to staff or other juveniles? YES NO
11. Is the juvenile carrying medication or does the juvenile report being on medication which should be continuously administered or available? YES NO

(Officer-Juvenile Questionnaire on back)

OFFICER-JUVENILE QUESTIONNAIRE

- 12. Are you presently taking medication for diabetes, heart disease, seizures, arthritis, asthma, ulcers, high blood pressure, or psychiatric disorder? YES NO
- 13. Do you have a special diet prescribed by a physician? YES NO
Type _____
- 14. Do you have history of venereal disease or abnormal discharge? YES NO
- 15. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness? YES NO
- 16. Are you allergic to any medication? YES NO
- 17. Have you fainted recently or had a recent head injury? YES NO
- 18. Do you have epilepsy? YES NO
- 19. Do you have a history of tuberculosis? YES NO
- 20. Do you have diabetes? YES NO
- 21. Do you have hepatitis? YES NO
- 22. If female, are you pregnant? YES NO
- 23. Are you currently on birth control pills? Y E S N O
- 24. Have you recently delivered? YES NO
- 25. Do you have a painful dental condition? YES NO
- 26. Do you have any other medical problem we should know about? YES NO

REMARKS:

(A copy of this form is included in the patient's medical record)

Health Status

Transferring Facility:

Date: ___/___/___
Time: ___ AM PM

Name: _____	
Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Race: B W H Other
Age: _____	Date of Birth: ___/___/___ Sex: M F

Allergies: _____ Food Handler Approved: Y / N Review Date: - / / -

Current Acute Conditions/Problems: _____

Chronic Conditions/Problems: _____

Current Medications - Name, Dosage, Frequency, Duration:

Acute Short-term Medications: _____

Chronic Long-term Medications: _____

Chronic Psychotropic Medications: _____

Current Treatments: _____ Dietary Restrictions: _____

Follow-up Care Needed: _____

Chronic Clinics: _____ Specialty Referrals: _____

Significant Medical History: _____

Physical Disabilities/Limitations: _____

Assistive Devices/Prosthetics: _____ Glasses: _____ Contacts: _____

Mental Health History/Concerns: _____ Substance Abuse: Alcohol: Drugs:

- Hx Suicide Attempt: Date: ___/___/___
- Hx Psychotropic Medication
- Former MPC/Dixon STC Placement

Signature and Title	Date: ___/___/___
---------------------	-------------------

Transfer Reception Screening

Facility: _____

Date: ___/___/___
Time: ___ AM PM

P: Disposition: (Instructions: Check or circle as appropriate)

S: Current Complaint: _____

Current Medications/Treatment: _____

0: Physical Appearance/Behavior: _____

Deformities: Acute/Chronic _____

T P R B/P ___/___

A: _____

- Routine, Sick Call
Instructions Given
- Emergency Referral
- AIDS Instruction Given
- Physician Referral:
 - Urgent / Routine
 - Medication Evaluation
 - Therapeutic Diet
 - Special Housing
 - Work/Program Limitation
 - Specialty Referrals
 - Chronic Clinics
 - Other
- Infirmary Placement

Other: _____

Signature and Title

Sick Call Slip

Date _____ Time _____

Name _____

Cell _____

Complaint _____

For how long _____

TO BE FILLED OUT BY SHIFT COMMANDER

Disposition and instructions

Date _____ Time _____ Initials _____

APPENDIX C
Age Charts for Periodic Health Examination

Preamble	95
Ages 7 - 12 years	97
Ages 13-18	99
Ages 19-39	102

These sample health assessment protocols are reprinted from the 1992 volume of the *American Family Physician* with the permission of the American Academy of Family Physicians.

SAMPLE HEALTH ASSESSMENT PROTOCOLS

American Academy of Family Physicians

Age Charts for PERIODIC HEALTH EXAMINATION

510	Preamble
510A	Ages Birth-1 8 Months
510B	Ages 19 Months-6 Years
510C	Ages 7-12 Years
5iOD	Ages 13-18 Years
510E	Ages 19-39 Years
510F	Ages 40-64 Years
510G	Ages 65 Years and Older

These recommendations are provided only as an assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations.

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Preamble to Age Charts for Periodic Health Examination

Periodic health examination, including immunizations, counseling, and other preventive services, are a part of continuing, comprehensive care in family practice. The content and frequency of these health examinations should be tailored to the patient's age, sex, and risk factors. Delivery of clinical preventive services should not be limited only to visits for health maintenance but also should be provided as a part of visits for other reasons such as acute and chronic care. For many patients, these visits provide the only opportunity to receive preventive services.

The following age-specific charts for periodic health examination are recommended by the Subcommittee on Periodic Health Intervention of the Commission on Public Health and Scientific Affairs as the minimum clinical preventive services to be provided for asymptomatic patients. They are based on *the Guide to Clinical Preventive Services: Report of the US. Preventive Services Task Force*, the American College of Physicians outcomes-based recommendations on hormone replacement therapy and recommendations of the Commission on Public Health and Scientific Affairs. In making these recommendations, the subcommittee notes:

- A) That all patients new to a medical practice should be urged to receive a comprehensive history and physical as well as the screening, laboratory and diagnostic procedures, counseling, immunizations and chemoprophylaxis appropriate for the patient's age, sex, and risk. Subsequent visits may be used in completion of workup.
- B) That former health records should be obtained for review and avoidance of duplications of laboratory testing.
- C) That the charts are not exhaustive and that physicians may add other preventive services either routinely or for individual patients based on clinical judgement.
- D) That as new scientific findings become available, the subcommittee anticipates changes in the recommendations.
- E) That the subcommittee has added interventions beyond the recommendations of the U.S. Preventive Services Task Force and other explicitly developed guidelines that it feels are necessary. These are noted with footnotes on the charts and shown in italics.
- F) The date in the lower right hand corner identifies the most recent update of these charts. The date in the lower left hand corner is the most recent printing. This document is updated annually.

American Academy of Family Physicians

Periodic Health Examination *

Ages: 7-12 Years

Schedule: See Footnote'

(See Preamble)

Screening		
History	<i>Physical Examination</i> ²	Laboratory/Diagnostic Procedures
<i>Interval medical and family history</i> '	'Height and weight Blood pressure <i>Tanner staging</i> '	<u>High-Risk Groups</u> <i>Total cholesterol</i> ^{3,5} <i>Lipoprotein analysis</i> ^{4,5} Tuberculin skin test (PPD) (HR1)
<i>'An updating of the previously obtained medical and family medical history is recommended by the subcommittee.</i>	² <i>A physical examination including Tanner stage is recommended at least once in this age group by the subcommittee.</i>	<i>'Child of a parent with a blood cholesterol of 240mg/dL or higher 'Child of a parent or grandparent with a documented history of premature (age less than 55 years) cardiovascular disease 'The exact frequency is not determined. It should be performed at least once.</i>
Patient & Parent Counseling		
Diet and Exercise	Substance Use	Sexual Practices
Fat (especially saturated fat), cholesterol, sweets and between-meal snacks, sodium <i>Nutritional assessment</i> Selection of exercise program	<i>Tobacco, alcohol, and other drugs: primary prevention</i>	<i>Sex education</i>
Injury Prevention	Dental Health	Other Primary Preventive Measures
Safety belts Smoke detector Storage of firearms, drugs, toxic chemicals, matches Bicycle safety helmets	Regular tooth brushing and dental visits	<u>High-Risk Groups</u> Skin protection from ultraviolet light (HR2)
Immunizations and Chemoprophylaxis		
<i>'Update of immunization status, including measles-mumps-rubella <u>High-Risk Groups</u> ³Fluoride supplements (HR3) ⁴Influenza vaccine (HR4) ⁵Pneumococcal vaccine (HR5)</i>		

Additional Notes

Leading Causes of Death:	Motor vehicle crashes	Remain Alert For:	Vision disorders
	Injuries (nonmotor vehicle)		Diminished hearing
	Congenital anomalies		Dental decay, malalignment, mouth breathing
	Leukemia		Signs of child abuse or neglect
	Homicide		Abnormal bereavement
	Heart disease		<i>Depressive symptoms</i>

High-Risk Categories

- HR1 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); family members of migrant workers; residents of homeless shelters; or persons with certain underlying medical disorders.
- HR2 Children with increased exposure to sunlight
- HR3 Children living in areas with inadequate water fluoridation (less than 0.7 parts per million).
- HR4 Children with chronic pulmonary or cardiovascular problems including asthma; or who required medical followup or hospitalization during the past year for chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications).
- HR5 Children aged two and over with chronic illnesses specifically associated with pneumococcal disease or its complications, anatomic or functional asplenia, sickle cell disease, nephrotic syndrome or chronic renal failure, cerebrospinal fluid leaks, or conditions associated with immunosuppression (including HIV).

*This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force *and the AAFP Commission on Public Health and Scientific Affairs*. Clinicians may wish to add other preventive services on a routine basis, and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

Developmental disorders
Behavioral and learning disorders
Parent/family dysfunction

†Because of lack of data and differing patient risk profiles, the scheduling of visits and the frequency of the individual preventive services listed in this table are left to clinical discretion (*except as indicated in other footnotes*). *Additional visits should occur as risk factors are determined. Achievement of developmental or social milestones, such as entry to junior high school, may also warrant a visit. Each visit by patients in this age group should be considered an opportunity to assess and address risks.*

American Academy of Family Physicians
Periodic Health Examination *
Ages: 13-18 Years

Schedule: *At least one visit for preventive services should occur[†]*
(See Preamble)

Screening		
History	<i>Physical Examination¹</i>	Laboratory/Diagnostic Procedures
<i>Interval medical and family history¹</i> Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices	Height and weight Blood pressure Tanner staging <u>High-Risk Groups</u> Complete skin exam (HR1) Clinical testicular exam (HR2)	<u>High-Risk Groups</u> Rubella antibodies (HR3) VDRL/RPR (HR4) Chlamydial testing (HR5) Gonorrhea culture (HR6) Counseling and testing for HIV (HR7) Tuberculin skin test (PPD) (HR8) Hearing (HR9) Papanicolaou smear ³ Total cholesterol ^{4,5} Lipoprotein analysis ⁵
¹ An updating of the previously obtained medical and family medical history is recommended by the subcommittee.	² A physical examination including Tanner stage is recommended at least once in this age group by the subcommittee.	³ All women 18 years of age should have an annual Pap test and pelvic examination. All women between 13 and 18 who are or who have been sexually active , should also have an annual Pap test and pelvic examination . After a woman has had three or more consecutive satisfactory normal annual examinations , the Pap test may be performed at the discretion of the physician based on the assessment of patient risk but not less frequently than every three years. ⁴ Child of a parent with a blood cholesterol of 240mg/dL or higher ⁵ Child of a parent or grandparent with a documented history of premature (age less than 55 years) cardiovascular disease

Counseling		
Diet and Exercise	Substance Use	Sexual Practices
Fat (especially saturated fat), cholesterol, sodium, iron ⁶ , calcium ⁵ <i>Nutritional assessment</i> Selection of exercise program	Tobacco: cessation/primary prevention Alcohol and other drugs: cessation/primary prevention Driving/other dangerous activities while under the influence Treatment for abuse <u>High-Risk Groups</u> Sharing/using unsterilized needles & syringes (HR11)	Sexual development and behavior Sexually transmitted diseases: partner selection, condoms Unintended pregnancy and contraceptive options
‘For females		‘Often best performed early in adolescence and with the involvement of parents
Injury Prevention	Dental Health	Other Primary Preventive Measures
Safety belts Safety helmets Violent behavior Firearms* Smoke detector <i>Noise induced hearing loss</i> ⁹	Regular tooth brushing, flossing, dental visits	<i>Breast self-examination</i> ¹⁰ <i>Testicular self-examination</i> ¹¹ <u>High-Risk Groups</u> Discussion of hemoglobin testing (HR12) Skin protection from ultraviolet light (HR13)
‘Especially for males ‘Education regarding hearing loss from recreational and personal listening devices is recommended by the subcommittee.		¹⁰ The teaching of self-breast examination is recommended by the subcommittee at the time of initiation of pelvic examinations. ¹¹ The teaching of self-testicular examination is recommended by the subcommittee for male patients.
Immunizations and Chemoprophylaxis		
Tetanus-diphtheria (Td) booster” <u>High-Risk Groups</u> <i>Measles-mumps-rubella (MMR) vaccine</i> ¹³ Fluoride supplements (HR14) <i>Influenza vaccine</i> (HR15) <i>Pneumococcal vaccine</i> (HR16) <i>Hepatitis B vaccine</i> (HR17)		
¹² Once between ages 14 and 16 ¹³ A second measles immunization, preferably as MMR (Measles, Mumps, and Rubella Vaccine, Live), is recommended by the subcommittee for all patients unable to show proof of immunity who are entering post secondary school education and for those becoming employed in medical occupations with direct patient care.		

Additional Notes

Leading Causes of Death:	Motor vehicle crashes Homicide Suicide Injuries (nonmotor vehicle) Heart disease	Remain Alert For:	Depressive symptoms Suicide risk factors (HR10) Abnormal bereavement Tooth decay, malalignment, gingivitis Signs of child abuse and neglect
--------------------------	--	-------------------	---

(High-Risk Categories listed on following pages.)

High-Risk Categories

- HR1 Persons with increased recreational or occupational exposure to sunlight, a family or personal history of skin cancer, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).
- HR2 Males with a history of cryptorchidism, orchiopexy, or testicular atrophy.
- HR3 Females of childbearing age lacking evidence of immunity
- HR4 Persons who engage in sex with multiple partners in areas in which syphilis is prevalent, prostitutes, or contacts of person with active syphilis.
- HR5 Persons who attend clinics for sexually transmitted diseases; attend other high-risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).
- HR6 Persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea or persons with a history of repeated episodes of gonorrhea.
- HR7 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV-infected, bisexual or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985.
- HR8 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.
- HR9 Persons exposed regularly to excessive noise in recreational or other settings.
- HR10 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement
- HR11 Intravenous drug users.
- HR12 Persons of Caribbean, Latin America, Asian, Mediterranean or African descent.
- HR13 Persons with increased exposure to sunlight
- HR14 Persons living in areas with inadequate water fluoridation (less than 0.7 parts per million).
- HR15 Children with chronic pulmonary or cardiovascular problems including asthma; or who required medical followup or hospitalization during the past year for chronic metabolic disease (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications).
- HR16 Children aged two and over with chronic illnesses specifically associated with pneumococcal disease or its complications, anatomic or functional asplenia, sickle cell disease, nephrotic syndrome or chronic renal failure, cerebrospinal fluid leaks, or conditions associated with immunosuppression (including HIV).
- HR17 Homosexually and bisexually active men, intravenous drug users, recipients of some blood products, persons in health-related jobs with frequent exposure to blood or blood products, household and sexual contacts of HBV carriers, sexually active heterosexual persons with multiple sexual partners diagnosed as having recently acquired sexually transmitted disease, prostitutes, and persons who have a history of sexual activity with multiple partners in the previous six months.

†This list of preventive services is not exhaustive. It reflects only those topics reviewed by the U.S. Preventive Services Task Force and the AAFP Commission on Public Health and Scientific Affairs. Clinicians may wish to add other preventive services on a routine basis and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

Developmental disorders
Behavioral and learning disorders
Parent/family dysfunction

‡Additional visits should occur as other risk factors are determined such as initiation of sexual activity, experimentation with alcohol or other drugs, or licensure for operating a motor vehicle. Achievement of developmental milestones such as entry to high school may also warrant a visit. Each visit by patients in this age group should be considered on opportunity to assess and address risks.

American Academy of Family Physicians

Periodic Health Examination *

Ages: 19-39 Years

Schedule: Every 1-3 Years[†]

(See Preamble)

Screening		
History	Physical Examination	Laboratory/Diagnostic Procedures
<p><i>Interval medical and family history</i>¹ Dietary intake Physical activity Tobacco/alcohol/drug use Sexual practices</p>	<p>Height and weight Blood pressure² <i>Pelvic examination (for women)</i> <i>Clinical breast exam (for women)</i>³ <i>Clinical testicular exam (for men)</i> (HR4) <u>High-Risk Groups</u> Complete oral cavity exam (HR1) Palpation for thyroid nodules (HR2) Complete skin exam (HR5)</p>	<p>Nonfasting <i>or</i> fasting total blood cholesterol⁴ Papanicolaou smear⁵ <u>High-Risk Groups</u> Fasting plasma glucose (HR6) Rubella antibodies (HR7) VDRL/RPR (HR8) Urinalysis for bacteriuria⁶ (HR9) Chlamydial testing (HR10) Gonorrhea culture (HR11) Counseling and testing for HIV (HR12) Hearing (HR13) Tuberculin skin test (PPD) (HR14) Electrocardiogram (HR15) Mammogram (HR3) Colonoscopy (HR16)</p>
<p>¹<i>An updating of the previously obtained medical and family medical history is recommended by the subcommittee.</i></p>	<p>²<i>At every physician visit, with a minimum of every two years</i> ³<i>Every 1-3 years, starting at age 30 until age 40</i></p>	<p>⁴<i>At least every five years</i> ⁵<i>All women 18 years of age and over should have an annual Pap test and pelvic examination. After a woman has had three or more consecutive satisfactory normal annual examinations, the Pap test may be performed at the discretion of the physician based on the assessment of patient risk but not less frequently than every three years*.</i> ⁶<i>The optimal frequency for urine testing has not been determined. In general, dipsticks combining the leukocyte esterase and nitrite tests should be used to detect asymptomatic bacteriuria.</i></p>

Counseling		
Diet and Exercise	Substance Use	Sexual Practices
Fat (especially saturated fat), cholesterol, complex carbohydrates, fiber, sodium, iron, calcium <i>Nutritional assessment</i> Selection of exercise program	Tobacco: cessation/primary prevention Alcohol and other drugs: Limiting alcohol consumption Driving/other dangerous activities while under the influence Treatment for abuse <u>High-Risk Groups</u>	Sexually transmitted diseases: partner selection, condoms, anal intercourse Unintended pregnancy and contraceptive options <i>for men and women</i>
*For women	Sharing/using unsterilized needles & syringes (HR18)	
Injury Prevention	Dental Health	Other Primary Preventive Measures
Safety belts Safety helmets Violent behavior ³ Firearms ⁸ Smoke detector Smoking near bedding or upholstery <u>High-Risk Groups</u> Back-conditioning exercises (HR19) Prevention of childhood injuries (HR20) Falls in the elderly (HR21)	Regular tooth brushing, flossing, dental visits	<i>Breast self-examination</i> ⁹ <i>Testicular self-examination</i> ¹⁰ <u>High-Risk Groups</u> Discussion of hemoglobin testing (HR22) Skin Protection from ultraviolet light (HR23)
Especially for young males		<i>⁹The teaching of self-breast examination is recommended by the subcommittee at the time of initiation of pelvic examinations. ¹⁰The teaching of self-testicular examination is recommended by the subcommittee for male patients.</i>
Immunizations and Chemoprophylaxis		
Tetanus-diphtheria (Td) booster ¹¹ <u>High-Risk Groups</u> hepatitis B vaccine (HR24) pneumococcal vaccine (HR25) influenza vaccine* (HR26) measles-mumps-rubella vaccine (MMR)(HR27)		
*Every 10 years ¹¹ Annually		

Additional Notes

Leading Causes of Death:	Motor vehicle crashes Homicide Suicide Injuries (nonmotor vehicle) Heart disease <i>HIV infection (males)</i> ¹³	Remain Alert for:	Depressive symptoms Suicide risk factors (HR17) Abnormal bereavement Malignant skin lesions Tooth decay, gingivitis Signs of physical abuse
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¹³*HIV infection as leading cause of death among young adults in U.S. cities and states. JAMA 1993;269:2991-2994.*

(High-Risk Categories listed on following page.)

- HR1 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious Symptoms or lesions detected through self-examination.
- HR2 Persons with a history of upper-body irradiation.
- HR3 Women aged 35 and older with a family history of premenopausally diagnosed breast cancer in a first-degree relative.
- HR4 Men with a history of cryptorchidism, orchiopexy, or testicular atrophy.
- HR5 Persons with a family Or personal history Of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).
- HR6 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.
- HR7 Women lacking evidence of immunity.
- HRS Prostitutes, persons who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts of persons with active syphilis.
- HR9 Persons with diabetes.
- HR10 Persons who attend clinics for sexually transmitted diseases; attend other high-risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts, age less than 20).
- HRI I Prostitutes, persons with multiple sexual partners or a sexual partner with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea
- HR12 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV-infected, bisexual, or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history of transfusion between 1978 and 1985
- HR13 Persons exposed regularly to excessive noise.
- HR14 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common; migrant workers, residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).
- HR15 Men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots).
- HR16 Persons with a family history of familial polyposis coli or cancer family syndrome.
- HR17 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illnesses, living alone, or recent bereavement.
- HR18 Intravenous drug users.
- HR19 Persons at increased risk for low back injury because of past history, body configuration, or type of activities.
- HR20 Persons with children in the home or automobile.
- HR21 Persons with older adults in the home.
- HP.22 Young adults of Caribbean, Latin America, Asian, Mediterranean, or African descent
- HR23 Persons with increased exposure to sunlight
- HR24 Homosexually and *bisexually* active men, intravenous drug users, recipients of some blood products, persons in health-related jobs with frequent exposure to blood or blood products, household and sexual contacts of HBV carriers, sexually active heterosexual persons with multiple sexual partners diagnosed as having recently acquired sexually transmitted disease, prostitutes, and persons who have a history of sexual activity with multiple partners in the previous six months.
- HR25 Persons with medical conditions that increase the risk of pneumococcal infection (e.g., chronic cardiac or pulmonary disease, sickle cell disease, nephrotic syndrome, Hodgkin's disease, asplenia, diabetes mellitus, alcoholism, cirrhosis, multiple myeloma, renal disease or conditions associated with immunosuppression).
- HR26 Residents of chronic care facilities or persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction.
- HR27 Persons born after 1956 who lack evidence of immunity to measles (receipt of live vaccine on or after first birthday, laboratory evidence of immunity, or a history of physician-diagnosed measles).

*This list of preventive services is *not exhaustive*. It reflects only those topics reviewed by the U.S. Preventive Services Task Force and the AAFP Commission on Public Health and Scientific Affairs. Clinicians may wish to add other preventive services on a routine basis and after considering the patient's medical history and other individual circumstances. Examples of target conditions not specifically examined by the Task Force include:

Chronic obstructive pulmonary disease	Travel-related illness
Hepatobiliary disease	Prescription drug abuse
Bladder cancer	Occupational illness and injuries
Endometrial disease	

†The recommended schedule applies only to the periodic visit itself. The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

APPENDIX D

SUICIDE PREVENTION GUIDELINES

Suicide Assessment and Prevention Guidelines	107
Sample Mental Status Assessment Sheet	109
Sample Suicide Precaution Protocols	111

SUICIDE ASSESSMENT AND PREVENTION GUIDELINES

The initial health screening form (see samples, Appendix B) should contain some items regarding potential suicide risk. When it is suspected that a youth is suicidal, s/he should be referred to a mental health professional to determine the degree of suicide risk and the supervision level required. Degree of risk can be assessed using a form such as the sample included here. Also included are two sample protocols for supervising juveniles placed on various precaution levels.

SAMPLE MENTAL STATUS ASSESSMENT SHEET

Date _____

Institution _____

Juvenile's Name _____

Examiner _____

	<u>Y e s</u>	<u>No</u>
1. Depressed mood	_____	_____
2. Suicidal ideation or behavior	_____	_____
3. Agitation	_____	_____
4. Paranoia	_____	_____
5. Loose associations	_____	_____
6. Hallucinations	_____	_____
7. Delusions	_____	_____
8. Bizarre thoughts or behavior	_____	_____
9. Emotional or social withdrawal	_____	_____
10. Violent behavior or threats	_____	_____
11. Other	_____	_____

Specify _____

Descriptions and additional remarks:

SAMPLE SUICIDE PRECAUTION PROTOCOLS

If any staff suspects that a youth is depressed and/or suicidal, the medical department should be notified. The physician and/or on-call psychiatrist should then be consulted. Any of the following levels of precaution may be recommended:

LEVEL 1

In most circumstances, this level will pertain to juveniles who have actually recently attempted suicide. The on-call psychiatrist will have been notified. Efforts will be in progress to have the youth committed to a mental health facility.

The youth should be in a “safe room” or in the health clinic. Health staff should provide one to one constant attention while the youth is awake, with visual checks every five to ten minutes while the youth is asleep in a safe environment (described in Level 2). Toileting and bathing may or may not be visually supervised, depending on juvenile’s mood at the time; if visually unsupervised, staff should be standing close by with the door slightly ajar.

LEVEL 2

This level will pertain to youth who are considered at high risk for suicide. The on-call psychiatrist will have been consulted. Efforts will probably be made to have the youth committed to a mental health facility.

The juvenile should be either in a “safe room” or in the health clinic. Safety precautions should be observed. These should include searches of room and clothes for removal of all potentially harmful objects such as glass, pins, pencils, pens, and matches. Plastic bags should be removed. The room should be near the staff office, with no access to breakable glass and no electrical outlets (or outlets that can and should be turned off.) There be no bed in the room if possible, and no pipes from which sheets could be hung. There may be a mattress and pillow on the floor. The juvenile may have clothes (no belts), linen, and blankets. If the youth verbalizes or demonstrates immediate intent to harm himself/herself, bedding should be removed and the health staff notified. The youth should be checked at least every five minutes while awake and every ten minutes while asleep. He/she should have one to one attention when out of room, if potentially harmful objects (pencils, T.V., etc.) are brought into room, or if he/she seems unusually distraught. Toileting and bathing: same as for Level 1.

LEVEL 3

This level will pertain to juveniles whom the physician or on-call psychiatrist feel are at moderate risk for suicide. They may be youths who have previously been on Level 1 or 2 and whose mental status is improving.

Safety precautions should be taken. These should include searches of room and clothes for removal of obviously potentially harmful objects, such as broken glass, pins, and matches. Plastic bags should not be permitted. Bed and linen may be allowed in room.

The youth may have writing materials (and television in the health clinic) at staff discretion, but these should be removed when not in use. Toileting and bathing may be done in the as in the normal routine. The youth should be checked visually at least every ten minutes while awake, every one-half hour while asleep.

LEVEL 4

This level will most often pertain to children who are at risk for becoming severely depressed/suicidal. This assumption may be based on past history.

The youth may be dealt with as in the normal unit routine; however staff should observe the youth for symptoms of depression and signs of suicidal ideation, and should notify health staff if new signs or symptoms occur. The youth should be checked visually at least every half hour while awake and asleep.

The mental status of any given juvenile may vary greatly from day-to-day and sometimes from hour to hour; therefore, it is imperative that staff have good observational skills and knowledge of signs and symptoms to look for. If any staff member has reason to feel that a youth who is already on a precaution level should be moved to a higher level of precaution, the medical department should be notified, and the physician and/or psychiatrist again consulted.

APPENDIX E
NUTRITION GUIDELINES

Food Guide Pyramid	115
General Food Service Guidelines	116
Menu Patterns for Adolescents	116

THE FOOD GUIDE PYRAMID

The Pyramid is an outline of what to eat each day. It's a general guide that lets you choose a healthful diet that's right for you.



NATIONAL CENTER FOR NUTRITION AND DIETETICS OF THE AMERICAN DIETETIC ASSOCIATION AND ITS FOUNDATION



FATS, OILS, SWEETS

USE SPARINGLY

MILK, YOGURT, CHEESE

2-3 SERVINGS DAILY

MEAT, POULTRY, FISH, DRY BEANS, EGGS, NUTS

2-3 SERVINGS DAILY

VEGETABLES

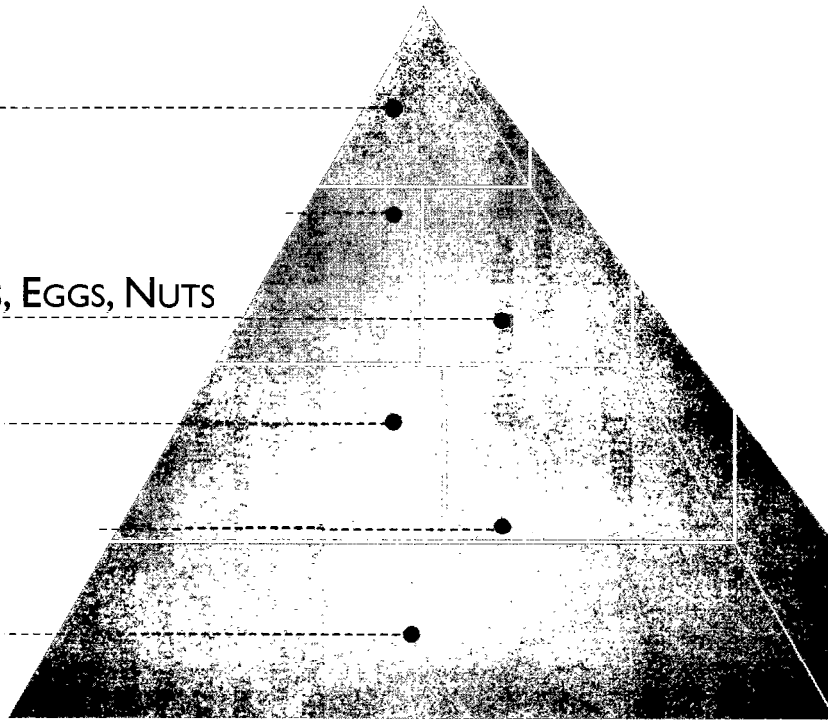
3-5 SERVINGS DAILY

FRUIT

2-4 SERVINGS DAILY

BREAD, CEREAL, RICE, PASTA

6-11 SERVINGS DAILY



The small tip of the Pyramid represents fats, oils and sweets. This group includes salad dressings, oils, butter, margarine, cream, soft drinks, candy and sweet desserts. These foods provide calories and little else nutritionally.

These two groups of foods come mostly from animals. They are important sources of protein, calcium, iron and zinc.

This level includes foods from plants. Most people need to eat more fruits and vegetables for the vitamins, minerals and fiber they supply.

At the base of the Pyramid are foods from grains. These foods supply fiber, carbohydrates, vitamins and minerals.

GENERAL FOOD SERVICE GUIDELINES

The nutritional requirements of teenagers vary according to age, sex, activity, and level of maturation. The amounts and types of food suggested below will satisfy the needs of most teenagers. However, those who are still growing or are very active will require increased portion sizes, primarily of grain and milk products, as well as fruits and vegetables. Meats add unnecessary protein and fat so should not be counted on alone to provide the additional nourishment. Foods that are rich in fat and sugar contribute energy (calories) with little other nutritional value and in excess are detrimental to health of all individuals. They should be limited especially for individuals of adequate or above average weight. For more specific suggestions for planning menus for adolescents see next page.

MENU PATTERNS FOR ADOLESCENTS

Teenagers have a wide range of energy needs, from 1,500 to 4,000 calories. Those who are still growing, very active, or male need the most. Females, those who have finished growing or who are not active need less. Pattern A is designed for those in the lower range and Pattern B for those in the higher range. (Approximately 2,100 and 3,400 calorie levels were used because they are midpoints in the lower and upper halves of the range.) The most suitable Pattern for an individual will be the one which allows that teenager to maintain an appropriate weight for height. Using the suggested types of foods will insure that the diet has a balance of nutrients as well as energy.

PATTERN A

(Calories are approximate and will vary with
serving size and preparation)

<u>Breakfast</u>	(calories)	<u>Lunch</u>	(calories)	<u>Dinner</u>	(calories)
Fruit (citrus) 1	(40)	Fruit 1	(40)	Milk 1	(120)
Milk 1	(120)	Milk 1	(120)	Protein 2 oz.	(200)
Cereal 1	(100)	Protein 2 oz.	(200)	Carbohydrate 1	(70)
Bread	(70)	Bread 2	(140)	Bread 2	(140)
Butter and Jam	(45 + 20)	Vegetable	(25)	Vegetable	(25)
		Butter (fat)	(45)	Dressing 1 Tb.	(135)
				Butter	(45)
				Dessert	(100)
				Snack Protein	(100)
				Snack Carbo 1	(115)

PATTERN B

Breakfast

	(calories)
Fruit (citrus) 1	(40)
Milk 2	(240)
Cereal 2	(200)
Bread 2	(140)
Butter and Jam	(90 +40)

Lunch

	(calories)
Fruit 1	(40)
Milk 1	(120)
Protein 4 oz.	(400)
Bread 3	(210)
Vegetable 1	(25)

Dinner

	(calories)
Milk 1	(120)
Protein 2 oz.	(200)
Carbohydrate 2	(140)
Bread 2	(140)
Vegetable 2	(50)
Butter (fat)	(45)
Dressing 2 Tb.	(270)
Butter	(45)
Dessert 2	(200)
Snack Protein	(100)
Snack Carbo 2	(230)

SAMPLE MEAL - PATTERN A [for PATTERN B increase to amounts in parentheses]

Breakfast

1/2 c. juice, or 1 fruit
1 c. milk
1 c. cold cereal (2 c.)
1 slice toast (2)
Butter and jam (2)

Lunch

Sandwich (ww brd.) (2)
with cheese/cold cuts
1/2 c. corn, etc. (1 c.)
Apple
Milk 1 c.

Dinner

1 c. milk (2 c.)
2 oz. beef (4 oz.)
1 potato (2)
Salad
Dressing 1 tb.
Ww roll (2)
Butter
2 cookies (4)
Snacks - cheese
Wedges, 1 oz.
Peanut butter
Crackers

Nutritionally adequate diets are derived from foods in the food guide pyramid with minimum amounts provided as follows:

Every teenager should have at least:

2-3 Servings from the Milk Group*

1 serving = 1 c. milk or yogurt or
2 c. cottage cheese or
1 1/2 oz. cheese or
1 c. pudding or
1 3/4 c. ice cream

*These products should ideally be low fat.

2-3 servings from the Meat Group

1 serving = 2 oz. cooked lean meat, fish, or poultry or
2 eggs **or**
2 slices of cheese or
1/2 c. cottage cheese or
1 c. dried beans or peas or
4 Tb. peanut butter

3-5 servings from the Vegetable Group and 2-4 servings from the Fruit Group

1 serving = 1/2 c. cooked vegetable or
1/2 c. vegetable juice or
1 c. raw vegetable or
1 c. raw fruit or
1 medium size fruit, i.e., apple, banana, etc.
Dark green vegetables and fruit 3-4 times weekly for Vitamin A.
Citrus fruit daily for Vitamin C.

6-1 1 servings from the Grain Group

1 serving = 1 slice bread
1 c. ready-to-eat cereal
1/2 c. cooked cereal
1/2 c. pasta
1/2 c. grits
Preferably, these should be whole grains.

APPENDIX F

POSITION STATEMENTS

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Women’s Health Care in Correctional Settings 129

PREAMBLE

Position Statements of the National Commission on Correctional Health Care

Occasionally an issue arises that has not been addressed by the National Commission's Standards or has changed since the Standards were last revised. Accordingly, NCCHC has adopted the following position statements that, along with the published standards, may assist juvenile facilities in designing their own procedures on these matters.

Please note that the position statements have been approved by the National Commission's Board of Directors, but do not necessarily reflect the position of the supporting organizations who named those individuals to the Board.

National Commission on Correctional Health Care

Position Statement

Administrative Management of HIV in Corrections

Introduction

Please note that the Commission's policies do not address the medical management of HIV-positive inmates or correctional staff, since this information is available from other national agencies such as the Centers for Disease Control (CDC) in Atlanta. The Commission's Board of Directors believes that the medical management of HIV-positive inmates and HCWs should parallel that offered to individuals in the non-correctional community.

I. HIV Testing for the Incarcerated

- A. Testing for HIV is valid as a diagnostic tool. With advances in the diagnosis and treatment of HIV, it is important that those who are seropositive be identified early. Accordingly, voluntary testing for the purpose of initiating treatment should be available to persons who request it. Anyone with clinical indication of HIV disease and anyone who has engaged in high-risk behaviors should be encouraged to test for HIV. While recent research has demonstrated that early treatment can delay the progression of the disease, it is not clear that large scale screening is efficacious.
- B. New research has indicated that pregnant women who are infected with HIV are less likely to transmit the virus to their newborn if they are treated with AZT during their pregnancy. In consideration of this new evidence it makes sense to educate women about this new finding and encourage them to be tested for HIV if they are pregnant.

II. Special Housing

- A. The Commission opposes segregated housing for HIV-positive inmates who have no symptoms of the disease. Since HIV is not airborne and is not spread by casual contact, HIV-positive inmates should be maintained in the general population in whatever housing is appropriate for their age, custody class, etc. However, people with AIDS may require medical isolation for their well-being as determined by the treating physician.

III. Special Precautions

- A. The NCCHC supports and recommends strict compliance with the Centers for Disease Control (CDC) statement on Universal Precautions in all settings within corrections:

“All HCWs should adhere to universal precautions, including the appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments. HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment and devices used in performing invasive procedures until the condition resolves.

and devices used in performing invasive procedures until the condition resolves. HCWs should also comply with current guidelines for disinfection and sterilization of reusable devices used in invasive procedures.” (Centers for Disease Control, Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure Prone Invasive Procedures, 1991)

- B. Except under unusual circumstances (e.g., the inmate is violent), correctional staff need not take special precautions in managing HIV-positive inmates. Masks, gowns, and/or gloves are not required in performing routine duties such as feeding, escorting, or transporting HIV-positive inmates.
- C. Medical staff need not take special precautions in performing routine, non-invasive procedures on HIV-positive inmates such as interviews or examinations. However, for any invasive procedure (e.g., blood drawing, intravenous placement, draining of abscesses, suturing, excisions, biopsies, dental work), all inmates should be considered potentially HIV-positive and all staff should take precautions as recommended by the CDC. The CDC’s recommendations also should be followed in the medical management of inmates with AIDS.

IV. Education/Counseling

- A. HIV/AIDS education should be provided to all staff and inmates in jails, prisons, and juvenile confinement facilities. This education should include information on modes of transmission, prevention, treatment, and disease progression. Educational programs should include culturally sensitive and scientifically accurate health information that provides clear and easily understandable explanations of practices that reduce the risk of becoming infected or transmitting HIV. It is highly recommended that information on the psychosocial implications of HIV infection as well as resources available to the infected person be included as well. When developing programs for juveniles, the recommendations of the CDC’s publication entitled: “Guidelines for Effective School Health Education to Prevent The Spread of AIDS,” Centers For Disease Control, MMWR Supplement, January 29, 1988, Vol. 37, No. S-2 or a subsequent revision may be used as a guide. Also, NCCHC recommends involvement of the target population in the development and provision of educational programs to encourage acceptance of the material. Staff should also receive training on confidentiality as it applies to HIV disease.
- B. All HIV-positive inmates and those with AIDS should receive counseling to help them adjust to their condition and to alert them to behavioral changes that may be required to prevent future contagion of others. Additionally, such inmates should be encouraged to voluntarily contact sexual or drug use partners and advise them of their condition.

V. Prevention

- A. Massive educational efforts should be undertaken to inform all inmates and all staff (correctional and medical) about HIV disease and the steps to be taken to prevent its spread. Further, while the Commission clearly does not condone illegal activity by

inmates, the terminal absoluteness of this disease, coupled with the potential for catastrophic epidemic, require (consistent with security) the unorthodox conduct of making available to inmates whatever appropriate protective devices can reduce the risk of contagion.

VI. Confidentiality

- A. Recognizing that being labeled as HIV-positive may put an inmate in a correctional institution at undue risk for compromised personal safety, it is particularly important that the rules of physician/patient confidentiality regarding HIV test results and diagnoses of AIDS be followed. Further, since the legal status regarding the confidentiality of such information varies from state to state and from time to time, the facility should keep informed of any changes enacted by legislatures or determined by the courts.

VII. Special Correctional Programs

- A. HIV-positive inmates and those with AIDS who otherwise meet eligibility criteria for special correctional programs (e.g., parole, medical reprieve) should be given the same consideration as are other inmates.

VIII. The HIV-Positive Correctional Health Care Worker

- A. Mandatory testing of correctional HCWs for HIV infection is not recommended.
- B. Correctional HCWs who are HIV-positive have a right to continue their career in the health care field in a capacity that does not pose an identifiable risk of HIV infection to their patients. HCWs who are HIV-positive should not be required to disclose their HIV status if their work does not include involvement in invasive procedures as defined by the CDC.
- C. HCWs who are involved in the performance of invasive procedures should disclose their seropositive status to the appropriate institutional medical and administrative authorities in his/her facility. Decisions on HCWs ability to perform specific procedures should be decided on an individual, case by case, basis.

IX. HIV Infection and Tuberculosis

- A. Given the increasing incidence of tuberculosis in the country in general, and noting the particular growth in drug resistant tuberculosis in particular, please note that a high prevalence of tuberculosis in the general population may require a variation from this position statement. Especially note that large numbers of HIV-infected inmates or health care workers who are particularly susceptible to tuberculosis may require a different position to protect these persons from the danger of infection.

Adopted by the National Commission on Correctional Health Care
Board of Directors - November 8, 1987.
Last amended September 25, 1994.

National Commission on Correctional Health Care

Position Statement

Correctional Health Care and the Prevention of Violence

In the last ten years, interpersonal violence (i.e., homicide, rape, robbery, aggravated assault, abuse and neglect of young and old people) has grown to epidemic proportions. In 1990, there were more than 23,200 homicides in America. In comparison to other industrialized countries, the United States 1990 murder rate was 11 times that of Japan, nearly 9 times that of England, over 4 times that of Italy, and 9 times that of Egypt and Greece. Our nation's youth and young adults, particularly among minority groups, are frequently involved in acts of interpersonal violence. During the 1980s alone, over 48,000 people were murdered by youth and young adults in the 12 to 24 year age range. Homicide is now the second leading cause of death among 15 to 24 year olds and the leading cause of death among 15 to 34 year old black American males. It's also been demonstrated that the effects of violence on youth increase the odds of their future delinquency and adult criminality overall by 40 percent. Victims of violence, in other words, are likely to become victimizers in future years.

As violence grows in America, a number of different agencies are responding in a number of different ways. The justice system's long range plans address reducing violent crime, improving the effectiveness of law enforcement agencies to combat violence, providing assistance to victims, and crime prevention programs. The medical and mental health professions have joined with the Centers for Disease Control and Prevention (CDC) in an initiative intended to treat violence as a major public health problem. Such an approach has an objective of preventing violence through surveillance, epidemiological analysis, and the evaluation of various intervention techniques. An important emphasis of this initiative has been to involve the health care community in the identification of victims of abuse and violence.

Very little emphasis has yet to be placed upon the use of intervention techniques that teach individuals alternatives to violence as a behavioral response. This would appear to be a particularly appropriate technique for use within correctional facilities where increasing numbers are now being incarcerated for violent crimes. This further suggests an important role for correctional health programs that might begin to address violent behavior within the correctional environment as a public health problem. Perhaps an equally important role for correctional health programs is the identification and treatment of the incarcerated who have lived with violence in their lives. Some experts believe that certain kinds of violent behaviors can be effectively treated enabling people to better cope with violence in their lives. Since most of those who are incarcerated eventually return to their communities, these kinds of intervention and treatment techniques might have a positive effect on reducing violence in the community.

Violence can be characterized in several ways. For example, Jenkins and Bell characterizes *expressive* violence as that which grows out of some kind of interpersonal altercation in which one person intends harm on another. Persons involved in expressive

violence typically know each other, are similar in age, and frequently share the same race and ethnic background.

Instrumental violence, in contrast, is usually premeditated and motive-driven (e.g., acquire property or economic gain). Typically, parties involved do not know one another and the harm caused is secondary to the motive.

Finally, *gang-related* violence results from gang membership and related membership activities involving retaliation or revenge. These distinctions imply that different intervention strategies may be required to effectively prevent the various kinds of violent behavior. Further, experts believe that expressive violence may be appropriately treated through public health intervention techniques, as opposed to socio-economic interventions for instrumental violence and political interventions for gang violence. All three kinds of violent behaviors are prevalent in society and, too, in correctional facility populations.

Correctional health programs are an important public health resource in the identification, care, and treatment of individuals who have been involved in violent acts. The National Commission heartily endorses the CDC's position that violence is a public health problem and calls upon correctional health programs to join with the CDC, and other professional groups, in addressing violence within the incarcerated population. It is the National Commission's position that standards for correctional health services should be used as the basis for correctional health services violence prevention, treatment, and education in these settings. Specifically, correctional health services should:

1. Incorporate violence risk assessment -- including child and domestic abuse, sexual abuse, and any personal victimization -- into receiving screening undertaken of all inmates upon intake, all inmate health assessments, and mental health evaluations.
2. Refer as appropriate all inmates with violent histories (i.e. those with *expressive violence*), including those who exhibit violent behaviors that place the safety and welfare of themselves or others in jeopardy, to treatment by appropriately trained health care providers. Treatment should not consist of only placing the inmate on medication, but should take a balanced biopsychosocial approach to the treatment of inmate violence.
3. Protocols and guidelines for violence prevention, intervention, and follow-up should be developed for use by qualified health professionals treating inmates. In addition, health care providers should receive training in these areas. Training should include information on policies and practices designed to prevent violence, non-physical methods for preventing and/or controlling disruptive behaviors, appropriate use of medical restraints, and effective techniques for personal safety.
4. Correctional officer training should include prevention of expressive violence and non-physical methods for prevention and/or controlling disruptive behaviors stemming from expressive violence. Correctional officer training should continue to address security issues designed to inhibit instrumental and gang-related violence.

5. All correctional facilities should establish contacts with community-based organizations able to assist in the treatment and continuity of care upon the inmate's release from the correctional facility.

Adopted by the National Commission on Correctional Health Care
Board of Directors - September 19, 1993.
Latest amended April 10, 1994.

References

Introduction of resolution establishing select committee on violence. (1992, March). *Congressional Record*, 138(30).

Hollinger P. C., Offer D . , Barter J. T., & Bell C . C . (1994). *Suicide and homicide among adolescents*. New York: Guilford Press.

Rosenberg, M. (1992, September 2) Youth violence: A public health problem. *Juvenile Justice Digest*, 20(17).

National Commission on Correctional Health Care

Position Statement

Women's Health Care in Correctional Settings

Background

The number of women under the jurisdiction of state and federal prison authorities at the end of 1989 reached a record 40,556. While this number represents a relatively small percentage of the overall prison population (5.7 %), the rate of growth for female inmates has exceeded that for males each year since 1981 (Greenfeld and Minor-Harper, 1990). An additional 37,383 women were held in local jails in 1989, which represents 9.5 percent of all jail inmates. Between 1983 and 1989, the rate of growth for female jail inmates was 138 percent, which was almost twice that for males (Snell, 1992).

Studies show that incarcerated women utilize health care services much more than men and the reasons for this increased utilization include a woman's more complicated reproductive system, sexually transmitted diseases, and pregnancies. Upon entry into corrections, women report problems with alcohol abuse, headaches, fatigue, drug abuse, and sexually transmitted diseases. Further, it has been estimated that 10 percent of women entering correctional facilities are noted to have psychiatric problems with depression being the most common diagnostic category (*CorHealth— The Newsletter of the American Correctional Health Services Association*, Summer 1993).

Entering a correctional facility is very stressful, but for women this issue is even more intense because of separation from their children; studies across the country show that approximately 75 to 85 percent of incarcerated women have children, most of them coming from single-parent households. It has been reported that two-thirds of female prison and jail inmates had children under 18 (Greenfeld and Minor-Harper, 1990; Snell, 1992). Another study noted that between 50 and 70 percent of incarcerated women had one or more dependent children who were living with them prior to their imprisonment (Baunach, 1985). Thus, appropriate services for female inmates should include parenting and child custody issues.

From 40 to 60 percent of the women in prisons and jails have reported they had been previously sexually or physically abused (Greenfeld and Minor-Harper, 1990; Snell, 1992; *CorHealth— The Newsletter of the American Correctional Health Services Association*, Summer 1993). Such experiences can lead to life long psychological problems ranging from depressive disorders, stress disorders, anxiety disorders, substance abuse (with its attendant physical health problems), behavioral disorders of violence and impulsivity, and learning problems. Further, being victimized can have serious consequences on women's ability to parent their children. Unfortunately, health care professionals have not been trained to take the experience of victimization into account when they treat patients and this shortcoming limits the quality of health care they are able to deliver to women. For example, it has been suggested that having been sexually assaulted discourages women from obtaining regular Pap smears.

A history of problems with alcohol and/or other drugs is another common complaint of women entering correctional facilities and because of this abuse, many of these women are at much greater risk of becoming HIV+ from having had unprotected sex or having used dirty needles. An estimated 72 percent of the women in state prisons in 1989 had used drugs at some time in their lives prior to their incarceration. A third of all female prison inmates reported they were under the influence of a drug at the time of their offense, and 39 percent reported they were using drugs daily in the month before their offense with 24 percent reporting daily use of a major drug (cocaine, heroin, methadone, LSD, or PCP) in that month (Greenfeld and Minor-Harper, 1990). That same year, almost 84 percent of convicted female jail inmates said they had used drugs, and 37.5 percent were under the influence at the time of arrest (Snell, 1992). By 1991, 79.5 percent of the women in state prisons said they had ever used drugs and 53.9 percent said they had used drugs in the month before their current offense (Snell and Morton, 1994).

Research regarding the provision of gynecological services for women in correctional settings has been limited, but it consistently has indicated that such services are inadequate. Annual gynecological exams are not done routinely in either jails or prisons, nor are they regularly performed upon admission. Appropriate initial screening questions about a woman's gynecologic history may not be asked, and in many correctional facilities, there are no physicians who are trained in obstetrics and gynecology, leading to inadequate and inappropriate gynecologic care. As a result, women in jails and prisons are at risk for the lack of detection of some diseases such as breast cancer, ovarian cancer, and abnormal Pap smears. In addition, because of past medical histories of many incarcerated women, their pregnancies tend to be more complicated. Further, many women enter jails and prisons while pregnant and they need adequate pre-natal care and reproductive counseling such as family planning and birth control. In addition, postpartum screening for physical and psychiatric complications are needed.

The circumstances of women's incarceration are unique. It has been estimated that a third of the female state prison inmates in 1991 were there for violent crimes, with a third of that number serving time for a homicide. Nearly two-thirds of all female inmates serving time for a violent crime had victimized someone they knew, and among these offenders, half had victimized either an intimate or a family member such as a parent, sibling, or even their own child (Snell and Morton, 1994). Women incarcerated for a violent offense were the most likely to report previously having experienced physical or sexual abuse; and, among women incarcerated for a violent crime, those who reported they had been abused were more likely than other offenders to have victimized a relative or intimate (Greenfeld and Minor-Harper, 1990).

The National Commission on Correctional Health Care (1992 a, b, c) recognizes the need to provide treatment to this special population. The Receiving Screening standard (J-3 1, P-3 1, and Y-27 Initial Health Screening) suggests inquiry into current gynecological problems and pregnancy for women and female adolescents; the Health Assessment standard (J-35, P-34, and Y-33 Health Appraisal) suggests pelvic examinations and Pap smears should be considered but are not mandated, except in prisons; the Health Promotion and Disease Prevention standard (J-45, P-45, and Y-14) recommends self-examination for breast cancer and family planning as a subject for health education; and the Dietary Services standard Y-53, along with Appendix E Nutrition Guidelines, address the issue of nutritional intake.

Standards J-56, P-56, and Y-58 and J-57, P-57, and Y-38 (Family Planning Services) which are used in the Commission's accreditation program for jails, prisons, and juvenile detention and confinement facilities (respectively) include the following:

J-56 & P-56 Pregnant Inmates (important)

Written policy and defined procedures require, and actual practice evidences, that comprehensive counseling and assistance are given to pregnant inmates in keeping with their express desires in planning for their unborn children, whether they desire abortion, adoptive service, or to keep the child.

Y-38 Pregnant Juveniles (essential)

In recognition of the high-risk nature of adolescent pregnancy, juveniles remaining in the facility after pregnancy has been diagnosed receive regular pre-natal and post-natal care, including medical examinations, appropriate activity levels, safety precautions, nutrition, guidance, and counseling.

J-57 & P-57 Pre-natal Care (essential)

Inmates remaining in the jail (prison) after pregnancy has been diagnosed receive regular pre-natal care, including medical examinations, advice on appropriate levels of activity and safety precautions, nutrition guidance, and counseling.

Y-58 Family Planning Services (important).

Written policy and defined procedures require that comprehensive family planning services, in accordance with state statutes, be available on the premises or by referral.

Position Statement

The National Commission on Correctional Health Care recognizes that the number of female inmates is large and is growing annually, and presents unique and increasing health problems for correctional facilities. Therefore, the Commission recommends the following,

1. All correctional institutions should be required to meet recognized community standards for female health services as promoted by standards set by the National Commission on Correctional Health Care.
2. Correctional health services and women's advocacy groups should collaborate to provide leadership for the development of policies and procedures that address women's special health care needs in corrections.
3. Correctional institutions should provide intake procedures that include histories on menstrual cycle, pregnancies, gynecologic problems, and nutritional intake (by conducting a nutritional assessment) (Anno, 1991).
4. Correctional institutions should provide intake examinations that include a breast exam and, depending on the patient's age, sexual history, and past medical history, a pelvic exam, Pap smear, and baseline mammogram (Anno, 1991).

5. Correctional institutions should provide laboratory tests to detect sexually transmitted diseases (STDs) including gonorrhea, syphilis, and chlamydia for all females, especially since many are asymptomatic for STDs. Additionally, females should receive a pregnancy test on admission to correctional facilities (Anno, 1991). Further, since new research has indicated that pregnant women who are infected with HIV are less likely to transmit the virus to their newborn if they are treated with AZT during their pregnancy, women should be educated about this new finding and encouraged to be tested for HIV if they are pregnant.
6. Comprehensive services for women's unique health problems should be provided in prisons, jails, and juvenile detention and confinement facilities:
 - A) Considering the special reproductive health needs of women, the frequency of repeating certain tests, exams, and procedures (e.g. Pap smears, mammograms, etc.) should be based on guidelines established by professional groups such as the American Cancer Society and the American College of Obstetricians and Gynecologists, and should take into account age and risk factors of the female correctional population (Anno, 1991).
 - B) Considering the high levels of victimization (sexual and physical) within the female inmate population, and considering the circumstances of incarceration of violent female offenders (i.e. , they frequently have committed interpersonal altercation violence against a family member or intimate), counseling to resolve issues of victimization and perpetration of violence against intimates (such as conflict resolution skills or parenting skills) should be available.
 - C) Considering the large number of women who are incarcerated who have dependent children, counseling on issues of parenting and child custody issues should be available to women in correctional institutions.
 - D) Considering the high rates of depression women report upon incarceration, counseling should be available to women in correctional facilities to address this issue.
 - E) Considering the high rates of alcohol and/or drug problems women report on incarceration, counseling should be available to women in correctional facilities to address this issue.
 - F) Considering the unique developmental needs of female adolescents, special attention should be given to their needs in the provision of the aforementioned services.
 - G) Considering that many female adolescents who enter the juvenile justice system have unique educational needs, special attention needs to be given to counseling and habilitation in this area.

Adopted by the National Commission on Correctional Health Care
Board of Directors - September 25, 1994.

References

- ACHSA president testifies before the Senate. (Summer, 1993). *CorHealth* --- *The newsletter of the American Correctional Health Services Association*, pp. 1-2.
- Anno, B. J. (1991). *Prison health care: Guidelines for the management of an adequate delivery system*. Chicago: National Commission on Correctional Health Care.
- Baunach, P. J. (1985). *Mothers in prison*. New Brunswick, NJ: Transaction Books.
- Greenfeld, L. A. and Minor-Harper S. (March 1990). *Women in prison*. Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (NCJ-127991).
- National Commission on Correctional Health Care (1992a). *Standards for health services in jails*. Chicago: author.
- National Commission on Correctional Health Care (1992b). *Standards for health services in juvenile detention and confinement facilities*. Chicago: author.
- National Commission on Correctional Health Care (1992c). *Standards for health services in prisons*. Chicago: Author.
- Snell, T. L. (March 1992). *Women in jail, 1989*. Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (NCJ-134732).
- Snell, T. L. and Morton, D. C. (March 1994). *Women in prison: Survey of state prison inmates 1991*. Washington D. C . : U. S . Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (NCJ-145321).

APPENDIX G

Guidelines on Bloodborne Pathogens 137

Friday
December 6, 1991

Part II (Excerpts)

Pages 64175 thru 64182

Department of Labor

**Occupational Safety and Health
Administration**

29 CFR Part 1910.1030

**Occupational Exposure to Bloodborne
Pathogens; Final Rule**

Final Rule

XI. The Standard

General Industry

Part 1910 of title 29 of the Code of Federal Regulations is amended as follows:

PART 1910—[AMENDED]

Subpart Z—[Amended]

1. The general authority citation for subpart Z of 29 CFR part 1910 continues to read as follows and a new citation for § 1910.1030 is added:

Authority: Secs. 6 and 8, Occupational Safety and Health Act, 29 U.S.C. 655, 657, Secretary of Labor's Orders Nos. 12-71 (36 FR 6754), 8-76 (41 FR 25059), or 9-83 (46 FR 35736), as applicable; and 29 CFR part 1911.

* * * * *
Section 1910.1030 also issued under 29 U.S.C. 653.
* * * * *

2. Section 1910.1030 is added to read as follows:

§1910.1030 Bloodborne Pathogens.

(a) *Scope and Application.* This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

(b) *Definitions.* For purposes of this section, the following shall apply:

Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.

Blood means human blood, human blood components, and products made from human blood.

Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

Clinical Laboratory means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to remove,

inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Director means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Handwashing Facilities means a facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines.

Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

HBV means hepatitis B virus.

HIV means human immunodeficiency virus.

Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other Potentially Infectious Materials means

(1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;

(2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

(3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Personal Protective Equipment is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

Production Facility means a facility engaged in industrial-scale, large-volume or high concentration production of HIV or HBV.

Regulated Waste means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

Research Laboratory means a laboratory producing or using research-laboratory-scale amounts of HIV or HBV. Research laboratories may produce high concentrations of HIV or HBV but not in the volume found in production facilities.

Source Individual means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

(c) *Exposure control*—(1) *Exposure Control Plan.* (i) Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to

eliminate or minimize employee exposure.

(ii) The Exposure Control Plan shall contain at least the following elements:

(A) The exposure determination required by paragraph(c)(z),

(B) The schedule and method of implementation for paragraphs (d) Methods of Compliance, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Recordkeeping, of this standard, and

(C) The procedure for the evaluation of circumstances surrounding exposure incidents as required by paragraph (f)(3)(i) of this standard.

(iii) Each employer shall ensure that a copy of the Exposure Control Plan is accessible to employees in accordance with 29 CFR 1910.20(e).

(iv) The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

(v) The Exposure Control Plan shall be made available to the Assistant Secretary and the Director upon request for examination and copying.

(2) *Exposure determination.* (i) Each employer who has an employee(s) with occupational exposure as defined by paragraph (b) of this section shall prepare an exposure determination. This exposure determination shall contain the following:

[A] A list of all job classifications in which all employees in those job classifications have occupational exposure:

(B) A list of job classifications in which some employees have occupational exposure, and

(C) A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that are performed by employees in job classifications listed in accordance with the provisions of paragraph (c)(2)(i)(B) of this standard.

(ii) This exposure determination shall be made without regard to the use of personal protective equipment.

(d) *Methods of compliance*—(1) General-Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

(2) *Engineering and work practice controls.* (i) Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.

(ii) Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

(iii) Employers shall provide handwashing facilities which are readily accessible to employees.

(iv) When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

(v) Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

(vi) Employers shall ensure that employees wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.

(vii) Contaminated needles and other contaminated sharps shall not be bent, recapped, or removed except as noted in paragraphs (d)(2)(vii)(A) and (d)(2)(vii)(B) below. Shearing or breaking of contaminated needles is prohibited.

(A) Contaminated needles and other contaminated sharps shall not be recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure.

(B) Such recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.

(viii) Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:

(A) Puncture resistant;

(B) Labeled or color-coded in accordance with this standard;

(C) Leakproof on the sides and bottom; and

(D) In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.

(ix) Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

(x) Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or benchtops where blood or other potentially infectious materials are present.

(xi) All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

(xii) Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

(xiii) Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping.

[A] The container for storage, transport, or shipping shall be labeled or color-coded according to paragraph (g)(1)(i) and closed prior to being stored, transported, or shipped. When a facility utilizes Universal Precautions in the handling of all specimens, the labeling/color-coding of specimens is not necessary provided containers are recognizable as containing specimens. This exemption only applies while such specimens/containers remain within the facility. Labeling or color-coding in accordance with paragraph (g)(1)(i) is required when such specimens/containers leave the facility.

(B) If outside contamination of the primary container occurs, the primary container shall be placed within a second container which prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded according to the requirements of this standard.

(C) If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

(xiv) Equipment which may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

(A) A readily observable label in accordance with paragraph (g)(1)(i)(H) shall be attached to the equipment stating which portions remain contaminated.

[B] The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

(3) Personal protective equipment-(i) Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

[ii] Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgement, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

[iii] Accessibility. The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the worksite or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

(iv) Cleaning, Laundering, and Disposal. The employer shall clean, launder, and dispose of personal protective equipment required by paragraphs (d) and (e) of this standard, at no cost to the employee.

(v) Repair and Replacement. The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

[vi] If a garment(s) is penetrated by blood or other potentially infectious

materials, the garment(s) shall be removed immediately or as soon as feasible.

(vii) All personal protective equipment shall be removed prior to leaving the work area.

[viii] When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

(ix) Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin: when performing vascular access procedures except as specified in paragraph (d)(3)(ix)(D); and when handling or touching contaminated items or surfaces.

(A) Disposable (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

(B) Disposable (single use) gloves shall not be washed or decontaminated for re-use.

(C) Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.

(D) If an employer in a volunteer blood donation center judges that routine gloving for all phlebotomies is not necessary then the employer shall:

(1) Periodically reevaluate this policy:

{2} Make gloves available to all employees who wish to use them for phlebotomy:

(3) Not discourage the use of gloves for phlebotomy: and

(4) Require that gloves be used for phlebotomy in the following circumstances:

(i) When the employee has cuts, scratches, or other breaks in his or her skin:

(ii) When the employee judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative source individual: and

(iii) When the employee is receiving training in phlebotomy.

[x] Masks, Eye Protection, and Face Shields. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, shall be worn whenever splashes, spray, spatter, or

droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

(xi) Gowns, Aprons, and Other Protective Body Clothing. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

[xii] Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, orthopaedic surgery).

(4) Housekeeping. (i) General. Employers shall ensure that the worksite is maintained in a clean and sanitary condition. The employer shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

(ii) All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.

(A) Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures: immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials: and at the end of the work shift if the surface may have become contaminated since the last cleaning.

(B) Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the workshift if they may have become contaminated during the shift.

(C) All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

(D) Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means.

such as a brush and dust pan, tongs, or forceps.

(E) Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

(iii) Regulated Waste.

(A) Contaminated Sharps Discarding and Containment. (i) Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:

(i) Closable;

(ii) Puncture resistant;

(iii) Leakproof on sides and bottom; and

(iv) Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard.

(2) During use, containers for contaminated sharps shall be:

(i) Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries);

(ii) Maintained upright throughout use; and

(iii) Replaced routinely and not be allowed to overfill.

(3) When moving containers of contaminated sharps from the area of use, the containers shall be:

(i) Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping;

(ii) Placed in a secondary container if leakage is possible. The second container shall be:

(A) Closable;

(B) Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping; and

(C) Labeled or color-coded according to paragraph (g)(1)(i) of this standard.

(4) Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of percutaneous injury.

(B) Other Regulated Waste Containment. (1) Regulated waste shall be placed in containers which are:

(i) Closable;

(ii) Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

(iii) Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard; and

(iv) Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

(2) If outside contamination of the regulated waste container occurs, it

shall be placed in a second container.

The second container shall be:

(i) Closable;

(ii) Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

(iii) Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard; and

(iv) Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

(C) Disposal of all regulated waste shall be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

(iv) Laundry.

(A) Contaminated laundry shall be handled as little as possible with a minimum of agitation. (1) Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

(2) Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard. When a facility utilizes Universal Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the containers as requiring compliance with Universal Precautions.

(3) Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through or leakage from the bag or container, the laundry shall be placed and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.

(B) The employer shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

(C) When a facility ships contaminated laundry off-site to a second facility which does not utilize Universal Precautions in the handling of all laundry, the facility generating the contaminated laundry must place such laundry in bags or containers which are labeled or color-coded in accordance with paragraph (g)(1)(i).

(e) *HIV and HBV Research Laboratories and Production Facilities.*

(1) This paragraph applies to research laboratories and production facilities engaged in the culture, production, concentration, experimentation, and manipulation of HIV and HBV. It does not apply to clinical or diagnostic laboratories engaged solely in the analysis of blood, tissues, or organs.

These requirements apply in addition to the other requirements of the standard.

(2) Research laboratories and production facilities shall meet the following criteria:

(i) Standard microbiological practices. All regulated waste shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy bloodborne pathogens.

(ii) Special practices.

(A) Laboratory doors shall be kept closed when work involving HIV or HBV is in progress.

(B) Contaminated materials that are to be decontaminated at a site away from the work area shall be placed in a durable, leakproof, labeled or color-coded container that is closed before being removed from the work area.

(C) Access to the work area shall be limited to authorized persons. Written policies and procedures shall be established whereby only persons who have been advised of the potential biohazard, who meet any specific entry requirements, and who comply with all entry and exit procedures shall be allowed to enter the work areas and animal rooms.

(D) When other potentially infectious materials or infected animals are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with paragraph (g)(1)(ii) of this standard.

(E) All activities involving other potentially infectious materials shall be conducted in biological safety cabinets or other physical-containment devices within the containment module. No work with these other potentially infectious materials shall be conducted on the open bench.

(F) Laboratory coats, gowns, smocks, uniforms, or other appropriate protective clothing shall be used in the work area and animal rooms. Protective clothing shall not be worn outside of the work area and shall be decontaminated before being laundered.

(G) Special care shall be taken to avoid skin contact with other potentially infectious materials. Gloves shall be worn when handling infected animals and when making hand contact with other potentially infectious materials is unavoidable.

(H) Before disposal all waste from work areas and from animal rooms shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy bloodborne pathogens.

(I) Vacuum lines shall be protected with liquid disinfectant traps and high-efficiency particulate air (HEPA) filters or filters of equivalent or superior efficiency and which are checked routinely and maintained or replaced as necessary.

(J) Hypodermic needles and syringes shall be used only for parenteral injection and aspiration of fluids from laboratory animals and diaphragm bottles. Only needle-locking syringes or disposable syringe-needle units (i.e., the needle is integral to the syringe) shall be used for the injection or aspiration of other potentially infectious materials. Extreme caution shall be used when handling needles and syringes. A needle shall not be bent, sheared, replaced in the sheath or guard, or removed from the syringe following use. The needle and syringe shall be promptly placed in a puncture-resistant container and autoclaved or decontaminated before reuse or disposal.

(K) All spills shall be immediately contained and cleaned up by appropriate professional staff or others properly trained and equipped to work with potentially concentrated infectious materials.

(L) A spill or accident that results in an exposure incident shall be immediately reported to the laboratory director or other responsible person.

(M) A biosafety manual shall be prepared or adopted and periodically reviewed and updated at least annually or more often if necessary. Personnel shall be advised of potential hazards, shall be required to read instructions on practices and procedures, and shall be required to follow them.

(iii) Containment equipment. (A) Certified biological safety cabinets [Class I, II, or III] or other appropriate combinations of personal protection or physical containment devices, such as special protective clothing, respirators, centrifuge safety cups, sealed centrifuge rotors, and containment caging for animals, shall be used for all activities with other potentially infectious materials that pose a threat of exposure to droplets, splashes, spills, or aerosols.

(B) Biological safety cabinets shall be certified when installed, whenever they are moved and at least annually.

(3) HIV and HBV research laboratories shall meet the following criteria:

(i) Each laboratory shall contain a facility for hand washing and an eye wash facility which is readily available within the work area.

(ii) An autoclave for decontamination of regulated waste shall be available.

(4) HIV and HBV production facilities shall meet the following criteria:

(i) The work areas shall be separated from areas that are open to unrestricted traffic flow within the building. Passage through two sets of doors shall be the basic requirement for entry into the work area from access corridors or other contiguous areas. Physical separation of the high-containment work area from access corridors or other areas or activities may also be provided by a double-doored clothes-change room (showers may be included), airlock, or other access facility that requires passing through two sets of doors before entering the work area.

(ii) The surfaces of doors, walls, floors and ceilings in the work area shall be water resistant so that they can be easily cleaned. Penetrations in these surfaces shall be sealed or capable of being sealed to facilitate decontamination.

(iii) Each work area shall contain a sink for washing hands and a readily available eye wash facility. The sink shall be foot, elbow, or automatically operated and shall be located near the exit door of the work area.

(iv) Access doors to the work area or containment module shall be self-closing.

(v) An autoclave for decontamination of regulated waste shall be available within or as near as possible to the work area.

(vi) A ducted exhaust-air ventilation system shall be provided. This system shall create directional airflow that draws air into the work area through the entry area. The exhaust air shall not be recirculated to any other area of the building, shall be discharged to the outside, and shall be dispersed away from occupied areas and air intakes. The proper direction of the airflow shall be verified (i.e., into the work area).

(5) *Training Requirements.* Additional training requirements for employees in HIV and HBV research laboratories and HIV and HBV production facilities are specified in paragraph (g)(2)(ix).

(f) *Hepatitis B vaccination and post-exposure evaluation and follow-up-(1) General.*

(i) The employer shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident.

(ii) The employer shall ensure that all medical evaluations and procedures including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

(A) Made available at no cost to the employee:

(B) Made available to the employee at a reasonable time and place:

(C) Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional; and

(D) Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place, except as specified by this paragraph (f).

(iii) The employer shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

(2) *Hepatitis B Vaccination.* (i) Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

(ii) The employer shall not make participation in a prescreening program a prerequisite for receiving hepatitis B vaccination.

(iii) If the employee initially declines hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the employer shall make available hepatitis B vaccination at that time.

(iv) The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the statement in appendix A.

(v) If a routine booster dose(s) of hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster dose(s) shall be made available in accordance with section (f)(1)(ii).

(3) *Post-exposure Evaluation and Follow-up.* Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements:

(i) Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred;

(ii) Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law:

(A) The source individual's blood shall be tested as soon as feasible and

after consent is obtained in order to determine HBV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

(B) When the source individual is already known to be infected with HBV or HIV, testing for the source individual's known HBV or HIV status need not be repeated.

(C) Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

(iii) Collection and testing of blood for HBV and HIV serological status:

(A) The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

(B) If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

(iv) Post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service;

(v) Counseling; and

(vi) Evaluation of reported illnesses.

(4) Information Provided to the Healthcare Professional.

(i) The employer shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.

(ii) The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided the following information:

(A) A copy of this regulation;

(B) A description of the exposed employee's duties as they relate to the exposure incident;

(C) Documentation of the route(s) of exposure and circumstances under which exposure occurred;

(D) Results of the source individual's blood testing, if available; and

(E) All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain.

(5) Healthcare Professional's Written Opinion. The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional's

written opinion within 15 days of the completion of the evaluation.

(i) The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

(ii) The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

(A) That the employee has been informed of the results of the evaluation; and

(B) That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

(iii) All other findings or diagnoses shall remain confidential and shall not be included in the written report.

(6) Medical recordkeeping. Medical records required by this standard shall be maintained in accordance with paragraph (h)(1) of this section.

(g) Communication of hazards to employees- (1) *Labels and signs.* (i) Labels. (A) Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport or ship blood or other potentially infectious materials, except as provided in paragraph (g)(1)(i)(E), (F) and (G).

(B) Labels required by this section shall include the following legend:



BIOHAZARD

BIOHAZARD

(C) These labels shall be fluorescent orange or orange-red or predominantly so, with lettering or symbols in a contrasting color.

(D) Labels required by affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

(E) Red bags or red containers may be substituted for labels.

(F) Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other

clinical use are exempted from the labeling requirements of paragraph (g).

(C) Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

(H) Labels required for contaminated equipment shall be in accordance with this paragraph and shall also state which portions of the equipment remain contaminated.

(I) Regulated waste that has been decontaminated need not be labeled or color-coded.

(ii) Signs. (A) The employer shall post signs at the entrance to work areas specified in paragraph (e). HIV and HBV Research Laboratory and Production Facilities, which shall bear the following legend:



BIOHAZARD

BIOHAZARD

(Name of the Infectious Agent)
[Special requirements for entering the area]
[Name, telephone number of the laboratory director or other responsible person.]

(B) These signs shall be fluorescent orange-red or predominantly so, with lettering or symbols in a contrasting color.

(2) Information and Training. (i) Employers shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee and during working hours.

(ii) Training shall be provided as follows:

(A) At the time of initial assignment to tasks where occupational exposure may take place;

(B) Within 90 days after the effective date of the standard; and

(C) At least annually thereafter.

(iii) For employees who have received training on bloodborne pathogens in the year preceding the effective date of the standard, only training with respect to the provisions of the standard which were not included need be provided.

(iv) Annual training for all employees shall be provided within one year of their previous training.

(v) Employers shall provide additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

(vi) Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.

(vii) The training program shall contain at a minimum the following elements:

[A] An accessible copy of the regulatory text of this standard and an explanation of its contents;

(B) A general explanation of the epidemiology and symptoms of bloodborne diseases;

(C) An explanation of the modes of transmission of bloodborne pathogens;

(D) An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;

(E) An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

(F) An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;

(G) Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;

(H) An explanation of the basis for selection of personal protective equipment;

(I) Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

(J) Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

(K) An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;

(L) Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;

(M) An explanation of the signs and labels and/or color coding required by paragraph (g)(1); and

(N) An opportunity for interactive questions and answers with the person conducting the training session.

(viii) The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

(ix) Additional Initial Training for Employees in HIV and HBV Laboratories and Production Facilities. Employees in HIV or HBV research laboratories and HIV or HBV production facilities shall receive the following initial training in addition to the above training requirements.

(A) The employer shall assure that employees demonstrate proficiency in standard microbiological practices and techniques and in the practices and operations specific to the facility before being allowed to work with HIV or HBV.

(B) The employer shall assure that employees have prior experience in the handling of human pathogens or tissue cultures before working with HIV or HBV.

(C) The employer shall provide a training program to employees who have no prior experience in handling human pathogens. Initial work activities shall not include the handling of infectious agents. A progression of work activities shall be assigned as techniques are learned and proficiency is developed. The employer shall assure that employees participate in work activities involving infectious agents only after proficiency has been demonstrated.

(h) *Recordkeeping—(1) Medical Records.* (i) The employer shall establish and maintain an accurate record for each employee with occupational exposure, in accordance with 29 CFR 1910.20.

(ii) This record shall include:

(A) The name and social security number of the employee;

(B) A copy of the employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by paragraph (f)(2);

(C) A copy of all results of examinations, medical testing, and follow-up procedures as required by paragraph (f)(3);

(D) The employer's copy of the healthcare professional's written opinion as required by paragraph (f)(5); and

(E) A copy of the information provided to the healthcare professional as required by paragraphs (f)(4)(ii)(B)(C) and (D).

(iii) Confidentiality. The employer shall ensure that employee medical records required by paragraph (h)(l) are:

[A] Kept confidential; and

[B] Are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this section or as may be required by law.

(iv) The employer shall maintain the records required by paragraph (h) for at least the duration of employment plus 30 years in accordance with 29 CFR 1910.20.

(2) *Training Records.* (i) *Training records shall include the following information:*

(A) The dates of the training sessions;

(B) The contents or a summary of the training sessions;

(C) The names and qualifications of persons conducting the training; and

(D) The names and job titles of all persons attending the training sessions.

(ii) Training records shall be maintained for 3 years from the date on which the training occurred.

(3) *Availability.* (i) The employer shall ensure that all records required to be maintained by this section shall be made available upon request to the Assistant Secretary and the Director for examination and copying.

(ii) Employee training records required by this paragraph shall be provided upon request for examination and copying to employees, to employee representatives, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.20.

(iii) Employee medical records required by this paragraph shall be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.20.

(4) *Transfer of Records.* (i) The employer shall comply with the requirements involving transfer of records set forth in 29 CFR 1910.20(h).

(ii) If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Director, at least three months prior to their disposal and transmit them to the Director, if required by the Director to do so, within that three month period.

(i) *Dates—(1) Effective Date.* The standard shall become effective on March 6, 1992.

(2) The Exposure Control Plan required by paragraph (c)(2) of this section shall be completed on or before May 5, 1992.

(3) Paragraph (g)(Z) information and Training and [h] Recordkeeping shall take effect on or before June 4, 1992.

(4) Paragraphs (d)(2) Engineering and Work Practice Controls, (d)(3) Personal Protective Equipment, (d)(4) Housekeeping, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and

Follow-up, and (g)(i) Labels and Signs, shall take effect July 6, 1992.

Appendix A to Section **1910.1030—Hepatitis B Vaccine Declination (Mandatory)**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine. at no charge to myself. However, I decline hepatitis

B vaccination at this time I understand that by declining this vaccine. I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine. I can receive the vaccination series at no charge to me.

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APPENDIX H

STANDING ORDERS VS. TREATMENT PROTOCOLS

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STANDING ORDERS VS. TREATMENT PROTOCOLS

Standing orders are written orders that specify the same course of treatment for each patient suspected of having a given condition. *Treatment protocols* are written orders that specify the steps to be taken in appraising a patient's physical status.

Standing Order for Moderate Alcohol Withdrawal

Administer Chlordiazepoxide (Librium) 50 mg IM stat and q 8 hours. Thiamine 50 mg IM stat and po q A.M.

Treatment Protocol for Moderate Alcohol Withdrawal

1. Symptoms/Presentation
 - History of alcohol abuse
 - History of recent (12 -72 hours) abstinence
 - Tremulousness
 - Diaphoresis
 - Restlessness
 - No hallucinations, no disorientation, no convulsions
2. Take vital signs.
3. Evaluate for history or signs of trauma.
4. Contact physician to discuss disposition/medication.
5. House in area of constant observation.
6. If disorientation, confusion, convulsions, etc. occur, arrange for immediate hospital emergency department transfer.

Note: More detailed therapeutic guidelines are acceptable in sites where nurse practitioners/physician assistants are employed and state regulations allow for enhanced responsibility.

APPENDIX I

INFORMATION ON THE CERTIFIED CORRECTIONAL HEALTH PROFESSIONAL
(CCHP) PROGRAM

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CERTIFIED CORRECTIONAL HEALTH PROFESSIONAL
A program of the National Commission on Correctional Health Care

2105 N. Southport, Suite 200, Chicago, Illinois 60614 (312) 528-0818 FAX: (312) 528-4915



ABOUT THE CCHP PROGRAM

Why Seek CCHP Certification

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

The Certified Correctional Health Professional program recognizes your knowledge of national standards for providing health services in correctional settings. Certification under the CCHP program identifies you as someone who has mastered the unique knowledge needed to provide care in these unique settings. 1000 correctional health care professionals are currently certified under the CCHP program.

Benefits of CCHP Certification

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

The CCHP designation can be used with your name on letterhead, business cards, and all forms of address. In addition, a CCHP receives the following:

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

How to Become Certified

Persons meeting the basic application requirements participate in an open book examination. Upon receiving a passing score, certification is awarded for a period of three years at which time recertification through examination is required. In the interim, CCHPs are required to demonstrate their participation in relevant continuing education activities.

Eligibility

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

Application Requirements

Persons interested in seeking CCHP certification must

- . submit a type-written application;
- . submit a resume or CV documenting a minimum of three years full time or six years part time professional experience in correctional health care;
- . submit valid credentials (e.g., license, degree, or educational equivalent) in their professional field; and
- . be of good character and professional reputation; providing three professional references.

Once these requirements have been documented, applicants are eligible to participate in the examination.

The Examination

The open book examination for the Certified Correctional Health Professional is offered on a semi-annual basis, in May and November. The examination is designed to assess your knowledge of the delivery of health care services in a correctional environment. Some of the examination questions are geared toward specific correctional settings (jail, prison or juvenile facility), others are more general in nature. The examination is not intended to measure clinical competency in your field; rather, it measures your knowledge of standards and practices of providing health care in the correctional setting. The examination items are predominantly multiple choice questions, the remainder are essay.

Governance of the Certified Correctional Health Professional Program

The Certified Correctional Health Professional program is governed by a Board of Trustees. The CCHP Board of Trustees consists of nine correctional health care experts from a variety of health professions. Three of the Trustees are elected by those who have attained their CCHP status. Three are appointed from the broad correctional health care field, and three

are members of the NCCHC Board of Directors. The CCHP Board of Trustees is responsible for the examination content, scoring and evaluation, as well as the awarding of the CCHP certification to successful candidates. The CCHP program is administered by the National Commission on Correctional Health Care.

Continuing Certification

Once certified, you must document participation in 12 hours of annual continuing professional education and submit a nominal fee for an updated certificate.

CCHP - Advanced Certification

After being certified for a minimum of three years, CCHPs are eligible to apply for the CCHP-Advanced (CCHP-A) certification. Certification under the CCHP-A program requires the completion of a more detailed application and obtaining a passing score on a four-hour, proctored, essay examination. This examination is given once a year.

Deadlines

CCHP examinations are held in May and November. Persons wanting to participate in the May examination must have their application and all required documents and fees postmarked no later than April 10. Persons wanting to participate in the November examination must have the application and all required documents and fees postmarked no later than October 10. Persons not meeting these deadlines will be automatically moved to the next exam cycle.

Questions

For further information about the Certified Correctional Health Professional program, contact us at (312) 528-0818.

APPENDIX J

HEALTH CARE ACCREDITATION INFORMATION

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National Commission on Correctional Health Care

ABOUT HEALTH SERVICE ACCREDITATION

Accreditation by the National Commission on Correctional Health Care is a process of external peer review in which the National Commission, a private nongovernmental association, grants public recognition to detention and correctional institutions that meet nationally established and accepted standards for the provision of health services.

The National Commission's accreditation program renders a professional judgment on the quality of health services provided in detention and correctional settings and assists in their continued improvement.

Since 1983, the National Commission has offered a voluntary accreditation program based upon national standards established by the health, legal, and corrections professions. (Some of the organizations represented on the National Commission include the American Medical Association, the National Juvenile Detention Association, the American Public Health Association, the National District Attorneys Association, and the American Nurses Association.)

Benefits of Accreditation

Accreditation promotes an efficient and well-managed system of health care services.

Accreditation adds prestige to facilities, increases staff morale, aids recruiting efforts, helps to obtain community support, and provides additional justification for budgetary requests.

Accreditation helps to protect financial assets by minimizing the occurrence of adverse events.

Accreditation, in many instances, reduces liability premiums and protects facilities from lawsuits related to health care.

Accreditation benefits incarcerated individuals by assuring them of adequate and appropriate health care according to nationally accepted standards.

Obtaining Accreditation

It begins by requesting a copy of the National Commission's Standards for *Health Services in Juvenile Detention and Confinement Facilities* and reviewing your facility's compliance with them. You then request an application for accreditation from the National Commission. You will be sent a Self-Survey Questionnaire to assist you in preparing for an accreditation site survey. National Commission staff are always available to assist you in the preparation. The survey, which is scheduled only when you feel you are ready, is conducted by health professionals experienced in correctional health care. The National Commission approaches surveys as an educational

experience for you and your staff, and we will work with you to help you achieve compliance with the standards.

Following the survey, the NCCHC's Accreditation Committee will evaluate the facility's compliance with its standards and make an accreditation decision. You will receive a comprehensive written report that includes recommendations to assist your continuing compliance with the standards. Then, once accredited, on an annual basis, you will be asked to submit a written report. Additional on-site visits will occur about every three years.

When a Facility's Health Services Are Contracted

A facility can undergo the accreditation process if it provides its own health care services or if the health services are provided by a contract provider. National Commission accreditation is an excellent way to establish requirements for the contract and to monitor the contractor's performance. Contractors often find their ability to achieve accreditation is the "competitive edge" to a contract award.

Small Facilities

The smallest facility in the NCCHC accreditation program has an average daily population of 26 (the largest has over 10,000). So, yes, small facilities can become accredited.

Cost of Accreditation

The cost of accreditation is based upon the facility type (e.g. jail, prison, juvenile), its average daily population, and whether or not it has satellites. With this information in hand, National Commission staff is able to provide you with an estimate of accreditation fees for your particular facility. After the first year's initial fee, there is a subsequent annual fee of about ½ as much, depending on the variables just mentioned.

For more information, please contact

National Commission on Correctional Health Care
2105 N. Southport, Chicago, IL 60614-4017 (312) 528-0818



NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

2105 N. Southport, Chicago, Illinois 60614, (312) 528-0818

FACT SHEET NCCHC's ACCREDITATION PROCESS

A completed application, signed by the person legally responsible for the facility, should be submitted at the earliest possible date.

PRE-SURVEY ACTIVITY

1. One copy of the completed self survey questionnaire (SSQ) should be returned to the National Commission for review. If problems are encountered or questions arise, call the Director of Operations at (312) 528-0818.
2. You may submit a copy of your manual of health services policies and procedures for review prior to the site survey.
3. When it appears, from the data contained in the SSQ and/or discussion, that your facility is ready for a site survey, you will be contacted and a date will be agreed upon for the survey.
4. Site surveys must be completed at least four weeks before the meeting of the Accreditation Committee (meetings are held in February, June and October). In order to include all facilities in the appropriate review schedule, it is necessary to have your assistance in setting the earliest possible date for the survey of your facility.

SURVEY

It is our intention not to interfere with your daily activities and we hope to make the process operate efficiently so that you can maximize the benefits of the survey. Your preparation and assistance in the areas listed below will help to ensure a smooth visit.

Correctional Staff

1. Notify the sheriff, warden or administrator of the visit and the need for a personal interview.
2. Inform security personnel that the surveyor(s) will choose a random sample of juveniles from a current juvenile roster, and a sample of correctional officers to conduct private interviews with these persons. Please arrange for a private interview room.
3. Advise security personnel that the surveyor(s) will need to tour the facility at some point during the survey.

Medical Staff

1. Arrange for the chief health administrator to schedule time for an extensive interview.
2. Arrange for all applicable individuals listed below to be available for private interviews. Please arrange for an appropriate room.

responsible physician	psychiatrist
dentist	psychologist
food service director	pharmacist
medical staff	health care personnel

3. Have your policy and procedures manual readily available.
4. Review the standards. Have documentation relative to the standards readily available. Facilities often provide a binder or folders of documentation which supports each NCCHC standard. For example, a folder with credentials of health services staff would be labelled Y-18.
5. Have the following documentation assembled and available for review:
 - ▶ Job descriptions for all health care staff (medical, dental and mental health).
 - ▶ Minutes of meetings between the health authority and facility administrator for the past year.
 - ▶ Documentation of monthly meetings of health staff for the past year.
 - ▶ Statistical reports for a one-year period.
 - ▶ Health services policy manual.
 - ▶ Institution's standard operating procedure manual.
 - ▶ Separate policy manuals for special services (if any): laboratory, radiology, physical therapy, etc.
 - ▶ Documentation of physician chart reviews.
 - ▶ Minutes of quality assurance committee meetings.
 - ▶ Documentation of external peer review (if any) in the form of letters or reports.
 - ▶ The facility's disaster plan.
 - ▶ Monthly sanitation reports or checklists.
 - ▶ Copies of credentials for all health staff employed full or part-time (medical, dental and mental health).
 - ▶ Plan/curriculum for orientation of new health staff.
 - ▶ In-service training plan/schedule/curriculum for health staff.
 - ▶ Documentation of in-service training received in the past year for each full-time health professional.
 - ▶ Curricula/schedule for health-related training of correctional staff.
 - ▶ Documentation indicating the number of correctional staff who have had:
 - (a) first-aid training, (b) CPR training, (c) other health-related training.
 - ▶ List of health professionals who are CPR-trained.
 - ▶ First-aid kit inspection logs or records.
 - ▶ Inventory sheets/logs/records for: (a) syringes and needles; (b) sharp instruments; (c) controlled drugs.
 - ▶ Copies of written agreements with all hospitals that provide services to juveniles.
 - ▶ The formulary used by the facility.
 - ▶ A copy of the juvenile handbook (if any) or other written material given to juveniles regarding access to health services.
 - ▶ A mock (blank) medical record containing copies of all forms used, filed in the order in which they appear in patients' charts.
 - ▶ Blank copies of any other health service forms used (except fiscal) that are not filed in the patients' charts.

- ▶ Sick call logs/appointment lists for a two-week period for medical, dental and mental health services.
- ▶ Copies of any standing orders or treatment protocols used.
- ▶ Meeting minutes (if there is an infection control committee) or other documentation regarding infection control practices.
- ▶ Examples of pamphlets, other materials and/or lists of video tapes used in the juvenile health education program.
- ▶ A list of the names and phone numbers of people, hospitals, ambulances, etc. to be called in an emergency.
- ▶ A list of dental treatment priorities.
- ▶ Sample menus (regular and therapeutic).
- ▶ Sample logs, cell cards or other evidence that health staff check individuals in segregation.
- ▶ A description of the scope of services provided in the infirmary (if any).
- ▶ A manual of nursing procedures for the infirmary (if any).
- ▶ The facility's plan and/or policies addressing suicide prevention.
- ▶ A list of any deaths at the facility during the past five years.

6. The surveyors will randomly select individual medical records for review.

7. An exit conference will be conducted at the end of the survey. This conference is intended to provide you with feedback regarding the survey, but is not conclusive and binding on the Accreditation Committee. Please allow one hour with the facility principals to review the surveyor(s) findings.

ACCREDITATION COMMITTEE

1. The data collected during the site survey are correlated, analyzed and presented to the Accreditation Committee for review and decision.
2. The Committee may:
 - (a) Award -- accreditation for an annual period;
 - (b) Award with Verification -- the facility's accreditation is contingent upon receipt and verification of relevant data (usually some missing information from the survey).
 - (c) Defer -- the decision on accreditation until the next review period (usually on the basis of deficiencies and/or missing data); or,
 - (d) Deny -- no accreditation is awarded to the facility.
3. Under deferral, the facility is asked to reimburse the Commission for out-of-pocket expenses incurred in a revisit to the facility. Only two (2) deferrals are permitted per accreditation.

NOTIFICATION

The Commission will notify the sheriff, warden or administrator by letter of the action of the Accreditation Committee. A certificate of accreditation will be sent with this letter, if payment of all outstanding fees has been received. If you have not received notice of the decision within thirty days of the meeting date, please contact the Commission directly.

NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

2105 N. Southport, Chicago, Illinois 60614, (312) 528-0818



APPLICATION FOR ACCREDITATION OF CORRECTIONAL HEALTH SERVICES PROGRAMS

Legal Name of Facility (to appear on certificate of accreditation):

Check one: J a i l P r i s o n J u v e n i l e Confinement

We hereby apply to the National Commission on Correctional Health Care (NCCHC) for the accreditation of the medical and health services program of the institution, named above, for which I am legally responsible. The survey and review of health care practices at this facility will be guided by standards originally developed by the American Medical Association and adopted and revised by the NCCHC. We agree to abide by NCCHC accreditation policies and to permit, at the time of the site survey, private and confidential interviews with correctional officers, inmates/residents, health care personnel and food service personnel; a review of all pertinent documentation, including health records; and, a tour of the facility, including general population and segregated and/or other special housing areas, health care locations, exercise and work areas and dining rooms and kitchens. We hereby acknowledge that if the facility is accredited, the health care program must be maintained during the period of accreditation and agree to notify the NCCHC in writing of any substantive change in the management of the health care program within 30 days of such occurrence. We understand that this application constitutes a contract for services, including annual enrollment in the NCCHC accreditation program. We will submit Annual Maintenance Reports and be billed annually for approximately half the initial accreditation cost. We further understand that a site visit will take place at least once every three years and that the facility may terminate enrollment in the NCCHC accreditation program at any time upon 60 days written notice.

Signature of Person Legally Responsible

Date

Name and Title (Printed or typed)

Note: A check or voucher for \$250.00, payable to the National Commission on Correctional Health Care, should accompany this application. This amount will be applied to the full accreditation charge, with the balance due at the time of the site survey. In the event of cancellation of this application for accreditation, we agree to be responsible for any travel expense incurred by NCCHC in the scheduling of the on-site visit.

C h e c k enclosed C h e c k to follow under separate cover

B i l l i n g/invoice required to process check.

FACILITY INFORMATION

1. _____
Name of Facility
2. _____
Mailing Address
3. _____
City State ZIP
4. _____ 5. Is this a multi-jurisdictional facility? _____
Year facility was constructed
6. If #5 is yes, which jurisdictions (i.e., counties) do you draw from?

7. Major Renovations/Expansions (completed and planned):

Name	Design-rated Capacity	Most Recent Population	Number of Correctional Officers
8. Main Unit: _____	_____	_____	_____
Satellite #1: _____ Miles from Main Unit _____	_____	_____	_____
Satellite #2: _____ Miles from Main Unit _____	_____	_____	_____
Satellite #3: _____ Miles from Main Unit _____	_____	_____	_____
Satellite #4: _____ Miles from Main Unit _____	_____	_____	_____

NOTE: a satellite is defined as a separate building where inmates are housed that does not have clinical facilities in the building nor a full-time, onsite responsible physician.

BILLING INFORMATION

9. Invoices for accreditation should be sent to the following:

Name		Title
Address		
City	State	Zip Code

PERSONNEL INFORMATION

10. _____ (_____) _____
Government official responsible for the facility Telephone Number
11. _____ (_____) _____
Name of physician responsible for medical care Telephone Number
12. _____ (_____) _____
Name of health administrator/supervisor Telephone Number

INMATE DATA

13. Total number of admissions in the prior year (or most recent 12-month period available) for main and satellite units: _____
14. Average daily intake: _____
15. Most recent population for the entire facility (main and satellite units):
- | | |
|---------------------|------------------------|
| _____ Adult Males | _____ Juvenile Males |
| _____ Adult Females | _____ Juvenile Females |
16. Inmate/Resident length of stay (in percentages):
- | <u>Jails/Juvenile Detention</u> | <u>Prisons/Juvenile Correctional</u> |
|---------------------------------|--------------------------------------|
| _____ % 0 - 24 hours | _____ % 1 - 30 days |
| _____ % 1 - 7 days | _____ % 31 - 90 days |
| _____ % 8 - 14 days | _____ % 91 - 180 days |
| _____ % 15 - 30 days | _____ % 181 - 365 days |
| _____ % 31 - 90 days | _____ % 1 - 3 years |
| _____ % 91+ days | _____ % 3+ years |
| 100% Total | 100% Total |
17. Is housing provided for any inmates other than those from this jurisdiction? _____
If yes, what is the average daily population for non-jurisdictional inmates?
Federal/State Prisoners _____ Other counties _____ Other states _____

HEALTH CARE SERVICES DATA

18. Number of health providers on-site:

<u>Full-time Equivalents*</u>	<u>#1</u>	<u>Satellites</u>		<u>#4</u>
		<u>#2</u>	<u>#3</u>	
Administrators _____	_____	_____		
Physicians _____	_____	_____	_____	
Physician Assistants _____		_____		_____
Nurse Practitioners _____				
Registered Nurses _____				_____
Licensed Practical Nurses _____				
EMTs/MAs _____				_____
Psychologists _____			_____	
Psychiatrists _____			_____	
Dentists _____	_____		_____	
Dental Assistants _____		_____		_____
Dental Hygienists _____			_____	
Health Records Personnel _____	_____			
X-Ray Technicians _____	_____	_____	_____	
Lab Technicians _____	_____	_____	_____	
Pharmacists/pharm techs _____	_____		_____	_____
Mental health workers _____	_____	_____	_____	
Other (please specify) _____			_____	

*Someone working only Saturday and Sunday would be 0.40 FTE's (16/40=0.40)

19. Type and number of hours per month of off-site health consultants (e.g., dentist or orthopedist, 10 hours). _____

20. Does the facility operate an infirmary? If yes, total number of beds: _____

Medical: Male _____ Female _____
 Mental health: Male _____ Female _____

21. Is there a forensic unit (separate housing available for mental health prisoners)? _____
 If yes, number of beds: _____

22. Are health services contracted? (Yes/No) _____
 If yes, give name of contractor and expiration date of current contract:

23. Community hospital(s), clinic(s), and/or other health care facilities used for in-patient, mental health or emergency services provided outside the facility:

24. Are there any plans to make substantial changes in the health care delivery system at the facility? If so, please describe:

25. Is the facility currently involved in any (Yes/No):

___ A. Legal action alleging inadequate medical or other health care for inmates?

If yes, when was the action filed? _____

Please (1) submit summary information about the case(s); and, (2) furnish a copy of any judgement, order or decree entered by the court, and all master, monitor or facility reports filed in the last twenty-four (24) months pursuant to such order, judgement, or decree. If no reports have been issued within the last twenty-four months, please provide a copy of the last such substantive report issues.

Summary description: _____

B. Action by a community, government, or quasi-government/public agency or group to review, investigate, or look into health services provided at the facility? If yes, please state the name of the group and describe its purpose. If any reports have been issued by this group, please provide a copy with your application.

26. For the current fiscal year, what is your total annual health services budget_____?

% for medical services_____

% for mental health services_____

% for dental services_____

% for medications_____

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature

Date

Accreditation Annual Maintenance Report

The National Commission on Correctional Health Care (NCCHC) requires that an Annual Maintenance Report (AMR) be submitted. The AMR contains information that is needed to determine continued compliance with NCCHC standards for maintenance of your accreditation status.

Instructions

Please complete (type or print) this form and return to NCCHC within 30 days of receipt. Answer all questions as completely as possible. Where the question contains "*last report*," reference is made to your last AMR, or to NCCHC's Accreditation Report following the most recent on-site survey. Where the question contains "*last calendar year*," reference is made to the period January 1 to December 31 of the current year. If more space is required to answer any question, please attach additional pages.

The report should be signed by the person legally responsible for the facility and the health services administrator. If the information on the following page is incorrect, please cross-out and provide corrected information on the appropriate lines.

Definitions

ADP - Average Daily Population

AMR - Annual Maintenance Report

CO - Correctional Officer or youth counselor - A person who is not primarily a health care provider and who has security and oversight duties.

Infirmary - An infirmary is an area established within the confinement facility in which organized bed care facilities and services are maintained and operated to accommodate two or more patients, and which is operated for the expressed or implied purpose of providing skilled nursing care for persons who are not in need of hospitalization.

Satellite Unit - A satellite is a facility that is dependent and subordinate to a main facility. A satellite unit meets all of the following conditions:

- programs and services provided at the satellite originate and are controlled by the main unit's administrative body;
- policies and procedures of the main unit address specific issues to the health care services provided at the satellite;
- nursing services are limited to no more than 40 hours per week;
- physician held clinics may be conducted at the satellite;
- a satellite does not have an infirmary;
- the responsible health authority, who does not have an office on-site, provides supervision and evaluation of the satellite's health staff; and
- all complex procedures and treatments are performed at other sites (e.g., the main health unit or a hospital).

Final determination of satellite status will be made by NCCHC upon review.

National Commission on Correctional Health Care
Annual Maintenance Report

10/95

FACILITY INFORMATION

Facility name _____

Address _____

City _____ State _____ Z i p _____

Type of Facility _____

Official legally responsible for the facility _____ (area code) Phone number _____

Person responsible for the day to day administration of the facility, if different from above. _____

Health services administrator _____ (area code) Phone number _____

Responsible physician _____ (area code) Phone number _____

Dentist _____ (area code) Phone number _____

Pharmacist _____ (area code) Phone number _____

Psychiatrist _____ (area code) Phone number _____

Person who should receive official notification of accreditation matters _____

Hospital contracted for chronic care _____

Address _____

Contact _____

(area code) Phone number _____

Hospital contracted for emergency care _____

Address _____

Contact _____

(area code) Phone number _____

Laboratory contracted for health services _____

Address _____

Contact _____

(area code) Phone number _____

SATELLITE UNITS

NOTE: Please refer to instruction page for definition of a satellite unit. Please use additional pages if necessary.

Number of satellites _____

Name of Satellites	1995 ADP	Today's Population
_____	_____	_____
_____	_____	_____

POPULATION

Average Daily Population (ADP) combined for satellites and main facility for the last calendar year _____

Today's total population for satellites and main facility combined _____

Last calendar year's total admissions for satellites and main facility combined _____

Break down of today's total population

_____ Adult Males # _____ Juvenile Males

_____ Adult Females # _____ Juvenile Females

CONTRACTED SERVICES

1. Is health care service contracted through a corporation? _____

If yes, name of contractor _____

Contact person _____ (area code) phone number

2. Does the facility operate an infirmary? _____ If yes, how many beds? _____

NOTE: If the infirmary is new (since the *last* report), attach a copy of the policy/procedures regarding infirmary care.

STAFFING

3. Percentage of COs current in CPR training _____%

4. Percentage of COs current in First Aid training _____%

5. Is there a CO who is current in both CPR and First Aid training on each shift? _____

6. Since the *last* report, have all health professionals received in-service training that would enable them to meet the 12 hours of continuing education requirement cited in Standard P/J-23, Y-21? _____
If no, please explain what steps, if any, are being taken to remedy the situation.

QUALITY IMPROVEMENT

7. How many charts does the responsible physician review monthly? _____ If facility has a Quality improvement committee, please attach minutes of the last two meetings.
8. Are 100% of the health assessments completed within the time frame set by NCCHC standards (seven days for prisons, 14 days for jails, and 14 days for juveniles facilities)? _____ If no, indicate the approximate percentage of health assessments that are delayed after the allotted period

From 1 to 5 days late _____% From 15 to 30 days late _____%

From 6 to 14 days late _____% More than 30 days late _____%

Please explain why there are delays as well as what steps, if any, are being taken to remedy the delay in the health assessments.

HEALTH SERVICES PROFILE

9. a) Since the last report, has there been any change in the sick call process? _____
If yes, please describe and attach relevant documentation.

b) How often are sick call requests triaged? _____

c) How long after making a medical request will an inmate see or receive a response from a health professional (in 95% of the cases)?

within 24 hours 24 - 48 hours 48 - 72 hours over 72 hours

d) How long after referral to a physician will it take to be seen (in 95% of the cases)?

within 24 hours 24 - 48 hours 48 - 72 hours over 72 hours

e) Please estimate the number of sick call requests that have been received over the last calendar year.

How many sick call visits did the physician conduct during the last calendar year? _____

10. Since the last report, has there been any occasion when security has overruled a medical decision?
_____ If yes, please explain. _____

11. Since the *last report* has there been any change in the management of pharmaceuticals? _____
If yes, please describe. _____

12. Since the last report, has there been any change in the arrangements or procedures for emergency service?
_____ If yes, please describe. _____

13. Since the *last report*, has there been any change in the delivery of dental care? If yes, please describe. _____

14. Since the *last report*, has there been any change in the delivery of mental health care? _____
If yes, please describe. _____

15. Since the *last report*, has there been any change in the charting or maintenance of medical records?
_____ If yes, please describe.

16. Since the *last report*:

- a) Has there been any legal action against the facility, its officials or staff alleging inadequate medical or other health care for prisoner(s) or detainee(s)? _____ If yes, please attach a copy of complaint.
- b) Has a court entered a new or amendatory order, judgement, or decree (other than procedural), that relates to health services? _____ If yes, please attach a copy.
- c) Has there been a Master or Monitor appointed to carry out a court order with respect to health services? _____ If yes, please attach a copy of the most recent report.
- d) Is the facility (or system) being required to do its own reporting to the court regarding follow-up on the court's order? _____ If yes, please attach a copy of the most recent report.

17. Is the health portion of the disaster drill rehearsed at least annually? _____ Please attach a report or critique of the last practiced disaster drill.

18. Have there been any inmate deaths since the *last report*? _____ If yes, please indicate on a separate page the number of deaths, their dates, and their causes.

ADMINISTRATION

19. Are administrative meetings with the health authority and the official legally responsible for the facility held at least quarterly? _____ Please attach a copy of the most recent administrative meeting minutes.

20. How often are health services staff meetings held? _____ Are minutes kept? _____
If yes, please attach a copy of the most recent health staff meeting minutes.

21. Is the policy/procedure manual revised and reviewed at least annually and approved by the health authority? _____ Please provide a signed copy of the cover page that indicates current annual review of the facility's policy manual. Also provide a brief summary statement on any policies and/or procedures that have been revised since the last *report*.

22. Are statistical reports on the utilization of health services kept? _____ If yes, please attach a copy of the most recent statistical report.

OTHER STATISTICAL DATA

The following information will be used primarily for national statistical tracking purposes. The information will be kept confidential. Data, if used by the NCCHC for reporting purposes, will be cumulative and not specific to any jail, prison or juvenile facility. Data requested are for the last calendar year.

23. Does the facility have a provision in its policy and procedure manual that addresses charging inmates a fee for health services? _____ If yes, please attach a copy of the policy.

24. If applicable, how many females in your facility have given birth within the last calendar year?

TUBERCULOSIS

25. Are inmates tested upon admission for tuberculosis? _____ If yes, which ones?

- All inmates High-risk inmates Inmates w/symptoms Inmates who request it

26. Are inmates retested annually for TB? _____ If yes, which ones?
 All inmates High-risk inmates Inmates w/symptoms Inmates who request it
 What type of test is provided:
 PPD/Mantoux Chest X-ray Tine Test Other
27. a) How many cases of TB infection were found during the last year? _____
 b) How many cases of active TB were found during the last year? _____
28. Have there been any cases of multiple drug-resistant tuberculosis? _____
 If yes, how many? _____
29. Where are inmates with TB housed?
 General Population Infirmary Segregation Other
 If "Other", please list where. _____

HIV - AIDS

30. Are inmates tested for HIV? _____ If yes, which ones?
 All inmates High-risk inmates Inmates w/symptoms Inmates who request it
31. a) How many total HIV tests were administered in the last year? _____
 b) How many cases of inmates with HIV were detected in the last year? _____
 c) How many cases of inmates with AIDS were there in the last year? _____
32. Where are inmates with AIDS housed?
 General Population Infirmary Segregation Other
 If "Other", please list where _____

SEXUALLY TRANSMITTED DISEASES

33. Please report the detected number of cases of the following diseases during the last year.

Chlamydia _____
 Gonorrhea _____
 Hepatitis B _____
 Syphilis _____

34. For the current fiscal year, what is your total annual health services budget? \$ _____
- | | |
|---|-------------|
| Percentage of total budget for medical services | _____ % |
| Percentage of total budget for mental health services | _____ % |
| Percentage of total budget for dental services | _____ % |
| Percentage of total budget for medications | _____ % |
| Other | _____ % |
| Total | _____ 100 % |

Check the items included in this budget

- capital items new construction CI equipment supplies personnel
 accreditation travel/conferences

35. Please complete the following chart. Provide the number of employees (FTEs) as well as the starting and maximum salaries for each position.

Staff	FTE*	Minimum Salary	Maximum Salary
Administrators			
Physicians			
Physician Assistants			
Nurse Practitioners			
Registered Nurses			
Licensed Practical Nurses			
Emergency Medical Technicians			
Medical Assistants			
Psychologists			
Psychiatrists			
Dentists			
Dental Assistants			
Health Records Personnel			
X-Ray Technicians			
Lab Technicians			
Pharmacists/pharm techs			
Mental health workers			
Other (please specify)			

*FTE is an abbreviation for full-time equivalent. For example, one person, working full time, five days a week is 1 .0 FTE; one person working half-time is 0.5 FTE; and 2 people working three quarter time is 1.5 FTE.

SIGNATURES

Name of person completing report (please print) _____
Phone number

Signature of the person legally responsible for facility _____
Date

Signature of the health services administrator _____
Date

AMR COMPLETION CHECK LIST

- All pages of the AMR have been completed.
- A copy of the minutes from the last two quality improvement committee meetings is enclosed, if applicable. (see page 3)
- Report or critique of the last disaster drill is enclosed. (see page 5)
- A copy of the minutes from the most recent administrative meeting is enclosed. (see page 5)
- A copy of the minutes from the most recent health staff meeting is enclosed. (see page 5)
- The signed cover page of the most recent policy and procedure manual is enclosed. (see page 5)
- Other appropriate documentation is enclosed.
- All required signatures are present.

Return to:

Accreditation Department
National Commission on Correctional Health Care
2105 N. Southport
Chicago, IL 60614

THANK YOU

GLOSSARY

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

ADMINISTRATIVE MEETINGS are held at least quarterly between the health authority and the official legally responsible for the facility, or their designees. At these meetings, problems are identified and solutions sought.

ALCOHOL DETOXIFICATION: See **DETOXIFICATION**.

The **ANNUAL STATISTICAL REPORT** should indicate the number of juveniles receiving health services by category as well as other pertinent information (e.g., operative procedures, referrals to specialists, ambulance services).

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

CHRONIC CARE is medical service rendered to a patient over an extended period of time to assist in recovery from illness or injury.

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

COMMUNICABLE DISEASES are those diseases capable of being transmitted from one person or species to another.

CONVALESCENT CARE is medical service rendered to a patient to assist in recovery from illness or injury.

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

The **DENTAL EXAMINATION** should include the taking or review of the patient's dental history; charting of teeth; examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer, and adequate illumination; and x-rays if needed for diagnosis.

DENTAL SCREENING, a part of the initial health appraisal, includes visual observation of the teeth and gums.

DETOXIFICATION refers to the process by which an individual is gradually withdrawn from a drug by the administration of decreasing doses of the drug upon which the person is physiologically dependent, one that is cross-tolerant to it, or a drug that has been demonstrated to be effective on the basis of medical research.

DISASTER PLAN, HEALTH ASPECTS OF: Health aspects of the disaster plan, among other items, include the triaging process, outlining where care can be provided, and laying out a back-up plan.

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

DISTRIBUTION OF MEDICATION is the system of delivery and storage of and accounting for drugs from the source of supply to the nursing station or the point at which they are administered to the patient.

DISPOSAL OF MEDICATION refers to the destruction of the patient's medication upon his/her discharge from the facility or discontinuation of the medication, the return of the sealed, unused packaged medication to the pharmacy, or the provision of the discharged patient with the medication, in line with the principle of continuity of care.

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

DRUG DETOXIFICATION: See **DETOXIFICATION**.

ECTOPARASITES are organisms (such as lice) that infest human skin.

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

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

A **HEALTH ADMINISTRATOR** is a person who by education (RN, MPH, MHA, or a related discipline) is capable of assuming responsibility for arranging for all levels of health care and ensuring quality and accessibility of all services provided to juveniles.

The **HEALTH APPRAISAL** is the process whereby the health status of an individual is evaluated. The extent of the health appraisal, including medical examination, is defined by the responsible physician, but includes at least the items noted in standard Y-33.

The **HEALTH AUTHORITY** is the individual delegated the responsibility for the facility's health care services, including arrangements for all levels of health care and the ensuring of quality and accessibility for all health services provided to juveniles.

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

HEALTH-TRAINED STAFF are personnel without health care licenses who are trained in limited aspects of health care, as determined by the responsible physician.

HOSPITAL CARE is the in-patient care for an illness or diagnosis that requires observation and/or management in a licensed hospital.

INFIRMARY is an area established within the confinement facility in which organized bed care facilities and services are maintained and operated to accommodate two or more patients for a period of 24 hours or more, and which is operated for the expressed or implied purpose of providing skilled nursing care for persons who are not in need of hospitalization.

INFIRMARY CARE is defined as in-patient bed care by or under the supervision of a registered nurse for an illness or diagnosis that requires limited observation and/or management but does not require admission to a licensed hospital.

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

INITIAL HEALTH SCREENING: See RECEIVING SCREENING.

INTERNAL QUALITY ASSURANCE: See MONITORING OF SERVICES.

LARGE-MUSCLE ACTIVITY includes those activities involving large-muscle groups such as walking, jogging in place, basketball, ping-pong, and isometrics.

MEDICAL PREVENTIVE MAINTENANCE: See PREVENTIVE MAINTENANCE.

MEDICAL RESTRAINTS: See RESTRAINTS.

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

MONITORING OF SERVICES is the process for ensuring that high-quality health care services are being rendered in the facility by all providers. The monitoring is accomplished by on-site observation and review (e.g., study of juveniles' complaints about care; review of health records, pharmaceutical processes, standing orders, and performance of care). This process is also referred to as INTERNAL QUALITY ASSURANCE.

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

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

ORTHOTICS: see **PROSTHESES**

PLANNED, SUPERVISED BASIS (for exercise). Facilities meet compliance of exercise on a “planned, supervised basis” under the following conditions. It is recognized that many facilities do not have a separate facility or room for exercising. The dayroom adjacent to the living area may be used for this purpose, and meets compliance if planned, programmed activities are directly supervised by staff and/or trained volunteers. Television and table games do not meet compliance. Regarding the use of outside yards, gymnasias, and multi-purpose rooms, making available opportunities for exercise (e.g., basketball, handball, jogging, running, and calisthenics) satisfies compliance even if juveniles do not take advantage of these opportunities.

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

PROCUREMENT OF MEDICATION is the system for ordering medication for the pharmacy.

PROSTHESES are artificial devices to replace missing body parts. Examples are items such as artificial limbs, an eye, or a heart valve. Orthotics are specialized mechanical devices to support or supplement weakened or abnormal joints or limbs. Examples are items such as hip pins, braces, or eyeglasses.

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

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

QUALITY ASSURANCE COMMITTEE is a group of health providers working at the facility (the responsible physician and representatives of other departments) who meet on a fixed schedule to monitor and evaluate the health care services provided.

QUALITY ASSURANCE PROGRAMS ensure the quality and consistency of the health services provided in the facility, usually through periodic review of patients’ charts.

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

RESPONSIBLE PHYSICIAN is an individual physician who is responsible for the final decisions regarding matters of medical judgement at the facility.

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

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

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

SKILLED NURSING CARE: See INFIRMARY CARE.

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

STANDING MEDICAL ORDERS are pre-established written plans for the definitive treatment of persons with identified or emergency medical conditions to which the orders pertain. They specify the same course of treatment for each patient suspected of having a given condition.

SUPERVISION is defined as the overseeing of an accomplishment of a function or activity.

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

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

VIOLENCE RISK ASSESSMENT consists of questions to determine if a juvenile has a violent history should be obtained from each juvenile upon intake. Such questions would include child and domestic abuse, sexual abuse, and any personal victimization. All juveniles with violent histories, including those who exhibit violent behaviors that place the safety of themselves or others in jeopardy, should be referred to treatment by appropriately trained health care providers. Treatment should not consist of only placing the juvenile on medication, but should take a balanced biopsychosocial approach to the treatment of violence.

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National Commission on Correctional Health Care
2105 N. Southport, Chicago, IL 60614-4017
(312) 528-0818

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