POLICY STATEMENT
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject:		Policy Number:
Access to Health Care		**13.2.1**
Date of Issue:	**Authority:**	**Effective Date:**
August 3, 2020	**Signature on File** **John E. Wetzel**	**August 10, 2020**

I. AUTHORITY

The authority of the Secretary of Corrections to direct the operation of the Department of Corrections is established by Sections 201, 206, 506, and 901-B of the Administrative Code of 1929, 71 P.S. §§61, 66, 186, and 310-1, Act of April 9, 1929, P.L. 177, No. 175, as amended.

II. PURPOSE

This policy establishes procedures by which the Department of Corrections and medical vendor staff can ensure that all inmates have access to health care and provide professional health care services that comply with Department policies and procedures, ACA standards, and applicable laws.[1]

III. APPLICABILITY

This policy is applicable to all staff, inmates, and contract staff at facilities under the jurisdiction of the Department.

IV. DEFINITIONS

All pertinent definitions are contained in the procedures manual for this policy.

[1] 5-6A-4376 (5-ACI-6A-41)

V. POLICY

It is the policy of the Department to ensure that every inmate has access to health care that includes, but is not limited to, inmate health care, initial intake screening and medical clearance for transfer, physical examinations, dental services, corrective eyewear, access to emergency care, inpatient unit medical procedures, communicable diseases and infection control, medical management of inmates with terminal conditions, medical orders for special items, review of diagnostic, pharmacy guidelines, management of pregnant inmates, nursing protocols, direct observation therapy, and quality improvement.[2]

VI. PROCEDURES

All pertinent procedures are contained in the procedures manual for this policy.

VII. SUSPENSION DURING EMERGENCY

In an emergency or extended disruption of normal facility operation, the Secretary/ designee may suspend any provision or section of this policy for a specified period.

VIII. RIGHTS UNDER THIS POLICY

This policy does not create rights in any person nor should it be interpreted or applied in such a manner as to abridge the rights of any individual. This policy should be interpreted to have sufficient flexibility to be consistent with law and to permit the accomplishment of the purpose of the policies of the Department.

IX. RELEASE OF INFORMATION AN DISSEMINATION OF POLICY

A. Release of Information

1. Policy

   This policy document is public information and may be released upon request.

2. Procedures Manual (if applicable)

   The procedures manual for this policy is <u>not public information</u> and shall not be released in its entirety or in part, without the prior approval of the Secretary/ designee. This manual or parts thereof may be released to any Department employee on an as needed basis.

B. Distribution of Policy

1. General Distribution

   The Department's policy and procedures manuals (when applicable) shall be distributed to the members of the Central Office Executive Staff, all Facility

[2] 5-3D-4281 (5-ACI-3D-08)

Managers, and Community Corrections Regional Directors on a routine basis. Distribution to other individuals and/or agencies is subject to the approval of the Secretary/designee.

2. Distribution to Staff

It is the responsibility of those individuals receiving policies and procedures, as indicated in the “General Distribution“ section above, to ensure that each employee expected or required to perform the necessary procedures/duties is issued a copy of the policy and procedure.

X. SUPERSEDED POLICY AND CROSS REFERENCE

A. Superseded Policy Statement

1. Department Policy Statement

13.2.1, issued May 7, 2019, by Secretary John E. Wetzel.

2. Facility Policy

This policy supersedes all facility policy on this subject.

B. Cross References

1. Administrative Manuals

a. 4.1.1, Human Resources and Labor Relations
b. 5.1.1, Staff Development and Training
c. 6.3.1, Facility Security
d. 6.5.1, Administration of Security Level 5 Housing Units
e. 6.7.1, Incident Command System
f. 6.7.2, Special Response Teams
g. 11.2.1, Reception and Classification
h. 11.4.1, Case Summary
i. 13.1.1, Management and Administration of Health Care
j. 13.8.1, Access to Mental Health Care
k. 15.1.1, Safety
l. DC-ADM 003, Release of Information
m. DC-ADM 006, Reasonable Accommodations for Inmates with Disabilities
n. DC-ADM 008, Prison Rape Elimination Act (PREA)
o. DC-ADM 201, Use of Force
p. DC-ADM 801, Inmate Discipline
q. DC-ADM 802, Administrative Custody Procedures
r. DC-ADM 804, Inmate Grievance System
s. DC-ADM 812, Inmate Visiting Privileges
t. DC-ADM 820, Co-Payment for Medical Services

2. ACA Cross References

   a. Administration of Correctional Agencies: 2-CO-3B-02

   b. Adult Correctional Institutions: 5-4B-0029 (formerly 4-4370; 5-ACI-4B-28), 5-1C-4062 (5-ACI-1C-15), 5-1E-4099 (5-ACI-1E-05), 5-2C-4144 (5-ACI-2C-13), 5-3B-4215 (5-ACI-3B-05), 5-3B-4220 (5-ACI-3B-10), 5-3D-4281 (5-ACI-3D-08), 5-3D-4281-1 (5-ACI-3D-09), 5-3D-4281-2 (5-ACI-3D-10), 5-3D-4281-4 (5-ACI-3D-12), 5-3D-4281-5 (5-ACI-3D-13), 5-5A-4285 (5-ACI-5A-01), 5-5A-4288 (5-ACI-5A-04), 5-5C-4322 (5-ACI-5C-11), 5-6A-4344 (5-ACI-6A-01), 5-6A-4345 (5-ACI-6A-02), 5-6A-4346 (5-ACI-6A-03), 5-6A-4347 (5-ACI-6A-04), 5-6A-4348 (5-ACI-6A-05), 5-6A-4349 (5-ACI-6A-06), 5-6A-4350 (5-ACI-6A-07), 5-6A-4351 (5-ACI-6A-08), 5-6A-4352 (5-ACI-6A-09), 5-6A-4353 (5-ACI-6A-10), 5-6A-4354 (5-ACI-6A-12), 5-6A-4355 (5-ACI-6A-14), 5-6A-4356 (5-ACI-6A-15), 5-6A-4357 (5-ACI-6A-16), 5-6A-4358 (5-ACI-6A-17), 5-6A-4359 (5-ACI-6A-18), 5-6A-4360 (5-ACI-6A-19), 5-6A-4361 (5-ACI-6A-20), 5-6A-4362 (5-ACI-6A-21), 5-6A-4363 (5-ACI-6A-22), 5-6A-4363-1 (5-ACI-6A-23), 5-6A-4364 (5-ACI-6A-24), 5-6A-4365 (5-ACI-6A-25), 5-6A-4367 (5-ACI-6A-27), 5-6A-4368 (5-ACI-6A-28), 5-6A-4370 (5-ACI-6A-31), 5-6A-4371 (5-ACI-6A-32), 5-6A-4375 (5-ACI-6A-40), 5-6A-4376 (5-ACI-6A-41), 5-6A-4377 (5-ACI-6A-42), 5-6A-4378 (5-ACI-6A-43), 5-6A-4379 (5-ACI-6A-44), 5-6B-4381 (5-ACI-6B-02), 5-6B-4386 (5-ACI-6B-05), 5-6B-4387 (5-ACI-6B-06), 5-6B-4389 (5-ACI-6B-08), 5-6B-4390 (5-ACI-6B-09), 5-6B-4393 (5-ACI-6B-12), 5-6C-4394 (5-ACI-6C-01), 5-6C-4396 (5-ACI-6C-03), 5-6C-4397 (5-ACI-6C-04), 5-6C-4398 (5-ACI-6C-05), 5-4A-4400 (5-ACI-4A-01), 5-6C-4403 (5-ACI-6C-10), 5-6D-4411 (5-ACI-6D-03), 5-6D-4413 (5-ACI-6D-05), 5-6D-4414 (5-ACI-6D-06), 5-6D-4424 (5-ACI-6D-10), 5-2A-4427 (5-ACI-2A-03), 5-5E-4436 (5-ACI-5E-10), 5-5F-4446 (5-ACI-5F-05)

   c. Adult Community Residential Services: 4-ACRS-4C-03, 4-ACRS-4C-04, 4-ACRS-4C-05, 4-ACRS-4C-07, 4-ACRS-4C-08, 4-ACRS-4C-09, 4-ACRS-4C-10, 4-ACRS-4C-14, 4-ACRS-4C-15, 4-ACRS-4C-17, 4-ACRS-4C-21, 4-ACRS-4C-24, 4-ACRS-5A-02

   d. Correctional Training Academies: 1-CTA-3A-19, 1-CTA-3E-05, 1-CTA-3F-01, 1-CTA-3F-02, 1-CTA-3F-03, 1-CTA-3F-04

3. Others

   a. Federal Bureau of Prisons Clinical Practice Guidelines, October 2015, Management of Tuberculosis.

   b. Morbidity and Mortality Weekly Report – December 30, 2005/Volume 54/No. RR-17, Guidelines for Preventing the Transmission of mycobacterium tuberculosis via Health-Care Settings, 2005, Department of Health and Human Services, Centers for Disease Control and Prevention.

PROCEDURES MANUAL
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject:		Policy Number:
Access to Health Care		**13.2.1**
Date of Issue:	**Authority:**	**Effective Date:**
August 3, 2020	**Signature on File** **John E. Wetzel**	**August 10, 2020**

Release of Information:

Policy Document: The Department of Corrections policy document on this subject is public information and may be released upon request.

Procedures Manual: This Procedures Manual is **not public information** and **will not be released** in its entirety or in part, without the prior approval of the Secretary/designee. This manual or parts thereof may be released to any Department employee on an as needed basis.

Procedure Development: All required procedures will be developed in compliance with the standards set forth in this manual and/or the governing policy. These standards may be exceeded, but in all cases these standards are the minimum standard that must be achieved. In the event a deviation or variance is required, a written request is to be submitted to the appropriate Executive Deputy Secretary/Regional Deputy Secretary and the Bureau of Standards, Audits, Assessments, and Compliance for review and approval prior to implementation. Absent such approval, all procedures set forth in this manual must be met.

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BULLETIN
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject: **Access to Health Care Procedures Manual Section 1 – Inmate Health Care Plan**		
Policy Number: **13.2.1, Section 01-1**		
Original Issue Date: **October 9, 2012**		
Date of Issue: **June 29, 2015**	**Authority:** **Signature on File** **John E. Wetzel**	**Effective Date:** **July 9, 2015**

The purpose of this bulletin is to update **Subsection C. Non-Provided Medical Services** of Department policy **13.2.1, "Access to Health Care." The below listed language in red has been DELETED**:

Subsection C.3.

3. sexual reassignment surgery and related treatment. If an inmate has commenced a course of treatment for reassignment prior to incarceration, a contracted Health Care Provider will evaluate him/her and limited medically necessary treatment may be administered to prevent complications associated with reassignment. This limited treatment will not include surgery;

Subsection C.11.

11. mammoplasties performed for augmentation or prosthetic implants;

Subsection C.17.

17. bone growth stimulator, unless for long bones;

Subsection C. Non-Provided Medical Services shall now read:

Medical services not provided by the Department include, but are not limited to, the following:

1. cosmetic surgery or services;

2. extraordinary medical expenses for infants beyond routine newborn care – refer to **Section 13** of this procedures manual;

3. sterilization (including castration);

4. investigation of or treatment for infertility, reversal of sterilization, artificial insemination or in-vitro fertilization;

5. refractive eye surgery;

6. penile prosthesis;

7. pharmaceuticals used for non-FDA approved conditions unless the guidelines in **Subsection A.6.u. above** are met;

8. biofeedback and acupuncture;

9. weight reduction programs, unless medically necessary;

10. mammoplasties performed for augmentation;

11. surgical or dental procedures to correct congenital or developmental malformations, unless medically/psychiatrically necessary;

12. chiropractic or naturopathic services;

13. treatment of impotence;

14. dental cosmetic procedures;

15. gold dental restorations;

16. special footwear that is not medically necessary;

17. sperm/egg donation; and

18. other fertility tests/treatment.

Section 1 – Inmate Health Care Plan

A. Provided Medical/Mental Health/Dental Services

The following list of medical/mental health/dental services shall be routinely available to every inmate of the Department. Health care encounters, including medical and mental health interviews, examinations, and procedures, shall be conducted in a setting that respects the inmate's privacy. A female inmate shall be provided a female escort for encounters with a male health care provider.[1]

1. Medically Necessary Care

2. Emergency Services[2]

   a. Every inmate shall have access to regular and specialized medical, mental health, dental services, and emergency health care service on a seven day a week, 24-hour basis.[3]

   b. Corrections officers and other contact staff shall be trained in accordance with Department policy **5.1.1, "Staff Development and Training"** in the following areas:[4]

      (1) response to health-related situations, within four minutes upon notification/realization of the emergency;

      (2) recognition of the signs and symptoms, and knowledge of action required in potential emergency situations;

      (3) administration of first aid;

      (4) certification in cardiopulmonary resuscitation (CPR) in accordance with the recommendations of the certifying health organization;[5]

      (5) methods of obtaining assistance (summoning help);

      (6) signs and symptoms of mental illness, retardation, and chemical dependency;

      (7) procedures for inmate escorts/transfers to appropriate medical facilities, or facilities and/or health care providers; and

      (8) suicide prevention.

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[1] 4-4403
[2] 4-ACRS-4C-03, 4-ACRS-4C-04, 1-CTA-3F-01, 1-CTA-3F-02, 1-CTA-3A-19
[3] 4-4348, 4-4351
[4] 4-4351, 4-4389, 1-CTA-3A-19
[5] 1-CTA-3F-02

3. Intake Health Screening in accordance with **Section 2, Initial Intake and Screening and Medical Clearance for Transfer and Physical Exams** in accordance with **Section 3, Physical Examinations** of this procedures manual

4. In-patient Care in accordance with **Section 7, Inpatient Unit Medical Procedures** of this procedures manual

5. Out-patient Care in accordance with **Subsection A. 8. below**.

6. Specialty Services

   The following procedures concerning access to specialty services and consultations will be performed in accordance with Department policy **13.1.1, "Management and Administration of Health Care," Section 2** of the **Medical Records User Manual**.

   a. The **DC-441, Consultation Record (Attachment 1-A, Part A**) will be completed by the practitioner and then reviewed by the Site Medical Director/designee.

   b. After initial completion of the **DC-441**, the pink carbon copy will be separated from the original and placed under the Consultation divider in the medical record. This serves as an indicator in the chart that the consultation was written and is being processed.

   c. The entire utilization review process will be completed within seven working days from the date the consultation/service was ordered.

   d. Depending on the type of service or procedure requested, it may be approved immediately by the Site Medical Director/designee per the **Services and Procedures Approved via Protocol (Attachment 1-B)**.

   e. This is then forwarded to the Contracted Health Care Provider's case management department where an authorization number will be generated and returned to the site according to the **Specialty Services Request and Pre-Authorization Flow Sheet (Attachment 1-C)**.

   f. Upon receipt of the authorization number, the Contracted Health Care Provider's clinical coordinator will place the authorization information on the original **DC-441** and the yellow carbon.

   g. A service or procedure may be requested that cannot be approved per protocol, but instead necessitates review by the Regional Medical Director or State Medical Director (outpatient surgery, MRI, PET scan, scheduled admissions and others). His/Her utilization review recommendation may consist of:

      (1) approval;

      (2) more information requested; and

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(3) alternate treatment plan recommended as outlined in the **Specialty Services Request and Pre-Authorization Flow Sheet**.

h. Additional information requested and transmitted back and forth will be attached to the **DC-441** before it is filed in the medical record.

i. Every area on the **DC-441** must be thoroughly and legibly documented in order to ascertain timely/appropriate access to care.

j. In the event the Site Medical Director does not agree with a utilization review decision, the appeals process will be used in accordance with the **Specialty Services Request and Pre-Authorization Flow Sheet**.

k. The Contracted Health Care Provider's clinical coordinator at each site is required to keep an accurate up-to-date, electronic tracking tool using the **Specialty Service Request Tracking Log (Attachment 1-D)** to monitor Specialty Service Requests, including both off-site and on-site services.

l. This tracking tool, as well as monthly statewide summaries of utilization information, will be provided to the facility Corrections Health Care Administrator (CHCA) and the Bureau of Health Care Services (BHCS) Utilization Review Department by the tenth of each month.

m. The monthly **Specialty Service Request Tracking Log** will be reviewed at each facility's monthly Quality Improvement (QI) meeting. Timeliness of services provided and review of inception and effectiveness of alternate treatment plans will be discussed and incorporated into the QI meeting minutes.

n. Specialty Consultations

(1) The vendor will be required to complete the diagnostic process and begin initial treatment within 60 days. However, when there is any clinical suspicion of a potentially serious or life threatening illness, regardless of the number of diagnostic tests that may be required, the process must be immediate.

(2) After the initial on-site/off-site consultation has been completed and the recommendations of the provider have been reviewed, documentation will be made by the physician in the **DC-472, Progress Notes (Attachment 1-E)** regarding the approved plan of care for the inmate (further diagnostic or lab tests, a follow-up visit to the specialist or a referral to another specialist, surgery, etc.). The CHCA and the Contracted Health Care Provider will maintain a tracking log to monitor all consultations. If the recommendation/approved plan of care cannot be completed within the prescribed timeframe, an explanation will be noted (chemotherapy medications, physical therapy, security transportation problems, etc.). Compliance will be deemed appropriate as long as services were initiated within the appropriate timeframe. The log will be reviewed at the monthly Quality Improvement (QI) meetings.

(a) On-Site Specialty Consultations

i. An inmate must be seen by the specialty care provider within 30 days of the approval for on-site services with the exception of stat orders for which the vendor will provide specialty care immediately. All other exceptions may only be approved by the Chief of Clinical Services.

ii. The Contracted Health Care Provider will provide on-site specialty clinics when six or more referrals are made within a 30-day period. If the equipment to complete the assessment is not available, the inmate(s) will be seen off-site. The CHCA/designee will be responsible for monitoring compliance with this provision.

iii. Prior to the clinic, the inmates who are to attend will be notified via local procedure (call out sheet, etc.).

iv. A medical professional may be assigned to assist the specialist in clinics. The medical professional will be responsible to ensure the inmate is seen. An inmate who refuses care must sign a **DC-462, Release from Responsibility for Medical/Psychiatric Treatment (Attachment 1-F)**.

v. A completed **DC-441** and the medical record will be available to the specialist.

vi. The Medical Director/designee will review the specialist's recommendations within 48 hours. The on-site specialist may chart in the medical record with approval from the Medical Director.

vii. The original **DC-441** will be sent to the medical records department after the Medical Director/designee has reviewed it. Once the original is received and placed in the chart, the pink copy will be destroyed.

viii. Additional information requested and transmitted back and forth will be attached to the **DC-441** before it is filed in the medical record.

(b) Off-Site Specialty Consultations

i. An inmate must be seen by the specialty care provider within 60 days of the approval for off-site services with the exception of stat orders for which the vendor will provide specialty care immediately. All other exceptions may only be approved by the Chief of Clinical Services.

ii. Telemedicine services will be used when medically appropriate to avoid unnecessary off-site trips. In accordance with Department policy **13.1.1**, telemedicine consultations will be completed within 60 days of approved

service. Exceptions may only be approved by the Chief of Clinical Services. The vendor will not be responsible when an inmate fails to report for a scheduled telemedicine clinic. The vendor will notify the CHCA when an inmate fails to report for a scheduled telemedicine clinic.

iii. When the appointment is made, it will be recorded on the **DC-441** and yellow copy as to the time, date, and the name of the consultant. If the appointment has to be rescheduled, the new information can be transcribed on the original **DC-441**. The Contracted Health Care Provider will provide written justification for the necessity of the off-site consult to the CHCA.

iv. An inmate scheduled for an off-site consultation or medical service will be processed in accordance with Department policy **6.3.1, "Facility Security."**

v. The original **DC-441** will be sent to the specialist in a sealed envelope marked **CONFIDENTIAL** with the Corrections Officer on the day of the appointment. Special transportation precautions or instructions will be conspicuously noted on the outside of the envelope.

vi. The specialist will record his/her findings and recommendations on the **DC-441**, and it will be returned to the medical department at the time of the inmate's return.

vii. In the event that the Medical Director/designee is not on-site, the nurse will review the consultant's recommendations for any orders that require immediate attention and contact the on-call physician.

viii. The Medical Director/designee will review the **DC-441** within 48 hours of receipt by the facility and follow-up care will be documented on the **DC-472**.

ix. The original **DC-441** will be sent to the medical records department after the Medical Director/designee has reviewed it. Once the original is received and placed in the chart, the pink copy will be destroyed.

x. Additional information requested and transmitted back and forth will be attached to the **DC-441** before it is filed in the medical record.

xi. An appeal process exists in the event that a consensus cannot be reached between the Site Medical Director/designee and Regional/State Contracted Health Care Provider physician. Verbal communication will occur via the process described in the **Specialty Services Request and Pre-Authorization Flow Sheet**.

(3) Off-Site Medical Assessment of an Inmate who is a Disabled Veteran

(a) The Veterans Administrations (VA) requires an annual assessment of disabled veterans in order to determine continued eligibility and/or consideration for an increase in disability benefits.

(b) The VA will notify the inmate, in writing, that he/she is due for the annual assessment. The inmate will notify the medical department of the need for the off-site medical assessment.

(c) The CHCA will contact the VA Hospital to schedule this assessment, and the transport of the inmate will be processed in accordance with Department policy **6.3.1, "Facility Security."**

o. Clinics for Management of Chronic Illness[6]

(1) The CHCA and the Contracted Health Care Provider will develop a formal system, to include individual treatment plans, to ensure inmate access to routine and follow-up care.[7]

(2) A list of inmates for each Chronic Care Clinic will be developed and maintained confidentially.

(3) The nurse assigned to the chronic clinic will ensure the inmate is seen when scheduled. An inmate who refuses to participate in the Chronic Care Clinic must sign a **DC-462**. The CHCA will develop a system for the follow up of inmate "no shows" or refusals.

(4) An inmate will be scheduled for the Clinic a minimum of twice a year.

(5) Inmate education will be completed and documented in the chart using the **DC-543, Inmate Health Education Record**.

(6) Referral to other disciplines will be made as appropriate (counseling, psychologist, etc.) using the **DC-97, Mental Health Referral** and/or **DC-441** form.

(7) Every clinic visit will be documented in the inmate's medical record using the **DC-472** and the **DC-468, Chronic Illness Flow Sheet**.

(8) Chronic disease management will be in accordance with established physician parameters as referenced in the **Quality Improvement Procedures Manual**.

[6] 4-4359
[7] 4-4350

p. Long Term Care/Skilled and Personal Care Services will be in accordance with Department policy **13.1.1**.

q. Hospice care will be in accordance with **Section 9, Medical Management of Inmates with Terminal Conditions** of this procedures manual.

r. Renal Dialysis

(1) Renal dialysis will be available to an inmate when deemed medically necessary.

(2) A physician/PA will order the necessary tests to evaluate an inmate's need for dialysis, based upon the dialysis guidelines contained in the Department's QI Procedures Manual, and provide results to the facility Medical Director/designee.

(3) The Medical Director/designee will consult with the Dialysis Director via telephone to review test results and determine if an inmate meets the criteria for dialysis.

(4) The Medical Director/designee will contact the Clinical Coordinator at the BHCS to coordinate the transfer of the inmate within 48 hours. The transfer will be in accordance with Department policy **6.3.1**.

(5) If it is determined that an inmate is not a candidate, the facility Medical Director/designee must continue to monitor the inmate based upon recommendations of the Dialysis Director.

s. Intra-System Transfers for Medical Purposes[8]

t. Psychiatric/Psychological Services[9]

Refer to Department policy **13.8.1, "Access to Mental Health Care."**

u. Dental Services

Refer to **Section 4, Dental Services** of this procedures manual.

v. Pre and Post-Natal Services[10]

Refer to **Section 13, Management of Pregnant Inmates** of this procedures manual.

w. Durable Medical Equipment

x. Optical Care

[8] 4-4348
[9] 4-ACRS-4C-15
[10] 4-ACRS-4C-14

y. Hearing

z. Routine Newborn Nursing Care (Refer to **Section 13** of this procedures manual).

7. Periodic Physical Examinations in accordance with **Department policy 13.1.1, "Management and Administration of Health Care," Section 2** of the Medical Records User Manual.

8. Sick Call

Sick Call is available to every inmate and will be conducted as follows:

a. sick call for medical/dental concerns will be held Monday through Friday except on state observed holidays. A physician, PA, ***CRNP***, or dentist conducts routine sick call;[11]

b. an inmate who experiences medical/dental problems and who wishes to be seen at sick call must place a **DC-500, Sick Call Request (Attachment 1-G)** in a locked box in the housing unit;[12]

c. the CHCA will ensure that medical staff retrieve ***and triage*** the **DC-500s *seven days a week***;[13]

d. the **DC-500s** will be available with the medical record for sick call;

e. a list of inmates who submitted a **DC-500** will be initiated for each housing unit and will be used for scheduling sick call. Medical information is confidential and is not to be included on the sick call list;[14]

f. an inmate "no show" is to be documented in his/her **DC-472**;

g. the **DC-500s** may be destroyed after the inmate is seen or fails to show as scheduled;

h. the sick call list will be retained by the medical records supervisor/designee for four years;

i. a registered nurse, PA, ***or CRNP*** may initially assess an inmate. Medical conditions that require follow-up will be referred to a PA, ***CRNP***, or physician. The CHCA/designee will ensure that the inmate is seen;[15]

[11] 4-4346
[12] 4-4346
[13] 4-4346
[14] 4-4346
[15] 4-4346

j. every referral to a physician, PA, ***or CRNP*** will be handled as follows:

(1) the inmate will be educated regarding his/her condition and this will be documented in the **DC-472**;

(2) referral will be made to other disciplines as appropriate (counseling, psychologist, etc); and

(3) an inmate who refuses to participate must sign a **DC-462**.

k. every medication line and sick call line will be conducted in an area where the inmate awaiting services is protected from the elements; and

l. **DC-ADM 820, "Co-Payment for Medical Services"** stipulates the co-pay amount for medical services for sick call.

9. Access to Health Care for Inmates in Restricted Housing Units (RHUs) and Inpatient Mental Health Units (MHUs).

a. Medical Department Initial Assessment

(1) the Medical Department will be notified when an inmate is placed in the RHU/SMU/MHU. A nurse will review the inmate's medical record for current medical or psychiatric care and treatment needs;[16]

(2) a **DC-510, Suicide Risk Indicators Checklist** (refer to Department policy **13.8.1, "Access to Mental Health Care," Section 1, Psychological Services, Attachment 1-F**) is completed in accordance with Department policy **6.5.1, "Administration of Security Level 5 Housing Units;"** and

(3) if the inmate is participating in the self-medication program, his/her medication must be returned to the medical department. The nurse will administer the inmate's medication as long as he/she remains in the RHU/SMU/MHU.

b. Access to Sick Call, Emergency Care and/or Medical Attention

(1) RHU/SMU/MHU/SSNU visits and rounds, including the observation of each inmate will be made daily (including holidays and weekends) by a health care provider and documented in the **DC-701**, **Security Level 5 Housing Unit Log**. Rounds are made to ensure that inmates have access to the health care system. Rounds may be coordinated with standing security counts. A health care provider will see every inmate who signed up for sick call;[17]

(2) a physician must visit the RHU/SMU/MHU/SSNU at least once per week; and

[16] 4-4400
[17] 4-4400

(3) an inmate in the RHU/SMU/MHU/SSNU is to sign up for sick call in the manner described in **Subsection A.8. above**. The health care provider may determine that any request to be seen at the time of rounding (inmate did not sign up for sick call) is urgent and needs immediate attention or can advise the inmate to follow usual sick call procedures. In the event that urgent medical attention is needed, the Corrections Officer will notify the medical department.[18]

10. Discharge Planning Services (referrals for medical/psychiatric follow-up for an inmate who are being released from prison and/or being discharged to a Community Corrections Center [CCC])[19] in accordance with **Section 7, Inpatient Unit Medical Procedures** of this procedures manual.

11. Pharmacy Services

    a. pharmaceuticals will be prescribed for Food and Drug Administration (FDA) approved clinical indication;[20]

    b. pharmaceuticals used for non-FDA approved conditions may be used under the following circumstances:

        (1) the drug is generally accepted as a treatment for a non-FDA approved condition;

        (2) is consistent with community standards for medical care; and/or

        (3) the final decision to use the drug is made by the treating physician.

    c. refer to **Section 12, Pharmacy Guidelines** and **Section 15, Direct Observation Therapy** of this procedures manual.

B. Medical Services Provided on a Case-By-Case Basis

1. Organ Transplant

   The Department will provide an organ transplant when medically necessary to sustain life and health on a case-by-case basis.

   a. The facility CHCA will notify the Clinical Coordinator, BHCS when the facility medical director identifies an inmate as a candidate for an organ transplant.

   b. Diagnostic work-up for organ transplantation will be approved by the Chief of Clinical Services/designee and the Contracted Health Care Provider.

[18] 4-4346
[19] 4-4347
[20] 4-4378

c. The Deputy Secretary for Administration will be notified of final approval for an inmate organ transplant.

(1) The Chief of Clinical Services/designee, BHCS will form a transplant review committee comprised of the Corporate Medical Director/designee for the Contract Health Care Provider, and the Assistant Medical Director, BHCS to review the clinical findings of the facility Medical Director and the transplant center.

(2) The transplant will be approved if the transplant review committee deems the inmate recipient a suitable candidate and if the transplant is medically necessary to sustain life and health.

(3) The Chief of Clinical Services will notify the facility CHCA of the approval and the inmate will be permanently transferred to a facility within one hour of the transplant center, if possible.

(4) The Contracted Health Care Provider will be responsible for all costs related to the diagnostic work-up, assessment, treatment, surgical intervention and/or medical complications associated with an autologous/recipient transplant.

(5) The Transplant Committee's recommendation will be final.

2. Inmate Organ Transplant Donation

a. When an inmate wishes to donate an organ for transplantation, the CHCA will be the primary contact for the inmate, family, transplant center, facility and Department entities. The CHCA will coordinate all inquiries and transplant activities until completion of the approved course of action.

b. The Chief of Clinical Services/designee may authorize a donor/recipient transplant for an inmate to donate an organ only to the following family members:

(1) full blood sibling – both birth parents in common (25% chance of a full HLA match. 50% chance of a half-match);

(2) blood half-sibling – one birth parent in common (50% chance of a half-match);

(3) birth parent – (50% chance of a half-match); or

(4) birth child – (50% chance of a half-match).

c. Upon notification by an inmate, family member, transplant center, nurse, and vendor staff, the CHCA will:

(1) review and initiate the **DC-594, Transplant Organ Donation Checklist (Attachment 1-H)**;

(2) obtain a **DC-108, Authorization for Release of Information Form** in accordance with Department policy **DC-ADM 003, "Release of Information"** from the inmate for all applicable parties, including vendor staff;

(3) identify involved family contacts and transplant center coordinator (names, addresses and phone numbers in accordance with the **DC-594**);

(4) mail the **DC-595, Pennsylvania Department of Corrections – Initial Organ Donation Costs Letter to Inmate Relative(s) and Transplant Center (Attachment 1-I)**, to family contacts and the transplant center coordinator;

(5) provide the **DC-596, Pennsylvania Department of Corrections – Inmate Organ Donor Agreement Letter (Attachment 1-J)** to the inmate;

(6) upon notification by family contacts and/or the transplant center coordinator that they wish to proceed, the CHCA will send them a **DC-597, Pennsylvania Department of Corrections – Specific Organ Donation Costs Letter to Inmate Relative(s) and Transplant Center (Attachment 1-K)** outlining specific cost estimates and further details of the transplant procedure. The **DC-597** will include the initial payment required, if any for histocompatibility testing. The instruction will specify that all monies must be sent to the CHCA. The **DC-597** will be signed by the Facility Manager. The **DC-597** will include a signature line for the recipient and a copy to be returned acknowledging the responsibility to pay all costs of organ donation;

(7) upon receipt of the signed **DC-597** and funds to cover the cost of histocompatibility testing, the CHCA will arrange with the medical contract or the transplant center coordinator for the histocompatibility testing;

(8) upon notification by the transplant center coordinator that the inmate is selected as a donor, the CHCA will send a **DC-598, Pennsylvania Department of Corrections – Final Estimated Organ Donation Costs Letter to Inmate Relative(s) and Transplant Center (Attachment 1-L)** signed by the Facility Manager to the appropriate family contact or transplant center coordinator providing estimated Department costs for the particular organ harvesting procedure. The **DC-598** will stipulate that estimated costs must be paid in advance and will provide instructions for payment;

(9) when payment is received, the CHCA will coordinate with the transplant center coordinator and security staff to schedule the organ harvesting procedure;

(10) following completion of all testing and harvesting procedures and resolution of all medical complications, the CHCA will reconcile all charges and payments. If appropriate, excess payments will be refunded to payers;

(11) all transplant forms and copied letters including the **DC-594**, **DC-595**, **DC-596**, **DC-597**, and **DC-598** will be filed under the **DC-539, Consent Divider**, located under the Legal/Correspondence Tab, in the medical record; and

(12) all **DC-108** forms shall be filed under the **DC-532, Release of Information Divider**, located under the Legal/Correspondence Tab, in the medical record.

C. Non-Provided Medical Services[21]

Medical services not provided by the Department include, but are not limited to, the following:

1. cosmetic surgery or services;

2. extraordinary medical expenses for infants beyond routine newborn care – refer to **Section 13** of this procedures manual;

3. ~~sexual reassignment surgery and related treatment. If an inmate has commenced a course of treatment for reassignment prior to incarceration, a contracted Health Care Provider will evaluate him/her and limited medically necessary treatment may be administered to prevent complications associated with reassignment. This limited treatment will not include surgery~~; (see Bulletin)

4. sterilization (including castration);

5. investigation of or treatment for infertility, reversal of sterilization, artificial insemination or invitro fertilization;

6. refractive eye surgery;

7. penile prosthesis;

8. pharmaceuticals used for non-FDA approved conditions unless the guidelines in **Subsection A.6.u. above** are met;

9. biofeedback and acupuncture;

10. weight reduction programs, unless medically necessary;

11. mammoplasties performed for augmentation ~~or prosthetic implants~~; (see Bulletin)

12. surgical or dental procedures to correct congenital or developmental malformations, unless medically/psychiatrically necessary;

13. chiropractic or naturopathic services;

[21] 4-4398

14. treatment of impotence;

15. dental cosmetic procedures;

16. gold dental restorations;

17. ~~bone growth stimulator, unless for long bones~~; (see Bulletin)

18. special footwear that is not medically necessary;

19. sperm/egg donation; and

20. other fertility tests/treatment.

D. Notification of Next of Kin[22]

1. In the event an inmate is seriously injured, the CHCA/designee will notify the Shift Commander or Duty Officer in order to report the incident in accordance with Department policy **6.3.1, Section 17, Reporting of Extraordinary Occurrences**. The required **DC-121, Report of Extraordinary Occurrence**, will serve as official notice of the incident. The Shift Commander/Duty Officer will notify the inmate's next of kin.

2. In the event an inmate becomes seriously/critically ill or injured or an inmate dies during normal business hours, the Facility Manager will designate the CHCA or the facility's Public Information Officer (PIO) as the staff member responsible for notifying the inmate's next of kin. If the incident occurs after normal business hours, the facility's Duty Officer/designee will notify the inmate's next of kin.

3. The CHCA, PIO, or Duty Officer will attempt to contact the inmate's next of kin via telephone. When telephone contact is made with the next of kin, the staff member will provide all the information possible in accordance with Department policy **DC-ADM 003**, regarding the release of confidential personal information, as well as confidential medical information. This information will include, but not be limited to:

    a. the inmate's name;

    b. the circumstances surrounding the incident (illness or injury);

    c. the name and location of the treatment center, if the inmate is no longer in the facility;

    d. the telephone number of the treatment center;

    e. the name of the physician treatment the inmate, if available; and

[22] 4-ACRS-4C-21, 1-CTA-3F-04

f. the visiting procedures of the treatment center, if known to the staff member.

4. After notification of next of kin, an entry will be made in the facility's Daily Occurrence Report and in the injured inmate's medical record. The entries will confirm the time and date of notification and will be signed by the person who made the notification. The CHCA, PIO, or Duty Officer will also prepare a letter for the Facility Manager's signature documenting the information that was relayed to the inmate's next of kin during the telephone call. This letter will be mailed as soon as possible via overnight mail to the inmate's next of kin.

5. In the event the next of kin designated by the inmate cannot be reached via telephone, and in the event of an emergency, the CHCA, PIO, or Duty Officer will contact local law enforcement officials in the next of kin's home location and ask for their assistance in contacting the next of kin. Of local law enforcement is unavailable to assist, the CHCA, PIO, or Duty Officer will prepare a letter for the Facility Manager's signature containing the information listed above surrounding the incident. The letter will be mailed as soon as possible via overnight mail to the inmate's next of kin.

6. In the event of an inmate death, the CHCA/designee will ensure that the procedures set forth in Department policies **6.3.1, Section 17** and **13.1.1, Section 9, Notification and Clinical review of Inmate Deaths and Attempted Suicides** are completed.

E. Inmates Working in the Medical Department[23]

1. An inmate may perform housekeeping tasks under close supervision in the medical department.

2. Except for approved activities as part of the Inmate Medical Volunteer Program outlined in Department policy **13.1.1, Section 15**, inmate medical volunteers are not permitted to perform the following duties:

   a. direct patient care services;

   b. schedule health care appointments;

   c. determine access of other inmates to health care services;

   d. handle or have access to surgical instruments, syringes, needles, medications, or health records; and

   e. operate any medical equipment.

[23] 4-4393

BULLETIN
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject: **Access to Health Care Procedures Manual Section 2 – Initial Intake and Screening**		
Policy Number: **13.02.01, Section 02-02**		
Original Issue Date: **May 26, 2016**		
Date of Issue: **December 11, 2019**	**Authority:** **Signature on File** **John E. Wetzel**	**Effective Date:** **December 23, 2019**

The purpose of this bulletin is to provide direction for nursing staff and psychiatric practitioners when new inmates or parole violators are received that are taking psychotropic medication, or may not be taking psychotropic medication, but have a history of mental illness. ***This bulletin supersedes the previous bulletin on this subject (Bulletin 02-01); changes are noted in bold and italics***.

Subsection B. Medical Screening of PVs and New Receptions, 1.b.(6) shall be changed and/or have the following information added:

(6) Psychiatric Referrals: New Arrival inmates at the Reception[1]

(a) Inmates who arrive on psychotropic medications

During working hours or off hours

i. The assigned nurse shall contact the on-site or on call psychiatry provider for bridging medication orders for an immediate 30-day supply. The psychiatry provider shall order in the electronic health record (EHR) or give verbal bridging medication orders for an immediate 30-day supply.

ii. Bridge orders for psychotropic medications must be completed on the day of arrival to the Department of Corrections (DOC).

[1] 5-6A-4368, 5-6A-4370

iii. These inmates shall be referred to be seen by a psychiatry provider for an initial psychiatric evaluation within five working days.

(b) Inmates who are not on psychotropic medications upon arrival to the Diagnostic and Classification Center (DCC), who report prior history of mental illness, who are identified by the nurse evaluation as needing Mental Health Care, and/or inmates who request psychotropic medications:

i. During working hours

Inmates shall be referred to Psychology for assessment. Psychology shall assess the inmate on the same day and, if needed, initiate a psychiatric referral by completing the **DC-560, Mental Health Contact Note**. The **DC-560** shall include a summary with detailed explanation of the assessment that includes any inmate statements/reports; observed signs/symptoms/behaviors; symptomology interventions and practices that have been tried to address the concern; and any other concise and pertinent information necessary to determine the appropriate course of treatment.

ii. During off hours

aa. The Registered Nurse Supervisor (RNS)/designee shall contact and review the case with the on call psychiatry provider if it is an emergency. The psychiatry provider shall give verbal medication orders for an immediate 30-day supply, provided it is clinically indicated and/or recommend an appropriate course of treatment. Refer the inmate to be seen by psychiatry based on the recommendations.

bb. These inmates shall be referred for follow-up assessment with Psychology within the next working day.

Subsection B. Medical Screening of PVs and New Receptions, 1.d. Psychiatrist/PCRNP shall do the following:[2] shall be changed and/or have the following information added:

(1) complete a Mental Health Evaluation (Initial Psychiatric Evaluation [IPE]) within five working days for inmates who arrive at the DCC facility on psychotropic medication(s);

(2) telepsychiatry may be utilized to complete the Initial Psychiatric Assessment or Brief Psychiatric Assessment at the DCC/reception centers (State Correctional Institution [SCI] Camp Hill, SCI Phoenix, SCI Greene, and SCI Muncy) for the new commits and PV returns. Individual psychiatry providers must be approved by the Bureau of Health Care Services (BHCS) to complete the Telepsychiatric Assessments. This is not intended to replace on-site Psychiatric Assessments at the reception centers;

(3) document the evaluation on the **DC-525, Psychiatric Assessment (Initial, Brief), (Attachment 2-C)**, or a summary of the evaluation shall be documented in the progress note(s), with the following information:

[2] 5-6A-4370, 5-6A-4371

(a) chief complaint;

(b) history of present illness;

(c) mental status examination;

(d) diagnosis;

(e) any impending risk/risk assessment; and

(f) treatment and follow-up recommendations with any needed referrals.

(4) patients, who are not on psychotropic medications upon arrival to the DCC, who are identified by the nurse evaluation as needing Mental Health Care and/or inmates who request psychotropic medications, shall be referred to Psychology for assessment;

(a) Psychology shall assess and, if needed, initiate a Psychiatric Referral by completing the **DC-560**. This shall include a summary with detailed explanation of the assessment that includes any inmate statements/reports; observed signs/symptoms/behaviors; symptomology interventions and practices that have been tried to address the concern; and any other concise and pertinent information necessary to determine the appropriate course of treatment.

(b) The Psychiatrist/PCRNP at each DCC facility shall complete the Mental Health Evaluation within 14 days for a routine **DC-560** referral.

(5) if an inmate presents with an urgent or emergent mental health need, the RN shall complete the **DC-586NN**, **General Psychiatric Concern NET,** and refer the inmate to Psychology for assessment. Psychology shall assess and, if needed, refer the patient to Psychiatry as an emergency referral.[3] The psychiatry provider shall document the initial emergency interaction, treatment provided, and follow-up recommendations on the **DC-472C, *Psychiatry Progress Note***. Any inmate referred for emergency assessment that does not have an IPE for the active DOC number, shall be scheduled for a Psychiatric Evaluation; and

(6) if the psychiatrist/PCRNP is not on-site, or present during off hours/weekends/ holidays, the RN shall complete a **DC-586NN**, and notify the on call psychiatrist/PCRNP. The communication with the psychiatry provider shall be documented as a progress note by the RN/designee. The patient shall be treated as directed/ordered by the on call psychiatrist/PCRNP, and referred for a follow-up by the on-site psychiatry provider the next working day.

[3] 5-6A-4368

Subsection B.2. PV Specifics, c., d., and *e*. shall be changed and/or have the following information added:

c. PV returns (including Technical PVs) on psychotropic medications[4]

(1) During working hours

(a) ***When the inmate is*** on prescribed psychotropic medications or reports having been on psychotropic medications within the last three months, the assigned nurse shall contact and review the case with the on-site or on call psychiatry provider. The psychiatry provider shall order in the EHR or give verbal bridging medication orders for an immediate 30-day supply, provided it is clinically indicated and/or recommend appropriate course of treatment. The inmate shall be referred for follow-up with Psychiatry for a brief assessment within three working days.

(b) ***The psychiatry provider shall complete the DC-472C by selecting type PV Return, which shall reflect the summary of presenting symptoms, risk assessment, interim history since his or her last release including, but not limited to any treatment that was received in the community/any significant life events/stressors etc.***

(c) ***The psychiatry provider shall decide if a new BPE is required and a follow-up appointment shall be scheduled within six to eight weeks.***

(d) ***The psychiatry provider shall initiate/treat with medication, as deemed clinically necessary. Labs/consents/referrals etc. shall be completed as needed.***

(e) If the last IPE is over ***five*** years old, the PV shall ***be scheduled for*** a new IPE. The new IPE (review all old records, include summary) shall occur within ***60*** days.

(2) During off hours

(a) ***When an inmate is*** on prescribed psychotropic medications or reports having been on psychotropic medications within the last three months, the RNS/designee shall contact and review the case with the on call psychiatry provider. The psychiatry provider shall give bridging verbal medication orders for an immediate 30-day supply, provided it is clinically indicated and/or recommend appropriate course of treatment. The inmate shall be referred for follow-up with Psychiatry for ***an*** assessment within three working days.

(b) The inmate shall be referred for follow-up assessment with Psychology within the next working day.

[4] 5-6A-4368, 5-6A-4370

d. PV returns (including Technical PVs) who are not on psychotropic medications upon arrival, who report prior history of mental illness, who are identified by the nurse evaluation as needing Mental Health Care, and/or inmates who request psychotropic medications.[5]

(1) During working hours

The inmate shall be referred to Psychology for assessment. Psychology shall assess the inmate same day and, if needed, initiate a psychiatric referral by completing the **DC-560** (for routine referrals). This shall include a summary with detailed explanation of the assessment that includes any inmate statements/reports; observed signs/symptoms/ behaviors; symptomology interventions and practices that have been tried to address the concern; and any other concise and pertinent information necessary to determine the appropriate course of treatment and they are scheduled to be seen by psychiatry. The inmate shall be referred for follow-up with Psychiatry for an assessment within 14 days.

(2) During off hours

The RNS/designee shall contact and review the case with the on call psychiatry provider <u>if it is an emergency</u>. The psychiatry provider shall give verbal medication orders for an immediate 30-day supply, <u>provided it is clinically indicated and/or recommend appropriate course of treatment</u> and they are scheduled to be seen by psychiatry based on the recommendations. The inmate shall be referred for follow-up assessment with Psychology within the next working day.

e. ***When detox only inmates are referred to Psychiatry for psychiatric concerns, the psychiatry provider shall complete a DC-472C by selecting PV Return. The inmate shall be referred to appropriate staff at the institution to arrange a follow-up appointment with a community provider upon release.***

Subsection B.3. Technical PV Specifics, c., (1), (d) and (e) shall be changed and/or have the following information added:

(d) PV returns on psychotropic medications – Please refer to **Subsection B.2.c. and d. above**.

(e) PVs returning during off hours, holidays, or weekends – Please refer to **Subsection B.2.c. and d. above**.

[5] 5-6A-4368, 5-6A-4370

Section 2 – Initial Intake and Screening

This section establishes procedures for the initial intake and screening of an inmate either as a Parole Violator (PV) or a new reception, to a corrections facility.[1] If an inmate refuses to participate in the initial intake, screening, or other medical procedure, the inmate shall be counseled and action shall be taken in accordance with Department policy **13.1.1, "Management and Administration of Health Care."**

A. Medical Department Responsibilities

1. The Medical Department shall receive a list of new inmate receptions from the Inmate Records Department and/or county jail.

2. Upon arrival at the facility, all inmates shall be screened and assessed by health-trained or qualified health care personnel.[2]

3. Medical Department staff shall make reasonable efforts to provide non-employee translation services for non-English speaking inmates, from the contracted Language Translation Services, located on DOCNet, for the purposes of communication with medical staff, and translating (orally and in writing) medical documents/educational materials. Translation services may be utilized as follows:[3]

   a. translator services shall only be available for on-site services and shall not be available for any reason when an inmate is away from the facility;

   b. medical or mental health staff (Corrections Health Care Administrator [CHCA], practitioners, dental, psychiatrists, Certified Registered Nurse Practitioners [CRNP], Psychiatric Certified Registered Nurse Practitioners [PCRNP], nursing/assistants, medical records, psychology, and contracted health care provider staff) shall be utilized if available. Non-medical staff shall be utilized in emergent situations and with documented consent from the inmate in accordance with Department policy **DC-ADM 003, "Release of Information."** If translation services are utilized, it shall be documented in the progress notes; and

   c. inmates shall not be utilized as translators/interpreters for medical purposes.

[1] 4-4285
[2] 4-4362
[3] 4-4288

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B. Medical Screening of PVs and New Receptions

1. The below listed steps are required for all inmates upon arrival to ensure access to Medical/Mental Health Services.[4]

   a. The Medical Records Department shall prepare intake packets and temporary medical records for inmates received as PVs or new receptions until permanent files are created or inactive medical records are reactivated.

   b. Nursing shall do the following:

      (1) if an inmate has an immediate emergency medical need, has an immediate need for medication, has fresh bruises or other evidence of injury, the inmate shall be assessed by a Registered Nurse (RN) and immediately be referred to a practitioner, if necessary;

      (2) if the inmate arrives after the practitioner has left for the day, and there is an emergency medical need, the on-call practitioner shall be contacted. The inmate shall be seen as directed/ordered by the practitioner. An inmate with non-emergency medical needs shall be scheduled to see the practitioner within seven days;

      (3) an inmate shall be counseled, monitored, assigned appropriate housing, and immediately referred to the psychologist for the following:[5]

         (a) the inmate shows signs of self-harm or other signs of acute emotional distress;[6]

         (b) the inmate shows tendencies of acting out with sexually aggressive behavior;[7]

         (c) the inmate is identified as high risk with a history of sexually assaultive behavior;[8] and/or

         (d) the inmate is identified as at risk for sexual victimization.[9]

      (4) the **Prison Rape Elimination Act (PREA) Risk Assessment Tool (PRAT)** shall be completed in accordance with Department policy **DC-ADM 008, "PREA." (28 C.F.R. §115.41)** Medical shall provide the inmate with a copy of the **Sexual Abuse Awareness Informational Brochure**; **(28 C.F.R. § 115.33[a][b])**

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[4] 4-4365
[5] 4-4281-2, 4-4281-4, 4-4281-5
[6] 4-4370
[7] 4-4281-2
[8] 4-4281-2
[9] 4-4281-4, 4-4281-5

(5) the assigned nurse shall complete the **DC-510, Suicide Risk Indicators Checklist** (refer to Department policy **13.8.1, "Access to Mental Health Care," Section 1**);

(6) a routine psychiatric referral shall be made for any inmate who was previously receiving mental health care, is taking psychotropic medications, and is in stable condition. The inmate shall be seen for a mental health evaluation within five working days;

(7) provide an oral and written explanation to the inmate regarding the following:

(a) access to health care services in accordance with this procedures manual;[10]

(b) sick call (including inmate co-payment in accordance with Department policy **DC-ADM 820, "Co-Payment for Medical Services"**);[11]

(c) emergency services in accordance with **Section 6, Access to Emergency Care/Nursing Protocols-Nursing Evaluation Tools (NETS)** of this procedures manual;

(d) dental care in accordance with **Section 4, Dental Services** of this procedures manual;

(e) psychiatric/psychological services in accordance with Department policy **13.8.1**; and

(f) access to the inmate grievance system.[12]

(8) examine the inmate for the presence of infestation (pediculosis);

NOTE: If infestation is present, the inmate shall be referred to a practitioner and the following shall apply:

(a) the practitioner will order the appropriate treatment;

(b) the Infection Control Nurse (ICN) will be notified for appropriate follow-up and tracking; and

(c) the inmate will be evaluated and managed post-treatment in accordance with **Section 8, Communicable Diseases and Infection Control, Attachment 8-X** of this procedures manual.

[10] 4-4344
[11] 4-4345
[12] 4-4344

(9) tuberculosis testing shall be in accordance with **Section 8** of this procedures manual;

(10) tetanus vaccination shall be administered in accordance with **Section 16 – Quality Improvement Plan, Appendix 16-B, Chapter 7, Preventive Health Care-Clinical Practice Guidelines** of this procedures manual;

(11) complete the **DC-471, New Reception/Parole Violator Return Screening Form – Male (Attachment 2-A)** or the **DC-471A, New Reception/Parole Violator Return Screening Form – Female (Attachment 2-B)**;[13]

NOTE: Both the inmate and the nurse shall sign and date the **DC-471/DC-471A**. If the inmate declines to sign, the inmate's refusal shall be noted on the form, and in a progress note, and a witness shall sign in the space provided.

(12) update/prepare the chronic care list;

(13) prepare x-ray list for chest x-ray;

(14) arrange lab work in accordance with **Section 3** of this procedures manual;

(15) eye screening – Snellen Visual Acuity Test (near and far);

(16) EKG (if the inmate has a past medical history, coronary artery disease, hypertension, or diabetes);

(17) complete a brief dental screening, and notify the Dental Department of the inmate's arrival;

(18) medication review;

(19) referral to a practitioner for medication order(s);

(20) transcription of non-medication order(s);

(21) administration of medication as ordered; and

(22) when all above referrals have been completed, the facility's health care services have been explained to the inmate, and the practitioner has been contacted/notified (if needed/required), the nurse/designee shall document his/her encounter with the inmate in the progress note(s), with the following information:

(a) type of reception (new or PV);

[13] 4-4362, 4-4363-1, 4-4364, 4-4370

(b) sending facility;

(c) description/identification of information/education provided;

(d) referrals made (i.e. ICN, dental, etc.); and

(e) documentation completed (i.e., **DC-471/DC-471A, DC-97, Mental Health Referral**, etc.)

c. Medical Practitioner shall do the following:

(1) within 72 hours of arrival, a practitioner shall conduct a chart review to assess any interruption in services and re-establish a continuum of care.[14] Depending on inmate clinical need and/or operational need, the practitioner may be required to assess the inmate on the day of reception;

(2) provide orders for assessment and continuity of care:

(a) medication orders in the electronic Medication Administration Record (eMAR);

(b) intake labs and diagnostic studies;

(c) testing for sexually transmissible diseases:[15]

i. Testing for sexually transmissible diseases shall be done in accordance with **Section 8** of this procedures manual.

ii. Serologic Tests for Syphilis (STS) shall be performed on every new inmate commitment, Hold for Various Authority (HVA), Community Corrections Center (CCC) return, escapee, PV, or returning inmate. An inmate on Authorized Temporary Absence (ATA) within a state, county, or federal prison system does not need the STS.

(d) in situations when an inmate has head lice, pubic lice, or scabies (body lice) order the appropriate chemical treatment; and

(e) additional orders for medical testing as clinically indicated.

(3) in accordance with **Section 3** of this procedures manual, within 14 days of arrival, the inmate shall receive an initial examination.[16] The initial examination shall be documented on the **DC-440, Initial Examination Form** and/or **DC-460 Gynecology Examination Record**;

[14] 4-4365
[15] 4-4365
[16] 4-4365

(4) conduct case reviews with the certified CRNP or PA on active or unresolved medical conditions;

(5) co-sign all PA's orders; and

(6) review all diagnostic studies.

d. Psychiatrist/PCRNP shall do the following:

(1) the psychiatrist/PCRNP at each Diagnostic and Classification Center (DCC) facility shall complete a Mental Health Evaluation (Initial Psychiatric Evaluation [IPE]) within five working days for those inmates who arrive on psychotropic medication(s);

(a) The psychiatrist/PCRNP shall dictate the IPE assessment.

(b) The psychiatrist/PCRNP shall document the completion of the IPE in the progress note.

(c) The evaluation shall be documented on the **DC-525, Psychiatric Assessment (Initial, Brief), (Attachment 2-C),** or a summary of the evaluation shall be documented in the progress note(s), with the following information:

i. chief complaint;

ii. history of present illness;

iii. mental status examination;

iv. diagnosis;

v. any impending risk/risk assessment; and

vi. treatment and follow-up recommendations with any needed referrals.

(d) The dictated IPE shall be filed in the medical record under the Psychiatry Divider within five days after dictation.

(2) patients, who are not on psychotropic medications upon arrival to the DCC, who are identified by the nurse evaluation as needing Mental Health Care and/or inmates who request psychotropic medications, shall be referred to Psychology for assessment;

(a) Psychology shall assess and, if needed, initiate a Psychiatric Referral by completing the **DC-97**, including an explanation of the reasons for the referral to Psychiatry.

(b) The Psychiatrist/PCRNP at each DCC facility shall complete the Mental Health Evaluation within 14 days for a routine **DC-97** referral.

(3) if an inmate presents with an urgent or emergent mental health need, the RN shall complete the **DC-586NN**, **General Psychiatric Concern NET,** and refer the inmate to Psychology for assessment. Psychology shall assess and, if needed, refer the patient to Psychiatry as an emergency referral. The Psychiatric Provider shall document the initial emergency interaction in the progress notes in Simple Object Access Protocol (SOAP) format, with treatment and follow-up recommendations. Any inmate referred for emergency assessment that does not have an IPE for the active Department of Corrections (DOC) number, shall be scheduled for a Psychiatric Evaluation; and

(4) if the psychiatrist/PCRNP is not on site, or present during off hours/weekends/ holidays, the RN shall complete a **DC-586NN**, and notify the on-call psychiatrist/PCRNP. The communication with the Psychiatric Provider shall be documented as a progress note by the RN/designee. The patient shall be treated as directed/ordered by the on-call psychiatrist/PCRNP, and referred for a follow-up by the on-site Psychiatric Provider the next working day.

e. Dentist

For each inmate, licensed dental staff shall conduct an examination and orientation within 14 days of arrival in accordance with **Section 4** of this procedures manual to determine the dental condition of the inmate upon intake.[17]

2. PV Specifics

When an inmate has been absent from the system, and is then returned to a facility, the below listed steps are required.[18]

a. If the inmate's electronic information, or inactive medical record is not at the receiving facility, the nurse supervisor/designee may contact the facility from which the inmate was released or previously held and inquire about the condition(s)/problem(s) the inmate had prior to release.

b. On the day of arrival, the assigned nurse or practitioner shall complete the **DC-510, Suicide Risk Indicators Checklist** (refer to Department policy **13.8.1, Section 1**).

c. PVs returning during business hours – the psychiatrist/PCRNP shall order medications as clinically indicated. The inmate shall be scheduled for follow-up with Psychiatry for a brief assessment within three working days:

[17] 4-4365
[18] 4-4362

(1) a follow-up appointment shall be scheduled per clinical recommendations following the brief assessment; and

(2) if the last IPE is over one year old, the PV shall have a new IPE completed. The new IPE (review all old records, include summary) shall occur within 30 days upon their arrival at the permanent facility.

d. PVs returning during off hours, holidays, or weekends – the Registered Nurse Supervisor (RNS)/designee shall call the on-call psychiatrist/PCRNP. Medications shall be ordered as clinically indicated. The inmate shall be scheduled for follow-up with Psychiatry for a brief assessment within three working days.

3. Technical PV Specifics

a. Upon reception, all Technical Parole Violators (TPVs) shall be identified by the Inmate Records Department and tracked for purposes of medical clearances and other processing. This list will be updated and made available to the Corrections Classification and Program Manager (CCPM), medical, facility parole staff and other staff in order to determine which medical process shall be followed.

b. An inmate identified by or classified by Inmate Records as a TPV shall be prioritized and expedited through the reception and intake process.

c. The CHCA/designee shall ensure that the medical clearance process is completed within three working days. Although medically cleared, if an inmate has not been transferred by seven days, full intake procedures shall be initiated.

(1) The expedited process shall include the following:

(a) PPD plant and read;

(b) chest x-ray with interpretation;

(c) if taking medication(s), a practitioner must evaluate then reorder medications as clinically indicated;

(d) PVs returning during business hours - the Psychiatrist/PCRNP shall order medications as clinically indicated. The inmate shall be scheduled for follow-up with Psychiatry for a brief assessment within three working days:

i. a follow-up appointment shall be scheduled per clinical recommendations following the brief assessment; and

ii. if the last IPE is over one year old, the PV shall have a new IPE completed. The new IPE (review all old records, including summary) shall occur at the permanent facility within 30 days upon their arrival.

(e) PVs returning during off hours, holidays, or weekends - the RNS/designee shall call the on-call psychiatrist/PCRNP. Medications shall be ordered as clinically indicated. The inmate shall be scheduled for follow-up with Psychiatry for a brief assessment within three working days; and

(f) if an urgent medical and/or psychiatric condition is identified, the inmate must be evaluated before being medically cleared.

(2) In accordance with Department policy **DC-ADM 008**, the PRAT shall be completed and the WebTAS system updated by nursing staff. Medical shall provide the inmate with a copy of the **Sexual Abuse Awareness Informational Brochure**;[19] **(28 C.F.R. § 115.33[a][b])**

(3) An inmate returning for detoxification from alcohol and/or drugs shall be treated under medical supervision, and shall be placed on a medical hold until clearance is provided by a medical practitioner.

[19] 4-4281-1

Section 3 – Physical Exams, Preventive Health Evaluations, and Clearance for Use of Force

This section establishes responsibilities and procedures for initial examinations, preventive health care, semi-annual assessment of inmate prescribed neuroleptic medication, medical clearance for activities, medical screening for Quehanna Boot Camp and State Correctional Institution (SCI) Pine Grove, commutation physicals, and medical implications during use of force. If an inmate refuses to participate in any of the exams/evaluations, the inmate shall be counseled and action shall be taken in accordance with Department policy **13.1.1, "Management and Administration of Health Care."**

A. Responsibilities

1. Bureau of Health Care Services (BHCS)

   The BHCS Chief of Clinical Services/designee shall serve as a consultant regarding inmates who are candidates for participation in the Motivational Boot Camp program, but have medical conditions which may preclude the inmate's participation in the program.

2. Corrections Health Care Administrator (CHCA) shall:

   a. ensure that all initial examinations and preventive care evaluations are conducted as required by policy, and that release from medical responsibility for medical treatment procedures are used when inmates refuse to participate in any aspect of their physical examinations;

   b. ensure that a tracking system of all physical examinations is maintained and reviewed monthly;[1]

   c. ensure each inmate has received all scheduled tests and procedures; and[2]

   d. ensure inmates classified as short minimum sentences, State Intermediate Punishment (SIP), and technical parole violators (TPV) are prioritized and expedited through the reception and intake process.

B. Initial Examinations

1. A new commitment inmate at a Diagnostic Classification Center (DCC) or reception center if not transferred within 14 days, shall receive an initial examination by a practitioner within 14 days of arrival in accordance with **Section 16, Chapter 7** of this procedures manual.[3]

[1] 4-4365
[2] 4-4365
[3] 4-4365, 4-ACRS-4C-07

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2. An inmate returning to the Department classified as a Parole Violator (PV) or Community Corrections Center (CCC) return, shall also receive a physical examination within 14 days of arrival.[4]

3. An inmate returning to the Department classified as Authorized Temporary Absence (ATA), SIP, or Hold for Various Authorities (HVA), shall receive a physical examination if he/she is greater than 50 years of age, and has been out for one or more year(s); or is less than 50 years of age, and has been out for three or more years. All ATA and HVA receptions shall be scheduled for Preventive Health Care.

4. The **DC-440, Initial Examination Form (Attachment 3-A)** shall be completed for all inmates when an initial examination is conducted; the **DC-460, Gynecology Examination Record (Attachment 3-B)**, shall also be included and completed for female inmates at that time.[5]

5. In order to provide preventive health services and education, health appraisals shall be conducted every three years on inmates under age 50, and annually for those age 50 and over, in accordance with **Section 16, Chapter 7** of this procedures manual.

6. In accordance with **Section 4** of this procedures manual, nursing staff shall complete an inspection of the mouth at the time of intake. If there are any suspected pathology concerns, a Registered Nurse (RN) shall assess the inmate, document the findings in the progress notes, and notify the facility dental office. An examination and orientation shall be performed by a licensed facility dentist within 14 days of arrival.

7. A complete medical evaluation shall be conducted on an inmate identified by Inmate Records/Counselor as eligible for Motivational Boot Camp placement in accordance with **Subsection G. below.**

8. At a minimum, the following shall be completed within 14 days of arrival for all new inmate commitments, PVs, CCC returns, HVAs, and returning inmates:[6]

   a. a practitioner must perform an initial examination with all data recorded on the **DC-440** and/or the **DC-460.** Nursing staff shall complete demographic information at the top of the **DC-440** and/or the **DC-460** in accordance with **Section 16, Chapter 7** of this procedures manual;[7]

   b. any identified, abnormal chemistry/lab results shall be followed-up and reported in accordance with **Section 8** of this procedures manual;

   c. an inmate who refuses any component or aspect of an initial examination shall sign a **DC-462, Release from Medical Responsibility for Medical Treatment Form** (refer

[4] 4-4365
[5] 4-4365
[6] 4-ACRS-4C-07
[7] 4-4365

to **Section 1** of this procedures manual). The practitioner or licensed nurse shall document the refusal and completion of the **DC-462** in the progress notes;

d. as part of the initial examination, and in accordance with **Subsection F. below**, an inmate shall be assessed by a practitioner for restrictions (housing, activities, employment, transfer mode), limitations, and assistive devices; and

e. as part of the initial examination, and in accordance with **Subsection I. below**, an inmate shall be assessed by a practitioner for medical clearance, or contraindications, for use of force devices; the practitioner shall complete the **DC-440A, Use of Force Clearance/Contraindications Form (Attachment 3-C).**

C. Preventive Care[8]

Reference **Section 16 – Quality Improvement Plan, Appendix 16-B, Chapter 7 - Preventive Health Care – Clinical Practice Guidelines Manual,** of this procedures manual. The Preventive Baseline visit shall occur within six months of arrival into the Department, or within the established timeline in **Chapter 7.**

1. The CHCA/designee shall ensure that health evaluations are completed in the month they are due. The list generated for the tuberculosis (TB) tracking system shall be used to schedule the health appraisals.

   a. An inmate who refuses a preventive care evaluation shall sign a **DC-462**. The practitioner or licensed nurse shall counsel the inmate as to the consequences of the refusal, and document such refusals and counseling in the progress notes.

   b. The CHCA/designee shall ensure the electronic tracking system for health appraisals is maintained.

2. Dental examinations shall be performed in accordance with **Section 4** of this procedures manual.

3. In accordance with **Subsection F. below**, the DOCNet Inmate Status Application shall be updated by the practitioner.

4. Any initial identification of a condition, or change in an existing condition, shall be documented in the progress notes by the practitioner.

5. An ongoing program of health education and wellness information shall be provided to all inmates by medical staff; the type of education/information provided shall be documented in the progress notes.[9]

[8] 4-4366, 4-4367
[9] 4-4361

D. Mental Health Unit (MHU)/Forensic Treatment Center (FTC) Admission Physical Examination

1. Upon admission to an MHU/FTC, it is essential to identify any medical or surgical problems which may be the cause of, or a contributing factor to, the presenting psychiatric symptoms.

2. Within 24 hours of admission, a provider shall initiate a history and physical examination (H&P) utilizing the **DC-440E, MHU/FTC Medical Evaluation Screening Form (Attachment 3-D)**; this shall be filed with the MHU/FTC admission record.

3. If the inmate was transferred directly from a MHU to a FTC, and the **DC-440E** was completed, the FTC provider shall only complete the standard **DC-440.**

4. At a minimum, the following laboratory studies shall be ordered: complete blood count (CBC), comprehensive metabolic profile (CMP), thyroid stimulating hormone (TSH), and urinalysis. If any of these tests are essential to the diagnosis, they are to be marked "STAT" and sent to the local laboratory.

5. If the H&P is performed by a physician assistant (PA) or nurse practitioner, it must be co-signed by a physician within 72 hours.

6. The psychiatrist making MHU/FTC rounds shall review and co-sign the H&P on the next working day.

7. If a medical or surgical problem is identified which may be the cause of, or a contributing factor to, the presenting psychiatric symptoms, the provider shall schedule a meeting with the MHU/FTC staff including the psychiatrist, to collaboratively discuss the case.

E. Semi-Annual Assessment of Inmates Prescribed Neuroleptic Medication

The **DC-470, Abnormal Involuntary Movement Scale (AIMS) (Attachment 3-E)** is the screening test selected for detection of Tardive Dyskinesia. This is a commonly used quantified questionnaire. Any practitioner or licensed nurse, trained in the use of the instrument, may administer the test.

1. Baseline AIMS shall be completed under the following circumstances:

   a. upon recommendation for treatment with neuroleptic medication, prior to the administration of the drug; or

   b. inmates who are on neuroleptic medications upon arrival to DCC.

2. All inmates currently taking neuroleptic medication shall be assessed at least once every six months, or more frequently as determined by the Psychiatrist/Psychiatric Certified Registered Nurse Practitioner (PCRNP).

3. Any inmate whose neuroleptic medication is discontinued shall be screened at the following intervals: three months, or whenever the Psychiatrist/PCRNP determines and documents the need for follow-up screening.

   NOTE: In rare instances, withdrawal movement disorders can emerge after three months following the discontinuation of a neuroleptic. This is more apt to occur following the use of a long acting, injectable neuroleptics. If movements are observed after the three month screening, the inmate shall be referred to the Psychiatrist/PCRNP for assessment.

4. The Psychiatrist/PCRNP may request more frequent AIMS exams based on the inmate's condition.

5. The AIMS examination may be completed by the Psychiatrist/PCRNP or licensed nurse who has been trained in this procedure.

6. When the AIMS test is performed by a Licensed RN, the results shall be reviewed by the Psychiatrist/PCRNP.

7. Only the Psychiatrist/PCRNP shall make a diagnosis of the presence of Tardive Dyskinesia. When such a diagnosis is made, the Psychiatrist/PCRNP shall work with the inmate to determine the most appropriate course of treatment, considering both the effects of Tardive Dyskinesia and the inmate's psychiatric condition. Action taken shall be fully documented in the inmate's medical record.

F. Medical Clearances for Activities, Athletic Programs, Employment, Food Service Workers, or Housing Restrictions (Ground Floor, Lower Bunk, Single Cell, etc.)[10]

1. At a minimum, the following procedures shall be conducted:

   a. a screening shall be completed by a practitioner during the inmate's initial examination. Clearances shall be ordered, documented in the progress notes, and the DOCNet Inmate Status Application shall be updated; and

   b. subsequent assessments shall be performed during the inmate's preventive care evaluations, and all results/findings/updates shall be documented in the progress notes; the Inmate Status Application shall be updated to reflect changes in clearances.

2. Additional Criteria for Food Service Workers[11]

   a. An inmate, infected with a disease in communicable form, capable of transmission by food, shall not work in a food services area.

[10] 4-4365
[11] 4-4322

b. Prior to assignment, an inmate shall be examined by a practitioner, and the results documented in the progress notes, as to specific health problems that shall prohibit him/her from working in the food service area:

(1) open wounds;

(2) acute respiratory infections; and

(3) acute Hepatitis A (inmate with old Hepatitis A may work in food service when medically cleared).

c. An inmate with a chronic disease (HIV, Hepatitis B and C) may work in food service.

G. Medical Screening for Inmate Candidates: SCI Quehanna Boot Camp and SCI Pine Grove (Youthful Offender Program [YOP])

1. Introduction

a. The goal of this medical screening program is to maximize the safe participation of inmates in the physical fitness programs of SCI Quehanna Boot Camp and SCI Pine Grove YOP. The goals of the pre-participation medical evaluation are:

(1) to identify medical problems associated with life-threatening complications during exercise; and

(2) to identify medical conditions requiring documentation that the patient is medically stable prior to participation in an exercise program.

b. At the time of evaluation for placement at SCI Quehanna Boot Camp, and SCI Pine Grove YOP, a physician/PA/CRNP, shall review the **DC-471/DC-471A, New Reception/Parole Violator Return Screening Form** (refer to **Section 2** of this procedures manual), the physical examination, comprehensive dental examination, and appropriate lab, Electro-Cardiogram (ECG), and x-ray reports to determine the inmate's medical eligibility for participation in these programs. The recommendations shall be recorded in the Progress Notes and the **DC-440B, Supplemental Medical Screening for Inmate Candidates SCI Quehanna Boot Camp and SCI Pine Grove YOP (Attachment 3-F).**

c. Additional fitness testing may be required prior to clearance for participation at the Boot Camp.

d. There are medical conditions that are associated with life threatening complications, and are considered disqualifying for high intensity exercise programs. Many of these are cardiovascular disorders and are associated with sudden death. The most common are:

(1) hypertrophic cardiomyopathy (HCM);

(2) coronary artery anomalies;

(3) myocarditis;

(4) valvular heart disease (rheumatic heart disease, symptomatic mitral valve prolapse);

(5) Marfan's syndrome;

(6) atherosclerotic coronary heart disease; and

(7) heart conduction abnormalities.

These conditions can be difficult to detect in the medical evaluation process, and most athletes who die suddenly from these conditions have no symptoms. If suspected, the candidate should be evaluated by a cardiologist prior to the recommendation for participation in an exercise program.

e. There are other medical conditions that are not automatically disqualifying. Chronic medical conditions require evaluation and documentation that they are stable (with or without medications) and the inmate is safe to fully participate in Boot Camp activities. If the medical status cannot be determined, a final decision on participation can be deferred, pending either further evaluation (e.g. echocardiogram) or the correction of disqualifying abnormal findings (e.g. elevated blood pressure). Finally, inmates with acute injuries or illnesses may be deferred until the natural healing process has been completed (e.g. fractured fibula). These include, but are not limited to:

(1) cardiovascular disorder:

(a) hypertension-(140/90) or greater, uncontrolled by medication within the past 30 days;

(b) history of bacterial endocarditis;

(c) arrhythmias not controlled within the past 30 days;

(d) heart murmur not specifically cleared by the physician as functional and benign; and

(e) electrocardiographic abnormalities other than heart block, or cardiac enlargement. However, a referral to a cardiologist is not necessary whenever the findings are determined to be a normal variant.

(2) an inmate with a chronic illness who is stable on medications or those receiving preventive therapy for TB may be processed if cleared by a physician;

(3) an inmate with asthma or diabetes mellitus must be considered on an individual basis as to his/her ability to perform rigorous physical activities (see **Quehanna Boot Camp Physical Fitness Manual Activities/Requirements, Attachment 3-G**), his/her ability to adjust his/her medication as appropriate, and the medical facilities available at the Boot Camp;

(4) an inmate with seizure disorders may be considered if he/she is controlled with medication and free of seizures for six (6) months;

(5) renal disorder:

(a) single kidney – restricted from contact sports;

(b) unexplained proteinuria; and

(c) myoglobinuria.

(6) hematologic disorders:

(a) sickle cell disease (sickle cell trait is acceptable);

(b) platelet abnormality; and

(c) hemoglobin less than 10 grams.

(7) symptomatic HIV;

(8) acute communicable disease;

(9) an inmate whose condition requires medical isolation;

(10) active ulcerative colitis or Inflammatory Bowel Disease (Crohn's Disease);

(11) chronic pancreatitis;

(12) significant abnormalities of liver function as determined by the physician or active hepatitis of any type (Hepatitis C treatment);

(13) chronic pelvic inflammatory disease;

(14) fever (> than 101.4);

(15) history of heat related illness;

(16) pregnancy and women within eight weeks postpartum;

(17) malignancies;

(18) musculoskeletal injuries/crippling musculoskeletal deformities/impairments, and healing fractures of any body part until healed. Special attention shall be made to the inmate's ability to perform Boot Camp exercises, as outlined in the **Quehanna Boot Camp Physical Fitness Manual Activities/Requirements;** and

(19) an inmate with a history of psychiatric illness, including eating disorders, must be evaluated and cleared by a psychiatrist as stable and able to function under the regulations of the Boot Camp.

f. The **DC-440B,** shall be used by practitioners from the sending facility, to document the evaluation for placement in the physical fitness programs.

2. Medical History

A thorough medical history is critical for detecting conditions that preclude, or restrict, participation in an exercise program. A complete personal history, family history, and review of systems, can detect 80 percent of conditions that might restrict participation, or require further evaluation. When a practitioner screens an inmate for these programs, the medical history questionnaire shall be reviewed with the inmate. Important components of the medical history are:

a. family history:

(1) family history of cardiovascular disease, sudden death, death at an age younger than 50; and

(2) family history of hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome, Marfan's Syndrome, arrhythmias.

b. past medical history:

(1) cardiopulmonary disease;

(2) hypertension;

(3) heart murmur;

(4) diabetes;

(5) seizures;

(6) renal disease;

(7) psychiatric disease;

(8) heat related illness;

(9) rapid increases or decreases in weight;

(10) previous exclusion from sports for any reason;

(11) prior surgery and complications;

(12) loss of function in a paired organ (eye, testis, kidney, etc.);

(13) current medications;

(14) immunization history;

(15) current pregnancy; and

(16) menstrual history in female inmates.

c. injury history:

(1) past injuries with sequelae (pain, limitations or impairments, etc.); and

(2) head injuries with loss of consciousness.

3. Review of Systems (ROS)

Most individuals with medical conditions associated with sudden death are asymptomatic; note the following symptoms with or without exercise:

a. cardiac:

(1) dyspnea;

(2) chest pain;

(3) syncope;

(4) palpitations;

(5) lightheadedness;

(6) wheezing; and

(7) heart murmur.

b. other:

(1) pregnant;

(2) severe head injury/loss of consciousness;

(3) eating disorder;

(4) excluded from participation in sports; and

(5) heat related illness.

4. Physical Examination

A practitioner shall complete a physical examination, with particular attention given to the following:

a. general:

(1) signs of Marfan's Syndrome - high arched palate, dislocated lens, arachnodactyly, chest deformities, mitral valve defects, tall with abnormal upper to lower body segment ratio;

(2) presence of skin infections; and

(3) visual acuity.

b. vital signs: temperature, blood pressure (lying, sitting, standing), resting pulse (rate and rhythm);

c. cardiac examination:

(1) presence of jugular venous distention;

(2) auscultation of a murmur in the supine, and standing positions, and during, and after, a Valsalva maneuver and/or squatting;

(3) palpation of all pulses; and

(4) presence of edema.

d. pulmonary: presence of adventitious sounds (wheezing, rhonchi, rales);

e. abdomen: organomegaly;

f. genitourinary: absence of a testis; and

g. musculoskeletal: examination of the spine and all joints.

5. Laboratory Testing

   a. Routine laboratory testing is not required.

   b. Any testing should be directed by the findings of the medical history and physical examination.

6. Recommendation for Participation

   a. The prospective candidate for these exercise programs (refer to **Quehanna Boot Camp Physical Fitness Manual Activities/Requirements**) shall receive one of the following recommendations:

      (1) full and unrestricted participation (includes chronic medical conditions determined to be stable with/without medication[s]);

      (2) recommendation for participation deferred pending further medical evaluation: In these cases, the practitioner is required to document in the progress notes the evaluation and/or treatment required, and discuss this information with the transferring and receiving CHCA/designee, Medical Director/designee, and inmate; and

      (3) participation in an exercise program not recommended: The reasons for this recommendation must be documented in the progress notes. Prior to informing the inmate of his/her inability to participate in the Boot Camp Program; the practitioner shall discuss with the Medical Director, and notify the Regional BHCS QI Nurse (CR-BHCS QI Nurses).

   b. An inmate who refuses any component or aspect of a health appraisal, screening, or assessment for consideration for the Boot Camp Program shall sign a **DC-462** in accordance with Department policy **13.1.1, Section 8**. The practitioner or licensed nurse shall document such refusals in the progress notes, which shall preclude participation in the program. The CHCA/designee shall inform the Unit Manager and the Deputy Superintendent for Centralized Services (DSCS) of the inmate's refusal to participate in the Boot Camp medical qualification process.

   c. The practitioner shall update the DOCNet Inmate Status Application for Boot Camp clearances.

7. Continued Eligibility for Inmates Who Develop a Medical Condition, or Suffer an Injury During the Boot Camp Program

   a. Boot Camp inmates are processed for eligibility at other SCI sites; however, some inmates develop medical conditions, or suffer injuries, while participating in the Boot Camp Program. The Quehanna Boot Camp Superintendent reserves the right to assess each instance on a case-by-case basis for continued participation.

b. The following procedure will be used to determine continued eligibility for inmates who develop a medical condition or suffer an injury that impacts their ability to participate in physical training, drill and ceremony, or treatment/education:

(1) the Registered Nurse Supervisor (RNS)/designee shall notify management staff of the inmate's condition, prognosis, and date of follow-up appointment and/or referral to medical specialist;

(2) the RNS/designee shall issue a "pink tag" to the inmate, clearly listing all medical restrictions and the date of the next medical appointment;

(3) the RNS/designee shall notify the appropriate staff regarding the inmate's housing, employment and activity restriction(s);

(4) if the inmate's medical condition is considered long term (lasting more than seven days) the RNS/designee shall schedule a Medical Review Committee to determine if the Boot Camp will be able to manage the inmate's medical condition appropriately. The Committee shall include:

(a) Superintendent;

(b) Major;

(c) CCPM;

(d) RN Supervisor/designee;

(e) Captain;

(f) Unit Manager; and

(g) BHCS – Chief of Clinical Services/designee.

(5) the Medical Review Committee shall review, at a minimum, the following information:

(a) medical restrictions;

(b) behavior management log;

(c) progress in the program;

(d) PT test results;

(e) work evaluations;

(f) treatment evaluations;

(g) education participation;

(h) disciplinary history;

(i) psychiatry history; and

(j) staff observations.

(6) the inmate's continued participation will be reviewed bi-weekly, after each medical appointment, or more often if necessary to determine if adjustments are needed; and

(7) the final determination for continuation in the program shall be made by the Superintendent.

H. Commutation Physical Examination

1. The CHCA/designee shall ensure, at a minimum, that the following procedures are conducted:

   a. a physical examination is completed by a practitioner, in accordance with Department policy **11.4.1, "Case Summary,"** and the **DC-473, Commutation Physical Examination Summary (Attachment 3-H)** is typed and signed by the practitioner;

   b. the **DC-521, Commutation Notice Form (Attachment 3-I)** is placed in the medical record on top of the Problem List tab, in a clear, plastic sleeve. The notice shall not be removed until the application for commutation is approved or denied; and

   c. all commutation forms shall be kept together in the legal section of the medical record.

2. The DSCS/designee shall contact the Pardons Case Specialist/designee, and forward an updated **DC-473** (with the "update" box checked) when the inmate's medical/psychiatric status changes significantly (hospitalization, death, or the applicant is diagnosed with a chronic or acute medical or psychiatric condition and/or terminal illness).

3. The inmate's HIV/AIDS information shall not be communicated to the Board of Pardons unless the inmate signs a **DC-108, Authorization for Release of Information**, in accordance with Department policy **DC-ADM 003, "Release of Information."**

I. Medical Implications During Use of Force

In accordance with Department policy **6.3.1, "Facility Security,"** nursing staff shall be contacted, in all cases, prior to the planned use of force to determine whether there are any medical contraindications to the use of the devices listed in this subsection. The RNS/Team Leader shall review the inmate's current **DC-440A** for any chronic illness/conditions, and the inmate medical record for any acute illness/conditions that may prevent the use of certain devices; these acute illness/conditions are outlined on the **DC-440A**. At the time of initial and

preventive health evaluations, the **DC-440A** shall be completed by a practitioner. A medical assessment of the inmate shall be conducted after each use of force by a practitioner/RN.

Medical conditions associated with positional asphyxia shall be documented by the practitioner in the progress notes, and on the **DC-440A,** at the time a physical examination/preventive health evaluation is conducted. Obesity, alcohol and drug use (sedative hypnotics, including barbiturates and benzodiazepines), and enlarged heart due to cardiac diseases such as Left Ventricular Hypertrophy (LVH), and cardiomyopathy shall be addressed appropriately.

1. Oleoresin Capsicum (OC)

   a. Medical contraindications for capsicum use shall be documented and include the following:

      (1) asthma, emphysema/COPD, and other chronic pulmonary diseases;

      (2) severe, unintended reaction to previous OC (dermatitis, or anaphylaxis);

      (3) corneal disease;

      (4) hypertension – uncontrolled and/or severe;

      (5) coronary artery disease – absolute contraindication;

      (6) congestive heart failure (CHF) – moderate to severe – uncontrolled;

      (7) cardiomyopathy – absolute contraindication; and

      (8) acute medical illness/conditions, as evaluated by a RN, at the time of the Planned Use of Force.

   b. The medical record of an inmate being evaluated for OC use, shall be reviewed for these medical conditions, and sensitivity reactions. Complicating conditions should be noted on the **DC-445, Allergy/Drug Sensitivity Label** located on the outside front face of the red medical jacket.

   c. If an inmate refuses a preventive health evaluation, and the use of OC is not already considered contraindicated, the **DC-440A** shall be updated based on the information available, and the use of OC will remain not contraindicated.

2. Restraint Chair

   There are no absolute contraindications for placement in a restraint chair; however, a RN shall be assigned to assess the inmate's circulation, and respiratory status, during the initial placement into the restraint chair, and every two hours thereafter, until the inmate is released, in accordance with Department policy **6.3.1.**

3. Electric Devices (Electric Immobilization Device [EID]/Taser® [drive stun only] and Remotely Activated Custody Control [RACC] Belt)

   a. The use of these devices has been associated with traumatic musculoskeletal injuries, head injuries, eye injuries, and rhabdomyolysis. After the use of any of these items, a practitioner/RN must conduct a physical assessment to detect such adverse effects.

   b. Medical contraindications for use of the EID/Taser® (drive stun only) and RACC Belt include, but are not limited to, the following:

      (1) pregnancy;

      (2) history of epilepsy;

      (3) history of ventricular tachycardia;

      (4) artificial pacemaker; and/or

      (5) automatic implantable/life vest cardiac defibrillator.

Section 4 – Dental Services

A. Reception/Reentry of Inmates into the Department

1. Access to Dental Services

   Upon admission, a dental screening (excluding intra-system transfers) by a qualified health care professional or health trained personnel, described in **Section 2** of this procedures manual shall be performed.[1] Documentation shall be made on the **DC-471, New Reception/Parole Violator Return Screening Form-Male** and **DC-471A, New Reception/Parole Violator Return Screening Form-Female** by a medical provider or a nurse.[2]

2. At reception, the Diagnostic and Classification Process begins for each inmate, including:

   a. new commitments;

   b. returned escapees;

   c. Community Corrections Center (CCC) returns;

   d. Parole Violators (PV); and

   e. Authorized Temporary Absence (ATA) from the Department for more than 90 days.

3. The dental component of the process consists of:

   a. dental examination;

   b. dental treatment plan;

   c. oral hygiene instruction; and

   d. dental orientation.

4. The examination shall be performed by a dentist within 30 days of reception. The oral hygiene instruction and orientation may be conducted by a dental hygienist within 30 days of arrival. In the event of a scheduling delay, the Dental Diagnostic and Classification Process shall take place, as described above, at the earliest opportunity.

5. The goal of this Dental Diagnostic and Classification Process is to attempt to identify the dental condition(s) of all inmates entering the Department and to prioritize them for treatment. The dental examination includes:

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[1] 5-6A-4360 (5-ACI-6A-19)
[2] 5-6A-4362 (5-ACI-6A-21)

a. a visual and tactile examination, by minimally using a dental light, mirror, explorer, periodontal probe; and

b. if available, a panoramic radiograph/digital image (panorex) shall be exposed on every inmate, regardless of the inmate's remaining dentition. In the event that the panoramic unit is not operational at the time of the appointment, the licensed dentist may perform a more limited dental examination.

(1) A panorex does not expire. Hence, after the initial image has been taken, additional panoramic images are not necessary until new, invasive, and/or extensive treatments requiring updated treatment planning are indicated.

(2) Digital panoramic and other radiographic images are available for viewing with the XV Web Application, which is a separate part of the electronic dental record.

6. After performing the dental examination, a dentist shall document findings on the electronic **Dental Tooth Chart (Attachment 4-A)**. Such documentation shall include:[3]

a. missing teeth;

b. caries;

c. teeth requiring extraction;

d. presence of dental prosthesis or other oral appliance;

e. need for dental prosthetics;

f. oral cancer screening;

g. periodontal assessment or Periodontal Screening and Recording (PSR) as outlined in the **Community Periodontal Index of Treatment Needs (Attachment 4-B)**;

h. American Society of Anesthesiology (ASA) classification;

i. dental Level of Care (LOC);

j. dental x-rays; and

k. electronic signature, date, and time of the encounter.

7. The dental treatment plan is recorded in the electronic **DC-458, Dental Intake Screening/Exam** form. It is the responsibility of the dentist performing the assessment to clearly, completely, and accurately record and explain all findings in a manner that other Department dentists may review and understand. Furthermore, it is the responsibility of

[3] 5-6A-4360 (5-ACI-6A-19)

the provider to add the indicated dental treatment into the electronic waiting list in Sapphire.

8. Following the dental examination and within the 30-day post-reception period, the inmate shall receive oral hygiene instruction and an orientation to the Department's Dental Services Program. The oral hygiene instruction and orientation shall be given by a hygienist. The dental orientation shall include the information listed below.[4]

   a. Personal oral hygiene, to include the following:

      (1) dental hygiene items available from the Commissary;

      (2) oral hygiene educational materials;

      (3) brush three times each day with a soft toothbrush and a toothpaste approved by the American Dental Association (ADA);

      (4) floss daily;

      (5) proper nutrition; and

      (6) avoidance of tobacco products.

   b. The Department's Dental Services Program includes:

      (1) examinations and limited examinations;

      (2) x-rays;

      (3) cleanings;

      (4) fillings;

      (5) endodontics;

      (6) non-surgical periodontics;

      (7) extractions and oral surgery;

      (8) partial dentures;

      (9) full dentures; and

      (10) therapy for Temporomandibular Joint (TMJ) Disorders, to include, but not limited to:

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(a) bruxism splints;

(b) warm compresses;

(c) medications;

(d) specialty consultations; and

(e) follow-up.

An inmate's ability to receive any of the foregoing services shall be determined by a licensed dentist.

c. Services not provided by the Department include the following:

(1) general anesthesia, conscious sedation, or Nitrous Oxide Analgesia;

(2) bleaching;

(3) dentistry or surgery for purely cosmetic purposes;

(4) orthodontics;

(5) dental implants;

(6) fixed prosthodontics services; and

(7) surgical periodontics.

9. Other information relevant to the dental orientation process includes:

a. how to properly access services as outlined in **Subsection A.11.f. below**;

b. co-payment guidelines for Dental Sick Call in accordance with Department policy **DC-ADM 820, "Co-Payment for Medical Services;"** and

c. rights to informed consent for and refusal of dental services.

10. When accessing dental services, inmates shall be responsible for the following:

a. showing proper respect to all dental personnel;

b. practicing good oral hygiene and nutritional habits while incarcerated;

c. properly caring for and maintaining delivered dental treatment, appliances, and prostheses;

d. understanding that he/she may be placed on a waiting list for dental treatment and may not be seen for a period of time after the dental examination was performed;

e. promptly reporting to the dental office when called. If unable to report when scheduled, notify the dental office; and

f. paying all costs associated in accordance with Department policy **DC-ADM 820** and/or replacement of dental prostheses/appliances that have been lost or broken during incarceration in accordance with **Section 10** of this procedures manual.

11. During the first 90 days following reception into the Department and, in addition to the Dental Diagnostic and Classification Process described in **Subsection A.2. above**, an inmate is eligible for the following dental services.

a. Emergency treatment (LOC 4).

b. Emergent dental treatment (LOC 3).

c. Routine (LOC 2) and preventive dental treatment (LOC 1) shall not become available until the initial 90-day, post-reception period has elapsed.

NOTE: LOC is delineated in the **Dental Levels of Care and Treatment Eligibility (Attachment 4-C)**.

d. Restricted Housing Unit (RHU) and other inmates in Segregation status are eligible for dental services in accordance with the guidelines in this procedures manual.

(1) An inmate in Segregation status may need dental care, but the inmate's behavior or other security concerns may preclude the rendering of dental treatment. In such instances, the dentist must briefly document the reasons for postponement of that care and attempt to reschedule the care at the first available opportunity.

(2) In the event that an inmate in Segregation status requires dental care but multiple attempts to schedule the patient have been unsuccessful, the dentist must inform superiors, through the chain of command, in order to have the inmate either report for treatment or report for documented counseling and refusal of dental care.

e. Specialized Programs

Upon reception, some inmates may be potential candidates for participation in one of the Department's specialized programs including, but not limited to, the Quehanna Motivational Boot Camp. For inmates participating in specialized programs, the full range of dental services may not be available.

(1) When prior to leaving the reception center for the specialized program, LOC 3 or 4 dental problems are found and time and resources permit, a licensed dentist

shall attempt to schedule the inmate to treat such problems prior to transfer and in accordance with this section.

(2) When a procedure cannot be appropriately addressed prior to the scheduled transfer, the licensed facility dentist shall place the inmate on a medical hold until the inmate's dental condition has been stabilized.

f. Dental treatment may be accessed via one of the following methods:

(1) **DC-135A, Inmate's Request to Staff Member** for routine requests and/or to make inquiries of the dental office;

(2) **DC-500, Sick Call Request Form** for perceived serious dental problems;

NOTE: In accordance with Department policy **DC-ADM 820,** co-payment fees are defined and may be levied when an inmate accesses Dental Sick Call.

(3) appropriate referral from medical staff;

(4) appropriate referral from care and custody staff; and

(5) in regards to access via **Subsections A.11.f.(1)-(3) above**, non-dental staff shall not routinely refer inmates to the dental office. Referrals from non-dental staff shall be rare and only when an emergency or an emergent dental condition is believed to be present. Inmates making dental requests to non-dental staff shall normally be instructed to access dental care via **Subsections A.11.f.(1) & (2) above**.

g. An inmate shall have access to the full range of dental services, offered by the Department, when he/she remains at the reception facility for more than 90 days and:

(1) achieves classification status and remains at the intake facility;

(2) achieves classification status and is transferred to a Parent Facility;

(3) has at least three months of additional incarceration time remaining;

(4) is medically cleared;

(5) demonstrates acceptable oral hygiene; and

(6) complies with all relevant treatment recommendations.

B. Responsibilities of the Parent Facility

1. The Dental responsibilities of the Parent Facility normally begin after the initial 90-day period has elapsed. During the initial 90 days, inmates generally achieve classification

status and are transferred to a Parent Facility. However, some inmates remain at the Reception Facility once they have been classified. In this instance, the Reception Facility becomes the Parent Facility.

2. The Parent Facility's responsibilities normally begin on either the 91st day of incarceration or when the classification process is complete and the inmate is assigned to a Parent Facility, whichever occurs sooner.

3. Within 30 days of arrival to the Parent Facility, a dentist will review the dental treatment plan. If the treatment plan or any of the required documentation in **Subsection A.6.a-k above** has not been completed, a dentist is required to gather the missing data.[5]

C. Dental Services Provided by the Department

Dental services shall be provided on a priority basis, as determined by a dentist.

1. Inmate's Refusal to Accept Recommended Dental Treatment

   a. When an inmate refuses to accept recommended dental treatment, the procedures outlined in Department policy **13.1.1, "Management and Administration of Health Care"** shall be followed.

   b. The dentist shall be responsible for the following:

      (1) informing the inmate of treatment needs and determine whether the inmate wishes to consent to care;

      (2) if the inmate elects to decline dental services, maintain professional demeanor while interviewing the inmate to determine whether the refusal might be reversed through education and counseling;

      (3) the **DC-462E, Release from Responsibility for Dental Treatment** (refusal form) cannot be properly completed in the absence of the inmate because the personal counseling component would be missing;

      (4) informing the inmate of the benefits of the treatment and the possible consequences of declining the treatment;

      (5) in addition to completion of the refusal form, the encounter shall also be documented, in Subjective Objective Assessment Plan (SOAP) format on the electronic version of the **DC-458A, Dental Progress Note**;

      (6) if the refusal is not reversed, the electronic refusal form shall be completed and the inmate shall be asked to sign the form. This form should specify the

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treatment being refused, the benefits of the treatment, and the risks of not going through with the treatment:

(a) if the inmate does not sign the form, record "refused to sign" in the appropriate area;

(b) next, the signature of a witness is also required;

(c) the date and time of the encounter are required; and

(d) if an inmate refuses all dental treatment at one time, the **DC-462E** should be completed to reflect the totality of the decision.

(7) when an inmate refuses any or all dental services, he/she may not be called to the dental office again until such time as:

(a) he/she comes due for Preventive Dental Services;

(b) he/she submits a Dental Sick Call request;

(c) a correspondence is received wherein the inmate informs the dental office that he/she has rescinded the earlier decision to refuse treatment. In this instance, the planned treatment shall be re-prioritized and the inmate shall be scheduled accordingly; and

NOTE: During an appointment, an inmate may verbally inform a dentist that he or she is rescinding an earlier decision to refuse treatment.

(d) in the event that one specific type of dental treatment was refused, other dental treatment shall continue only if the outcome is not dependent upon completion of the treatment being declined.

2. Treatment Prioritization

Dental treatment needs must be prioritized after an examination has been completed. To achieve this, the **Dental Levels of Care**[6] **and Treatment Eligibility** system is used. The Dental LOC designation indicates the severity of the inmate's dental condition and eligibility for types of dental treatment. A dentist assigns the Dental LOC.

a. Dental LOC 4 – Emergency Care

(1) A dentist shall make the determination as to whether a presenting dental problem is an emergency, as set forth in the **Dental Levels of Care and Treatment Eligibility**.

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(2) In the absence of a dentist during regular dental office hours, a medical provider can assess the patient and render appropriate measures.

(3) After regular dental office hours, a nurse may assess the patient utilizing the Nursing Evaluation Tools (NETS) and following instructions appropriately.

(4) Dental emergencies shall be given priority over all other Dental LOC classes and shall not be subject to co-payment charges.

(5) All inmates are eligible to have treatment for dental emergencies.

(6) Oral hygiene status is not a basis for disqualification.

(7) Appropriate care shall be rendered promptly.

(8) Transfer of an inmate shall not occur until the emergency condition has been stabilized and has been documented as such by a physician or dentist.

b. Dental LOC 3 – Emergent Care

Emergent Dental Care is defined as a condition(s) that requires intervention to prevent progression to an emergency. A dentist shall make the determination as to whether a presenting dental problem is an emergent condition, as set forth in **Dental Levels of Care and Treatment Eligibility**. In the absence of a dentist during regular dental office hours, a medical provider can assess the patient and render appropriate treatment. After regular dental office hours, a nurse may assess the patient utilizing the NETS and follow instructions appropriately.

c. Dental LOC 2 – Routine Care

Routine Care is defined as any condition, not of an emergency or emergent nature, requiring corrective and/or interceptive measures. Facility dental offices shall provide Routine Care for inmates as resources of staff time and materials are available. A dentist shall make the determination as to whether a presenting dental problem is a routine condition, as set forth in **Dental Levels of Care and Treatment Eligibility**.

d. Dental LOC 1 – Preventive Care

Facility dental offices shall provide Preventive Dental Care for inmates as resources of time and materials are available. A dentist shall make the determination and direct the Preventive Dental Care program, as set forth in **Dental Levels of Care and Treatment Eligibility**.

(1) An inmate in this category requires no dental treatment at this time.

(2) An inmate will be scheduled for routine Preventive Care, as determined by the hygiene recall system at the facility and in accordance with this procedures manual.

(3) All inmates are eligible for routine Preventive Care.

3. Dental Protocols

a. When inmates present with dental problems after regular dental office hours, facility medical staff shall follow established protocols.

b. Dental staff shall be notified of all after-hours dental encounters on the next business day.

c. Dental care, for the condition(s) presented after-hours, shall be rendered within a time frame that is reasonable for the specific condition(s) encountered.

d. When a dentist is absent during regular dental office hours, the dental hygienist shall follow protocols described in **Standing Authorization for the Provision of Professional Services by a Dental Hygienist, Under General Supervision (Attachment 4-D)** and **Authorization for the Performance of Radiologic Procedures by a Dental Hygienist, Under General Supervision (Attachment 4-E).**

At all times, when either a dentist is on site or in the absence of a dentist, Title 49, Chapter 33 of the Pennsylvania Code shall be the primary directives for professional practice and behavior.

4. Dental Sick Call

a. The purpose of the Dental Sick Call Program is to address inmate dental problems in the LOC 3 category. Dental Sick Call was neither intended to address Routine and Preventive dental needs nor to circumvent the dental office scheduling process.

b. Dental Sick Call shall be conducted a minimum of five days per week, except on state observed holidays and/or when a dentist is not available in the facility.

c. A **DC-500** and a **DC-138A, Cash Slip** are required when accessing Dental Sick Call;

d. For other dental office inquiries, a **DC-135A** is appropriate.

e. Whenever present, a dentist shall review all sick call requests and conduct the Dental Sick Call appointments.

f. With review by and approval from a dentist, a facility staff person is able to respond in writing to a written request from an inmate.

g. During a Dental Sick Call appointment, a dentist performs a limited dental examination, focusing on the problem(s) reported by the inmate.

h. Upon completion of the limited dental examination, a licensed facility dentist may perform any or all of the following, depending upon findings:

(1) triage the dental condition(s);

(2) manage the case appropriately without necessarily rendering definitive care during the encounter;

(3) prescribe medications and/or write indicated orders;

(4) charge, as appropriate, the co-payment fee to the inmate's financial account; and/or

(5) in the absence of a dentist, a dental hygienist may screen sick call patients and refer them to either a medical provider or to the dentist. The co-payment fee shall not be assessed when a dental hygienist screens a sick call patient.

5. Preventive Dentistry

A dentist will ensure that a program of preventive dental services is implemented and an effective recall system is maintained.

a. Preventive dentistry shall be provided for inmates as resources of staff time and materials are available.

b. At a minimum**,** each inmate shall be eligible for Preventive Dentistry services biennially. However, the actual frequency shall be dependent upon each inmate's needs, as determined by a dentist.

c. Each facility dental office must use a standardized program to track and schedule the preventive dental needs of all inmates in the facility.

d. Only a licensed facility dentist may order additional hygiene visits for an inmate.

e. When a dental hygienist screens and/or treats a patient, the **DC-458S, Preliminary Dental Screening Form (Attachment 4-F)** shall be used to record findings.

f. The Preventive Dental Program includes:[7]

(1) health history review;

(2) preliminary dental screening;

[7]5-6A-4360 (5-ACI-6A-19)

(3) complete dental examination;

(4) oral cancer screening;

(5) PSR grid and score;

(6) radiographs;

(7) oral prophylaxis (cleaning);

(8) oral hygiene instruction (OHI);

(9) sealants;

(10) fluoride treatments;

(11) dental educational materials; and

(12) nutritional counseling.

g. Documentation of preventive treatment rendered shall be completed on the electronic **DC-458A**.

6. Restorative Dentistry

a. Restorative Dentistry shall be provided for inmates as resources of time and materials are available.

b. Restorative treatment shall be completed to stop disease processes, repair teeth, improve function, and preserve the integrity of the dental arches.

c. Temporary and permanent restorations, using ADA approved materials, shall be offered.

NOTE: Radiolucent materials shall not be utilized for restorations.

d. Restorations shall be:

(1) limited to those that may be placed and/or fabricated in the office. Restorations involving laboratory processing shall not be offered;

(2) documented on the **DC-458** in accordance with the following standard requirements;

(a) emergency and Sick Call – SOAP format; and

(b) previously diagnosed and treated during a scheduled appointment – complete dental narrative.

e. Temporary restorations shall only be placed by a dentist. Teeth that have received temporary restorations shall be definitively treated within an appropriate time frame, and in accordance with dental practice standards, as determined by the professional judgment of a dentist.

7. Periodontal Therapy

Non-surgical Periodontal Therapy shall be provided for inmates as resources of time and materials are available. The goal of the Department's periodontal program is to maintain the health of the teeth and the periodontia as follows.

a. Evaluation

(1) The periodontal condition of the inmate shall be evaluated during preventive visits.

(2) The results of the periodontal evaluation shall be documented and shall include:

(a) oral hygiene status;

i. tissue color;

ii. presence of edema;

iii. presence of bleeding on probing;

iv. plaque accumulation; and

v. calculus deposits.

(b) tobacco usage;

(c) PSR grid and score;

(d) mobility classification; and

(e) when appropriate, charting of full mouth periodontal probing depths and American Association of Periodontists (AAP) classification.

b. Treatment

(1) A dentist shall diagnose, order, and appropriately supervise all periodontal treatment.

(2) Non-surgical therapy shall be provided.

(3) Prior to beginning therapy:

(a) the inmate shall be counseled as to the nature of his/her periodontal condition, the parameters of the suggested treatment, his/her role in the treatment process, and completion of informed consent;

(b) the electronic **DC-452C, Consent for Periodontal Therapy** shall be completed; and

(c) therapy shall not be provided or shall be discontinued when:

i. there is documented non-compliance with the parameters of the treatment process;

ii. it is determined that a successful outcome is unlikely; and

iii. if termination of periodontal treatment becomes necessary, the rationale shall be documented in the dental record by the treating dentist.

8. Endodontic (Root Canal) Therapy

Endodontic Therapy shall be provided for inmates as resources of time and materials are available. The components of Endodontic Therapy include:

a. a treatment plan with appropriate pre-operative films is required prior to initiating Endodontic Therapy;

b. films during the course of Endodontic Therapy, for the purpose of determining/verifying canal length and proper fit of obturation materials, are required;

c. post-operative films are required;

d. Endodontic Therapy shall be provided by a licensed facility dentist and shall generally be limited to sound anterior and bicuspid teeth that are critical to overall oral health;

e. the electronic **DC-452B, Consent to Endodontic (Root Canal) Treatment** with the parameters for beginning and discontinuing Endodontic Therapy shall be completed prior to initiation of treatment;

f. temporary restorations placed during the course of Endodontic Therapy shall be managed in accordance with **Subsection C.6.e. above**;

g. restorative treatment for the endodontically treated tooth/teeth shall be appropriately provided upon completion of the root canal(s);

h. when determined to be predictably completed and restorable, a dentist may render molar Endodontic Therapy; and

i. Endodontic Therapy shall not be undertaken if any of the following conditions are present:

(1) oral hygiene is inadequate;

(2) the tooth is periodontally compromised;

(3) high caries rate;

(4) extensive restoration of the tooth is required;

(5) poor prognosis of other teeth in the same quadrant; and/or

(6) the tooth is not essential to preserve arch integrity.

9. Oral Surgery

Oral surgery shall be provided for all inmates as resources of time and materials are available.

a. Pre-operative radiographs are required for proper diagnosis and treatment planning.

b. The electronic **DC-452A, Consent to Dental Surgical Procedure** shall be completed for all oral surgery procedures.

c. Oral surgery procedures that are beyond the scope of a dentist may be referred to the oral surgeon specialist retained by each facility. An electronic **Consultation Form** shall be completed by a dentist and submitted to the medical director for review and approval.[8]

d. Responsibilities when specialty oral surgery is to be performed shall include the following:

(1) communication with all concerned parties regarding the gathering of all diagnostic information and scheduling of an inmate requiring oral surgical treatment;

(2) assuring that the oral surgeon is accompanied by facility staff while practicing;

(3) dental office auxiliary staff shall provide assistance to the oral surgeon, as directed;

[8] 5-6A-4360 (5-ACI-6A-19)

(4) reviewing all documentation by the oral surgeon to ensure compliance with Department policy and procedures;

(5) distributing written **Post-Operative Instructions (English and Spanish) (Attachment 4-G)** to all patients who have undergone an oral surgical procedure;

(6) follow-up with all oral surgery patients who may be housed in the facility infirmary; and

(7) tracking all oral surgery patients to ensure timely completion of care, if additional oral surgical appointments are required, and continuing with other planned treatment.

e. Oral surgery for purely cosmetic reasons is not offered by the Department.

10. Prosthodontics

Prosthodontics shall be provided for inmates as resources of time and materials are available. The Department is not required to replace missing teeth, regardless of when or where they were removed.

a. Full and partial dentures may be provided at the discretion of a licensed facility dentist operating within the guidelines of this manual and in accordance with community standards of care.

b. If a dentist determines that an inmate requires prosthodontic services, the Department shall provide:

(1) removable partial dentures – one upper and one lower, per lifetime;

(2) complete dentures – one upper and one lower, per lifetime; and

(3) if it is determined that an inmate requires additional prosthodontics care for any reason, fabrication will occur following consultation with the Dental Administrator or the Dentist Supervisor and may be subject to co-payment fees in accordance with Department policy **DC-ADM 820** and at the discretion of the Dental Administrator.

c. No prosthetic case shall be initiated unless a documented Dental Treatment Plan is in place and has been appropriately/sequentially completed.

d. Appropriate pre-operative radiographs are required for the diagnosis and treatment planning of all prosthetic cases.

e. The laboratory prescription forms for all prosthetics cases shall be scanned and retained via uploading into the Documents section of the electronic dental record.

f. Relines shall be provided when conditions warrant.

g. A dentist shall evaluate and determine the need for a dental prosthesis based upon the factors listed below. Observed conditions that either indicate or contraindicate the need for a dental prosthesis shall be fully documented in the progress notes.

(1) The inmate shall demonstrate good oral hygiene.

(2) The periodontia shall be healthy and all abutment teeth shall be determined to be capable of withstanding the forces placed on them by a dental prosthesis.

(3) Dental prostheses shall be deferred until all sequential treatment has been completed. The inmate shall be apprised of the conditions to be met and his/her responsibility to comply before fabrication can begin.

(a) An inmate with poor oral hygiene and/or is refusing preventive or periodontal care shall not subsequently be approved to receive prosthodontic treatment until such time as the hygiene appointments have been completed and the inmate is exhibiting good oral hygiene.

(b) All required extractions shall have been completed.

(c) All restorations crucial to predictable partial denture fabrication shall have been completed.

(4) When treatment is deferred because an inmate is not cooperating or complying with some aspect of sequential care, protocol requires the dentist to re-evaluate and document the inmate's condition and/or compliance level every six months if the inmate continues to request prosthodontic treatment.

h. Dental prosthetics fabrication shall be further guided by the following:

(1) preservation of the integrity of the dental arch;

(2) in some situations, if minimum function exists, i.e., eight or more posterior teeth in occlusion, a dentist may determine that a partial denture is not needed;

(3) partial dentures are fabricated to replace missing anterior teeth in accordance with the guidelines in this section of dental policy;

(4) unless co-morbidities have been identified, an edentulous state does not adversely affect an individual's health; and

(5) care will be prioritized for inmates with a documented medical condition contributing to malabsorption or malnourishment.

i. Prostheses, repairs, and replacements shall be provided as indicated for inmates when resources of time and materials are available.

(1) An inmate who consents to the fabrication of a dental prosthesis has authorized the use of Department resources for that purpose. If the inmate subsequently refuses to accept the prosthesis once the fabrication process has begun, he/she will become responsible for any applicable laboratory fees.

(2) In the event of a broken or lost prosthesis, a dentist shall determine whether it is medically necessary to provide a repair or replacement to the inmate.

(a) There are no charges for routine Prosthodontic repairs.

(b) If determined to be eligible for replacement, the inmate shall pay applicable laboratory and materials costs, as itemized on the lab invoice.

(c) The inmate must complete a **DC-138A** authorizing the deduction of funds from his/her account to cover the costs of the services. The dentist shall ensure that the facility Business Office receives the original.

(d) If sufficient funds are not available, the prosthesis shall be replaced and payments shall be deducted from the inmate's account in accordance with Department policy **DC-ADM 820**.

(3) Prosthetic appliances, which have been fabricated as part of outside care, may be requested and delivered to the dental office. The dental office will not deliver an unsatisfactory dental prosthesis received from a non-Department source to an inmate. Upon delivery, the electronic **DC-461A, Request/Receipt for Dental Prosthetic Appliance from Outside Source** shall be completed.

11. Orthodontic Therapy

a. Orthodontic therapy is not offered by the Department.

b. An inmate may be received with fixed or removable orthodontic appliances. Presence of such appliances shall be documented on the **DC-458A**.

c. An inmate received with brackets, banding, or other fixed orthodontic appliances may have them removed with approval from the licensed facility dentist. The standard **DC-452, Consent to Operation or Other Medical/Dental Procedure** shall be completed.

d. If the licensed facility dentist determines that the orthodontic appliance(s) should not be removed, the inmate shall be counseled.

NOTE: If an inmate chooses to reject the recommendations of the dentist, the encounter shall be documented in the progress notes and a **DC-462E** shall be completed.

e. If the licensed facility dentist determines that an existing orthodontic appliance is necessary and that appliance requires maintenance, repair, or replacement, the case shall be reviewed by the Dental Administrator or a Dentist Supervisor.

f. At such times when it is deemed that an existing orthodontic appliance is no longer necessary, the items shall be confiscated and a **DC-154, Confiscated Items Receipt** shall be issued.

D. Adjunctive Treatment

1. The scope of treatment in the Department's oral health care program is limited to basic services provided in the general practice of dentistry, as outlined in this procedures manual.

2. Services outside the scope defined herein shall be referred to the Dental Administrator or a Dentist Supervisor for review and determination.

E. Dental Holds and Inmate Transfers

1. An inmate is to be placed on a dental hold using the **DC-482, Medical/Psychiatric Hold Form**, by the licensed facility dentist when:

   a. experiencing an emergency or emergent condition and/or undergoing an emergency or urgent dental treatment;

   b. an emergency or emergent dental condition has not yet fully stabilized; and/or

   c. movement might adversely affect his/her health and/or the outcome of the treatment.

2. The hold will continue until the inmate's dental condition has stabilized to a point where movement may occur safely.

3. Although the preferred course of action is for the licensed facility dentist to finish any ongoing procedures, occasionally, transfer of an inmate may become imminent. In this instance, it is incumbent on that dentist to give documented notification to the dentist of the receiving facility. A documented email or a telephone call to a dentist at the receiving facility shall fulfill this requirement.

F. Documentation in the Medical/Dental Record[9]

The Department has developed documentation guidelines for dental records in accordance with Department policy **13.1.1**.

[9] 5-6D-4413 (5-ACI-6D-05)

1. All forms shall be completed, managed, stored, and utilized as described below. Standardized abbreviations are outlined in the **Approved Abbreviations Listing (Attachment 4-H)**.

2. Any deviations or suggestions for change to these procedures shall be brought to the attention of the facility Corrections Health Care Administrator (CHCA). The facility CHCA and dentists shall then discuss proposals with the Dental Administrator or a Dentist Supervisor.

3. As of February 2018, all dental documentation is completed in the electronic health record (EHR). Licensed providers, documenting in accordance with their credentials, are to complete all required electronic forms for each encounter.

   NOTE: With the advent of electronic charting, paper charts will no longer be developed for new inmates entering the Department. However, some of these inmates will be incarcerated in facilities where film-based radiography is practiced. In such situations, the films will be stored in plastic pockets that are identified by the inmate name and Department number. These storage pockets shall be organized and maintained in the medical records area. When needed, the films can be accessed by the dental staff.

4. In the paper charts, all dental forms shall be kept in the dental section of the inmate's medical record, as described below, with the following exceptions:

   a. the **DC-452, DC-452A, DC-452B, DC-452C,** and **DC-462E** forms shall be stored in the Legal Section of the medical record; and

   b. the **DC-441, Consultation Record** is stored in the Consultation Section of the medical record.

5. Order of documents, from top to bottom.

   a. Intra-oral films shall not be stored loosely in the chart; rather, they shall be mounted chronologically in commercially available film mounts.

      NOTE: An effort shall be made to consolidate individual periapical and bitewing films chronologically into larger film mounts. Such consolidation will provide for better chart organization and ease of case review.

   b. All films shall be identified with:

      (1) date of exposure;

      (2) name; and

      (3) Department number.

      NOTE: There shall be no writing on intra-oral films.

c. Panoramic films shall be stored as follows:

(1) neatly trimmed so as not to compromise the diagnostic portion of the film to fit in the clear plastic pocket;

(2) identified, as described above, by transcribing on the non-diagnostic portion of the image; and

(3) digital films shall be printed and stored chronologically immediately beneath the clear plastic pocket.

d. All the following dental forms shall be stored in reverse chronological order (most recent to oldest) with the most recent form on top:

(1) **DC-458**;

(2) **DC-458A;** and

(3) **DC-85** (previous version of the **DC-48, Dental Record**, pre-1996).

e. Laboratory prescription forms shall be stored in the clear plastic pockets.

f. The following items should not be stored in the dental section of the medical record:

(1) inmate request slips with or without responses from staff;

(2) other inmate correspondence;

(3) inmate grievances; and

(4) legal documents.

g. Dental Progress Note documentation

(1) SOAP format shall be used for each entry. This is applicable to electronic entries.

(a) S – Subjective findings are problems described by the patient in his/her own words. If given in another language, these shall be translated into English and then recorded into the progress notes.

(b) O – Objective findings are factual, measurable observations viewed clinically via visual, tactile, and radiographic examination techniques.

(c) A – Assessment is the clinical impression or diagnosis of the observed condition.

(d) P – Plan includes the procedure or treatment performed or planned, recommendations given, medications dispensed, and any other measures taken to address the observed condition.

(2) SOAP format is not required for the types of entries listed below. A complete dental narrative shall be written in the progress notes for the following:

(a) all complete Dental Examinations recorded on the **DC-458**;

(b) treatment for previously diagnosed problems; and

(c) prosthodontic fabrication, adjustment, and repair encounters.

(3) The complete dental narrative shall minimally include the following items as applicable to the encounter:

(a) type, location, and number of radiographs exposed;

(b) type and amount of local anesthesia administered;

(c) tooth number or area treated;

(d) specific procedure performed, including, but not limited to:

i. excavation of decay from tooth surfaces;

ii. canal working lengths;

iii. canals instrumented;

iv. root canal file sizes; and

v. number and type of sutures placed.

(e) materials used, including, but not limited to:

i. medicaments;

ii. cavity liner;

iii. base;

iv. varnish;

v. acid etch;

vi. primer;

vii. bonding agent;

viii. type and shade of composite;

ix. amalgam; and

x. temporization material.

(f) other items included in a dental narrative as may be applicable:

i. complications and/or extraordinary occurrences during the appointment;

ii. actions taken by staff;

iii. reaction of the patient;

iv. comments made by the patient;

v. prescriptions;

vi. post-operative instructions;

vii. oral hygiene instruction and dental health education;

viii. fluoride treatments;

ix. condition of the patient at discharge;

x. ASA classification; and

xi. LOC designation.

G. Dental Infection Control Manual

1. The Department recognizes the need to have infection control procedures because of the commitment to provide a safe environment for inmates and staff. All treatment and associated activity must follow the guidelines recommended by the Center for Disease Control and as outlined in the **Dental Infection Control and Safety Manual (Attachment 4-I)**.

2. A Power Point Program, for the purpose of required annual staff education in Dental Infection Control, is available on the Department of Corrections (DOC) Intranet, Bureau of Health Care Services (BHCS) Website, Infection Control.

H. Dental Management Review[10]

1. Annually, each dental facility will be audited to ensure that the American Correctional Association (ACA) standards, acceptable dental practice standards, and the parameters of this policy and procedures manual are being followed routinely.

2. The review shall consist of random reviews of the following:

   a. charts;

   b. patient examinations;

   c. dental office inspection;

   d. adherence to Department policies;

   e. inmate correspondence and litigation;

   f. infection control procedures;

   g. safety;

   h. credentialing; and

   i. administrative procedures.

3. A team of one to three auditors selected by the Dental Administrator shall be assigned to conduct each review. At the conclusion of each review, a brief exit interview shall be held with staff designated by the Facility Manager. A report shall be written and submitted to the Dental Administrator, who will distribute the report to appropriate facility and Central Office staff.

4. If any areas are found to be deficient, a Corrective Action Plan will be developed and implemented by the facility within 21 days of receipt of the report. The Dental Administrator shall receive a copy of any Corrective Action Plan that is developed.

I. Handling of Amalgam Waste[11]

1. Amalgam waste must be disposed of properly to reduce the release of Mercury and Silver into the environment, in accordance with guidelines established by the ADA, Pennsylvania Department of Environmental Protection (DEP), and Department policy.

2. Types of Amalgam Waste

[10] 5-6A-4411 (5-ACI-6D-03)
[11] 5-6A-4358 (5-ACI-6A-17)

a. Non-contact Amalgam waste is excess uncontaminated material left over from a dental procedure. This includes the amalgam capsules and containers.

b. Contact Amalgam waste is material that has been contaminated during the treatment procedure. Examples include extracted teeth with amalgam restorations, carving scrap, and amalgam captured by chair side traps, filters, or screens.

c. Amalgam sludge is a mixture of liquid and solid collected in the vacuum filter.

3. Requirements

a. While assuming ultimate responsibility to follow the program, the facility dentist(s) shall delegate ordering, recovering, storage, and recycling of dental amalgam to a specific dental staff person.

b. With appropriate training and supervision, an inmate janitor may handle the waste material.

c. Stock amalgam capsules in single spill, double spill, and triple spill sizes to minimize waste.

d. Use universal precautions when handling amalgam waste.

e. Use disposable traps and vacuum pump filters. Change these items regularly in accordance with manufacturer's guidelines. Operations that do not currently have the ability to change filters will have 365 days from the effective date of this policy to comply.

f. Store amalgam waste in an approved container labeled, "Amalgam for Disposal." All contact amalgam must be placed in an eight-ounce sealable plastic container, or for filters/cartridges that have sealable containers, materials can be sealed in manufacturer packaging.

g. When sending the container to the disposal vendor, follow the vendor-specific disposal requirements for packaging, i.e., using bleach or using a 10:1 bleach solution.

h. All containers and other items must then be placed in sealable plastic bags which are then placed into the shipping container. All containers must have appropriate shipping labels as identified by the disposal facility.

i. Regardless of whether they are full or not, the Amalgam Waste Collection Buckets and their contents must be returned to the vendor annually.

j. A certificate, verifying receipt, appropriate handling, disposal, and/or recycling of the amalgam materials must be received from the vendor and shall be kept on file at the

facility. This certificate must be presented to the dental auditors at each annual inspection of the dental program.

k. Procurement of shipping containers shall be sufficient to allow for one “in-use” container and one additional container on-hand.

J. Silver Recovery

1. Silver recovery filtration for the x-ray film processor in dental must have a filtration system installed on the processer to collect any silver that is released when processing x-rays. The only exception to this will be if the x-ray machine is digital.

2. The silver recovery systems will be checked during annual inspections and reviews for compliance.

   a. Installation and servicing of silver recovery system with follow-up servicing (at least annually).

   b. Test Strips for monitoring filter saturation.

   c. Copy of **Sample Compliance Letter (Attachment 4-J)** sent to local sewer/water authority.

   d. Recycling records.

3. Each dental office will arrange with a vendor for the above required recycling process. The facility’s maintenance department will ensure accessibility for required installation or may opt to install themselves.

4. Dental offices will submit copies of all certificates and recycling documentation to their respective safety offices.

5. Any question may be directed to the Central Office Safety Division or the Dental Administrator.

K. Peer Review[12]

In accordance with Department policy **13.1.1, Section 12**, to evaluate and improve the quality and efficiency of health care including the performance of a Licensed Independent Provider (LIP), a Peer Review may be initiated in response to patient complaints, patient care issues identified by other clinical staff peers, facility staff, the BHCS, or Contracted Health Care Provider staff. Peer review applies to Commonwealth of Pennsylvania employees and Contracted Health Care Provider staff.

[12] 5-6D-4411 (5-ACI-6D-03)

Section 5 – Corrective Eyewear

A. Procedures

1. Upon initial intake, every inmate will receive an eye ***history/screening*** as part of his/her initial intake physical examination.

2. Nursing staff ***will*** complete ***near (hand held) and distance*** Snellen visual acuity testing upon reception ***and near vision at every periodic exam.[1] Testing will include each eye independently and together. The results will be recorded on the DC-488, Snellen Visual Acuity Test/Tonometry Test Results Form (Attachment 5-A) by documenting best corrected vision and whether correction was used.*** Abnormal test results will be referred to an optometrist.

3. Upon receipt of an inmate request for optometry care via sick call, the ***practitioner*** will ***assess*** the ***inmate to identify any medical causes. A Snellen Visual Acuity Test will be completed with a referral to the*** optometrist/ophthalmologist for any inmate who has an acuity value of either or both eyes ***worse than*** 20/40.

4. No referral ***to the optometrist/ophthalmologist*** will be made for failing depth and/or color perceptions. All anomalies of the eye (glaucoma, cataract, detached retina, cornea abrasion, etc.) will be recorded on the **DC-467, Problem List**, **DC-472, Progress Notes**, **DC-440, Physical Examination Form** (#6 eyes/pupils section, and the **DC-488, *Snellen Visual Acuity Test Results and Tonometry Test Results only***).

5. The Optometrist/Ophthalmologist will document ***inmate*** examinations on the **DC-451, Ophthalmologic/Optometric Examination Record Form (Attachment *5-B*)**.

B. Access to Eyeglasses

1. The Department will provide one pair of glasses when determined to be medically necessary by an Optometrist/Ophthalmologist[2]. The Department will offer a selection ***of frames for*** males and females. An inmate may select any frame from the kits provided, ***but will be charged an upgrade fee if he/she selects metal frames***. Single vision, bifocal, trifocal, or tint will be provided in scratch resistant, coated glass or plastic lenses, if medically indicated.

2. An inmate may purchase a second pair of glasses at his/her own expense to include sports goggles, tints (up to 20%), photogrey, polycarbonate lenses and any other option(s) or upgrade(s) available.

3. An inmate may not possess more than two pair of prescriptive eyeglasses at any one time. An inmate is not permitted to discard an extra pair of eyeglasses. The extra pair

[1] 4-ACRS-4C-17, 4-4365
[2] 4-4375

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must be sent to the inmate's home, at the inmate's expense, or given to the Security Office to dispose of properly.

4. Replacement lenses will be provided when there is a +0.50 diopter/20 degree axis shift and/or an improvement of one line of acuity and/or as indicated by the examining optometrist/ophthalmologist, or when the integrity of the current pair justifies new glasses because of severely scratched lenses, broken frames, etc. The Department will incur the cost of replacement of these lenses except as addressed in **Subsection B.6. below**.

5. The Department will repair and/or order all frames and lenses damaged or destroyed as a direct result of the inmate's work assignments. The work supervisor will determine whether the frames and/or lenses were damaged and/or destroyed as a direct result of an inmate work assignment and submit his/her findings and recommendations in writing to the Corrections Health Care Administrator (CHCA). If the breakage is determined to be work related, appropriate repair or replacement procedures will be initiated.

6. The inmate is responsible for the costs incurred for the replacement/repair of frames and/or lenses damaged or destroyed due to negligence or deliberate destruction.

7. If sufficient funds are not available in the inmate's account, and medical staff has determined that the inmate's visual health would be adversely affected, the eyewear will be repaired or replaced and payments will be deducted from the inmate's account. The medical department will ensure that the Contracted Health Care Provider coordinates with the business office to ensure that the inmate signs a **DC-138A, Cash Slip** authorizing the deduction of the money from his/her account to cover the cost of the repair or replacement.

8. An inmate is permitted to keep metal or plastic frames with glass or plastic lenses as approved by the intake facility. When transferring from the intake facility to another facility or a subsequent intra-facility transfer, the decision of the intake facility will be honored and the inmate will be permitted to retain current glasses until:

   a. the current prescription is no longer medically correct; or

   b. the lenses and/or frames are destroyed, lost or damaged.

C. Contact Lenses

1. Contact lenses will only be provided or permitted if they are deemed medically necessary for conditions such as Aphakia and Keratoconus; this will be addressed on a case-by-case basis. The Deapartment, through its Contracted Health Care Provider, will provide the necessary solutions for the maintenance of medically necessary contact lenses.

2. An inmate is permitted to keep contact lenses only if he/she does not have a pair of eyeglasses or until alternative eyeglasses are provided by the Department. When transferring from the intake facility to another facility or a subsequent intra-facility transfer,

the decision of the intake facility will be honored and inmates will be permitted to retain current contact lenses until:

a. the current prescription is no longer medically necessary; or

b. alternative eyeglasses are provided by the Department.

3. The Medical Department will notify the inmate's Unit Manager when the eyeglasses are ready. The Medical Department will ensure the contact lenses are removed from the inmate's possession and forward the contact lenses to the Property Officer.

4. If it is determined that an inmate's contact lenses are not medically necessary upon intake and he/she does not have a pair of eyeglasses, he/she will be permitted to keep them until acceptable glasses are provided. An inmate who is wearing contact lenses upon intake will be provided contact lens solution by the Contracted Health Care Provider until eyeglasses are provided by the Department.

D. Inmate Co-Pay

Every inmate will be subject to co-payment for eye care in accordance with Department policy **DC-ADM 820, "Co-Payment for Medical Services."**

CONFIDENTIAL

13.2.1, Access to Health Care

Section 6 – Access to Emergency Care

This section is confidential and not for public dissemination

BULLETIN
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject: **Access to Health Care Procedures Manual Section 7 – Infirmary Unit Medical Procedures**		
Policy Number: **13.2.1, Section 7-01**		
Original Issue Date:		
Date of Issue: **July 6, 2015**	**Authority:** **Signature on File** **John E. Wetzel**	**Effective Date:** **July 15, 2015**

The purpose of this bulletin is to update **Subsection D. 23-Hour Infirmary Observation** of Department policy **13.2.1, "Access to Health Care," Section 7 – Infirmary Unit Medical Procedures, Subsection D.** shall now read as follows:

Subsection D. 23-Hour Infirmary Observation

For other than routine cases (prep for next day surgery or diagnostic procedures, etc.):

1. a practitioner may order a 23-hour observation. The **Initial Infirmary Orders Form** will be completed;

2. ***when an inmate returns from an inpatient hospitalization, and no practitioner is on-site, the patient shall be admitted to the Infirmary for 23-hour observation. The patient is to be evaluated as soon as possible the next day.***

   a. ***Those sites without an Infirmary (Huntingdon, Frackville, Retreat, and Quehanna Boot Camp) must utilize their respective consolidated infirmary.***

   b. ***SCI Pine Grove may place patients into their Medical Annex.***

   c. ***SCI Laurel Highlands may utilize the patient's own long-term care or personal-care bed. For those SCI Laurel Highlands patients in general population, they must be observed overnight in a long-term care bed.***

3. a practitioner must evaluate within 23 hours each inmate in observation status to assess and determine if the inmate is to return to the housing unit or be admitted to an inpatient service. Documentation must be completed on the **DC-472**. A verbal order can be taken for discharge if the practitioner has determined the inmate is stable;

4. nursing staff may relocate an inmate to the infirmary to monitor preparation for next day surgery or diagnostic procedures without an infirmary admission order. Nursing staff will document actions and observations on the outpatient **DC-472**. Preparation orders will be obtained from a practitioner; and

5. if the practitioner does not discharge the inmate within a 23-hour period, the inmate must be admitted for infirmary care.

Section 7 – Infirmary Unit Medical Procedures

A. General

This section establishes the scope of infirmary care services which includes:

1. admissions;
2. specialized outpatient services;
3. 23 hour observation;
4. housing;
5. long term care;
6. discharge;
7. infection control and housekeeping functions; and
8. equipment and supplies.

B. Admissions

1. General Requirements

   a. The **Facility Infirmary Capabilities Listing (Attachment 7-A)** outlines the minimum services that every facility infirmary must provide.[1]

   b. A practitioner is on call or available 24 hours per day.[2]

   c. Health care personnel have access to a practitioner or registered nurse and are on duty 24 hours per day when patients are present.[3]

   d. Infirmary care is compliant with applicable state statutes and local licensing requirements.[4]

   e. Health problems requiring services, which exceed the capabilities of the inpatient unit, must be referred to other appropriate settings under appropriate security provisions.[5]

[1] 4-4352, 2-CO-4E-01
[2] 4-4352, 2-CO-4E-01
[3] 4-4352, 2-CO-4E-01
[4] 4-4352, 2-CO-4E-01
[5] 4-4348

There is a written list of referral sources to include emergency and routine care which is reviewed and updated annually.[6]

f. Infirmary care status includes the provisions of daily services which require the skills of licensed or certified medical personnel to include Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants. Such skills may include the following procedures:

(1) intravenous therapy with documentation completed on the **DC-504, Intravenous (IV) Flow Sheet (Attachment 7-B)**;

(2) feeding by nasogastric tube or other enteral tube: as documented by the Bureau of Health Care Services (BHCS) Clinical Dietician on the **DC-587, Nutritional Assessment Form**;

(3) oxygen therapy for unstable respiratory status (e.g., the inability to lie flat due to shortness of breath);

(4) new surgical/stoma therapy; and

(5) care of surgical wounds or open lesions with complications of healing or infection, e.g., cellulitis, purulent drainage, open lesions of the foot and pressure ulcers stages III, IV or multiple stage II wound care.

g. An inmate permanently transferred to an infirmary may have personal belongings and have access to programming.

h. Infirmary care status is reserved for an inmate who requires nursing assistance with medical assessment and treatment in accordance with the **Criteria for Admission to an Infirmary (Attachment 7-C)**.

2. Practitioner duties shall include the following:

a. Upon admission to the infirmary for infirmary care, an inpatient unit medical record must be initiated as directed in Department policy **13.1.1, "Management and Administration of Health Care," Section 10, Maintenance of Inmate Medical Records.**[7]

b. The practitioner will complete the **Initial Infirmary Orders Form (Attachment 7-D)** after hours, this form can be done as a verbal order which includes laboratory, x-ray, diagnostic studies and health service consultations. Required diet, activity level, observations, studies, and treatments must be specified in the orders when ordering infirmary care.

[6] 4-4348
[7] 4-4413

c. Within 24 hours, the practitioner must document an initial focused physical examination on the **DC-472, Progress Notes**. The following information must be included:

(1) a review of the medical chart;

(2) a physical exam focused on current and newly developed medical problems;

(3) after assessment, the practitioner must update the **DC-472** with an individualized medical treatment plan and orders to address current problems which include chronic and convalescent care. The plan includes directions to health care and other personnel regarding care and supervision of the patient;[8] and

(4) for infirmary care, the practitioner must complete daily rounds and document an assessment on the **DC-472** using the Subjective Objective Assessment Plan (SOAP) format.

3. Nursing duties include the following:

a. the RN will perform an initial nursing assessment; document findings on the **DC-472**. The note must include the chief complaint, vital signs, reason of admission, nursing assessment, and plan of care;

b. contact the practitioner to report the inmate's condition and to obtain physician orders;

c. initiate and maintain the **Inpatient Area Admission/Discharge Log (Attachment 7-E)** which will be used daily for updating the automated infirmary tracking log;

d. every Monday morning the **Inpatient Area Admission/Discharge Log** will be forwarded electronically to the regional BHCS Quality Improvement (QI) Nurse. Also, on a daily basis, Intake and reception centers will send the **Inpatient Area Admission/Discharge Log** to the BHCS QI Nurse;

e. initiate and maintain the inpatient medical record in accordance with Department policy **13.1.1, Section 10**;

f. complete the admission information on the **DC-474, Inpatient Unit Summary Form (Attachment 7-F)** at the time of admission to the inpatient unit. Documentation must be legible and include inmate data on each sheet (name, identification number, date of birth, facility), admission date, provisional diagnosis, allergies, and next of kin information;[9]

[8] 4-4350
[9] 4-4413

g. initiate a **DC-478, Inpatient Unit Nursing Care Plan (Attachment 7-G)**. The **DC-478** must include active medical or psychiatric problems, interventions and expected outcomes. **DC-478s** must be updated according to change of patient status;

h. orient the inmate to his/her room, including the proper usage of the call bell system, and issue a copy of local infirmary rules;

i. ensure the outpatient record is available in the inpatient unit, nurses' station;

j. assure infirmary linen and clothing is issued to the inmate;

k. transcribe and initial all verbal and written physician orders. The physician must sign off on all verbal orders within 72 hours;

l. document using the SOAP(IER) format on the **DC-472** at a minimum of once per shift or more often as indicated by medical condition;

m. record vital signs on admission and at a minimum of once per shift, unless otherwise ordered or if there is a change in condition. Vital signs include temperature, blood pressure, pulse, and respirations as ordered. Pulse oximetry documentation will be recorded on the progress notes. Vital signs must be documented on the **DC-475, Inpatient Vital Sign Flow Sheet (Attachment 7-H)**;

n. intake and output will be recorded on the **DC-489, Intake and Output Sheet (Attachment 7-I)** as required;

o. remain on-site and ensure a staff member remains within sight or sound observation of the patients at all times while in the inpatient/observation unit. In the event of an emergency, other staff may remain in the infirmary if the nurse must leave. The reason must be noted in the **Inpatient Daily Shift to Shift Report (Attachment 7-J)[10];**

p. give a verbal and written shift-to-shift report to the incoming infirmary nurse. The **Inpatient Daily Shift to Shift Report** must be completed by each infirmary nurse at the end of each shift. At the end of each day the **Inpatient Daily Shift to Shirt Report** must be filed in a binder maintained in the inpatient area. The report must remain in the binder until the inmate is discharged from the infirmary;

q. the Nurse Supervisor/designee will be responsible to review and sign the **Inpatient Daily Shift to Shift Report** daily; and

r. an inmate with a serious or chronic condition(s) who is admitted to the infirmary should be offered the opportunity to execute a **DC-498, Advance Directive**.

[10] 4-4352

C. Specialized Outpatient Services

1. Are defined as particular outpatient procedures/offsite medical services that require infirmary housing.

2. Patients receiving specialized outpatient services may be placed in the infirmary in a monitored bed for observation for up to 48 hours.

3. Documentation will occur in the outpatient section of the medical record.

4. The **Initial Infirmary Orders form** will be completed.

5. When medical personnel other than a practitioner initiate 48 hour observation, a practitioner must be notified immediately and the **Initial Infirmary Orders Form** will be completed. Relevant health history, current physical status, and nurses' observations must be completed on the **DC-472** or NET and conveyed to the practitioner. An order must be documented in the outpatient physician's orders and a corresponding progress note must be documented on the **DC-472**.

6. A practitioner must evaluate each inmate in observation status within 48 hours to assess and determine if the inmate is to return to the housing unit or be admitted to an inpatient service. Documentation must be completed on the **DC-472**. A verbal order can be taken for discharge if the practitioner has determined the inmate is stable.

7. The inmate must be admitted for infirmary care, if the practitioner does not discharge the inmate within a 48-hour period.

D. 23-Hour Infirmary Observation

For other than routine cases (prep for next day surgery or diagnostic procedures, etc.):

1. a practitioner may order a 23 hour observation. The **Initial Infirmary Orders Form** will be completed;

2. when medical personnel other than a practitioner initiates 23 hour observation, a practitioner must be notified immediately and the **Initial Infirmary Orders Form** will be completed. Relevant health history, current physical status, and nurses' observations must be documented on the **DC-472** or NET and conveyed to the practitioner. An order must be documented in the outpatient physician's orders and a corresponding progress note must be documented on the **DC-472**;

3. a practitioner must evaluate within 23 hours, each inmate in observation status to assess and determine if the inmate is to return to the housing unit or be admitted to an inpatient service. Documentation must be completed on the **DC-472**. A verbal order can be taken for discharge if the practitioner has determined the inmate is stable;

4. nursing staff may relocate an inmate to the infirmary to monitor preparation for next day surgery or diagnostic procedures without an infirmary admission order. Nursing staff will document actions and observations on the outpatient **DC-472**. Preparation orders will be obtained from a practitioner; and

5. if the practitioner does not discharge the inmate within a 23-hour period, the inmate must be admitted for infirmary care.

E. Housing Status

1. Housing status is permitted only for an inmate who requires no medical service but must be housed in the infirmary because he/she cannot be housed in population (e.g., is wheelchair bound in a non-handicap accessible facility). Housing status must not be used to monitor an inmate with medical conditions.

2. The Corrections Health Care Administrator (CHCA)/designee and Medical Director/designee must agree to place an inmate in temporary housing status until a permanent housing unit is obtained. The **Initial Infirmary Orders Form** and a narrative progress note must be documented to indicate infirmary housing status.

3. Nursing documentation on the **DC-472** is the same as general population inmates.

4. There must be a process for daily access of sick call as in general population.

5. The Deputy Superintendent for Centralized Services (DSCS) will be notified by the CHCA/designee to ensure that the housing status inmate has personal belongings and access to programming.

F. Long Term Care

1. Inmates requiring long term care may be admitted to the infirmary.

2. The Long Term Care Referrals procedures in Department policy **13.1.1, Section 7** will be followed.

G. Discharge

1. Discharge from Infirmary Care and Housing[11]

   a. If the inmate was admitted for infirmary care, only a physician may order the discharge. A corresponding progress note will be documented.

   b. A physician, Physician Assistant (PA) or Certified Registered Nurse Practitioner (CRNP) may order the discharge of an inmate from 23 hour observation. A corresponding progress note will be documented.

[11] 4-4352

c. Assisted care may be discontinued by a physician, PA or CRNP.

d. The practitioner may discharge the inmate from housing. Alternatively, the CHCA/designee may discharge the inmate from housing with the approval of the DSCS. A narrative progress note must be documented on the **DC-472**.

2. Physician Duties

a. Ensure that the discharge section of the **DC-474** is documented or dictated by a physician within 48 hours of discharge from the inpatient unit, it must include the following:

(1) date of discharge;

(2) discharge diagnosis;

(3) chief complaint and history;

(4) procedures/treatment/operations performed during admission;

(5) medications, duration, and for what conditions;

(6) summary of treatment;

(a) significant findings regarding all tests;

(b) complications including infections;

(c) diet;

(d) activity level; and

(e) inmate response to treatment final outcome.

(7) follow up plan; and

(8) disposition including a legible signature and title of the provider.

b. Ensure at the time of discharge, that any remaining orders are re-written on the **Physician's Orders Form** in the outpatient record.[12]

3. Nursing Duties

a. Document the date and time of discharge and discharge diagnosis on the **DC-472**.

[12] 4-4413

b. Document prescribed follow-up treatment, inmate teaching, and schedule all necessary appointments.

c. Deliver all records to the Medical Records Director/Supervisor/Technician/designee who must check the Inpatient Unit Record for completeness. The entire Inpatient Unit Records, with the exception of labs, consults, and electrocardiographs (ECGs), must then be placed under the Inpatient Ward section of the medical record. All labs, consults, and ECGs must be placed in their respective sections of the medical record.[13]

H. Infection Control and Housekeeping Functions

A standardized plan for infection control and housekeeping functions must be used for the inpatient area. The infection control and housekeeping functions must address, at a minimum, the following areas:

1. daily, weekly, and monthly cleaning schedules;

2. procedures for cleaning floors, surfaces, and bathrooms;

3. frequency of linen changes;

4. storage of clean and soiled linen;

5. disposal of medical waste;

6. areas which can be cleaned by inmate janitors and those which must be done by staff; and

7. procedures for cleaning blood/body fluid spills.

I. Equipment and Supplies

1. Inpatient unit equipment must be available, maintained and monitored for use including, but not limited to, the following items:[14]

   a. call bell system;

   b. O2 (oxygen) concentrator;

   c. peak flow meter;

   d. hospital beds;

[13] 4-4352
[14] 4-4427, 2-CO-4E-01

e. hoyer lift;

f. refrigerator with thermometer;

g. ice machine;

h. locked medicine cabinet;

i. geri chair;

j. shower chair;

k. gurney;

l. IV pole;

m. treatment equipment, such as nebulizers;

n. impervious and fire retardant mattress and pillows;

o. privacy screens for use during treatment or procedures, as applicable; and

p. portable suction apparatus.

2. Negative air pressure rooms must also be available for respiratory isolation.

3. Medical supplies including, but not limited to, the following must be available, as needed:

a. gowns;

b. masks (surgical and respiration protection);

c. exam gloves – sterile;

d. exam gloves – non-sterile;

e. shoe covers;

f. hand washing facilities and hand sanitizers;

g. sharps container;

h. bio-hazard waste containers;

i. red bags for bio-hazardous waste;

j. water permeable laundry bags; and

k. yellow bags for contaminated linens.

BULLETIN
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject: **Access to Health Care Procedures Manual Section 8 – Communicable Diseases and Infection Control**		
Policy Number: **13.02.01, Section 08-01**		
Original Issue Date: **January 9, 2017**		
Date of Issue: **September 4, 2019**	**Authority:** **Signature on File John E. Wetzel**	**Effective Date:** **September 11, 2019**

The purpose of this bulletin is to provide clarification regarding out-of-state parole violators. **Subsection D. Inmate Tuberculosis Control, 5.b.(1)** shall have the information below in bold/italics added and shall now read:[1]

5. Housing and Group Movements for newly Received Inmates During Screening for TB Infection or Disease (includes PVs and Authorized Temporary Absences [ATAs])

   a. If the inmate is symptomatic (dyspnea, cough, hemoptysis, fever, or diaphoresis) he/she shall be placed in a negative pressure room and further evaluated in accordance with this procedures manual.

   b. If asymptomatic, the inmate:

      (1) shall be housed separately until cleared for general population. (Each facility shall establish a local housing policy for a new inmate who is not medically cleared as to TB, based upon security issues and physical layout of the facility);

      NOTE: This can be on a general population housing unit, but managed in a way that he/she does not have contact with general population inmates until cleared, similar to a cell restriction.

[1] 5-6A-4354, 5-6A-4355

BULLETIN
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject: **Access to Health Care Procedures Manual Section 8 – Communicable Diseases and Infection Control**		
Policy Number: **13.02.01, Section 08-02**		
Original Issue Date: **January 9, 2017**		
Date of Issue: **December 2, 2019**	**Authority:** **Signature on File John E. Wetzel**	**Effective Date:** **December 16, 2019**

The purpose of this bulletin is to update **Subsection G. Management and Reporting of HIV Infection,** with information regarding HIV testing procedures and compliance with state law. **Subsection G.** shall now read:

G. Management and Reporting of HIV Infection[1]

1. Responsibilities

   a. Supervisors, Managers, and Coordinators[2]

      Department supervisors, managers, and coordinators are to ensure that every ***employee*** under his/her jurisdiction receives appropriate ***HIV/***AIDS education, follows applicable federal and state public health requirements on AIDS in the workplace, follows all appropriate Commonwealth HIV/AIDS infection policies and procedures, and adheres to confidentiality provisions for HIV/AIDS information on state employees and inmates. General questions on ***HIV***/AIDS can be addressed directly to the Pennsylvania Department of Health's (DOH) AIDS Factline at **1-800-662-6080**.

[1] 4-ACRS-4C-10
[2] 5-6A-4357

b. The Facility ***Infection Control Nurse (ICN)*** shall:

(1) ensure that confidentiality is maintained in accordance with the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq. (Attachment 8-R)**;

(2) act as a resource during Post Exposure Protocol procedures. Follow-up with the ***staff member or inmate*** who was involved in an exposure to ensure that:

(a) questions are directed to the appropriate personnel;

(b) copies of reports are collected, including medical and other information regarding an exposure to blood-borne pathogens. This information is maintained in a locked file in a secure area separate from personnel files;

(c) ***procedures are explained for obtaining certification of significant exposure for staff members*** in accordance with the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**; and

(d) subsequent to the exposure, ***the*** medical department ***shall provide*** appropriate intervention and referrals in accordance with Department policy **13.1.1, Section 5**;

(3) maintain a list of staff trained to provide HIV/AIDS Prevention (post-test) Counseling;

(4) provide educational materials as needed for the inmate population;

(5) shall encourage the inmate to disclose HIV/AIDS related information to the Parole Officer to ensure appropriate follow-up care; and[3]

(6) maintain a current list of community HIV/AIDS services.[4]

2. Transmission of HIV

a. There is **<u>no evidence</u>** that HIV is transmitted by casual social contact with infected individuals. While HIV has been isolated in many body fluids, only blood, semen, vaginal fluid, and breast milk have been implicated in its transmission. Therefore, the routes of transmission are via:

(1) intimate sexual contact;

(2) sharing of needles and syringes contaminated with blood;

(3) blood and blood products containing HIV;

(4) prenatal transmission from mother to neonate (mother-to-newborn) transmission; and

[3] 4-ACRS-4C-10
[4] 4-ACRS-4C-10

(5) possible transmission through mother's milk to infant.

b. HIV is transmitted primarily through direct sexual contact involving exchange of implicated body fluids or through the exchange of blood from a person who is infected with HIV. HIV infection is also transmitted by shared needles contaminated with blood. Other evidence for transmission through blood products has been found in the occurrence of AIDS in hemophilia patients receiving clotting factors made from infected blood ***prior to 1985***. Although HIV has occasionally been found in very small quantities in the saliva, urine, feces, and tears of a few people with HIV infection, current evidence indicates that these body fluids are not vehicles of transmission unless they contain visible blood.

3. Confidentiality[5]

a. Any HIV-related information of a medical nature may not be revealed by a HCW or volunteer of the Department, unless authorized by the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq.,** or other state or federal statute or regulation. Any written consent to disclosure of confidential HIV-related information shall include the various items and requirements as enumerated in the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**.

b. Communication within the correctional facility shall not divulge an ***individual's*** HIV/AIDS diagnosis or medical condition, except to those who are authorized by the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**. If written, such information is to be maintained in locked file drawers, compartments, or other secure space in accordance with **Subsection *G.3.f.* below**.

c. A list of inmates with HIV/AIDS shall not be posted, in accordance with this procedures manual.

d. The Department's rules, regulations, and directives governing confidentiality shall apply in accordance with Department policy **DC-ADM 003, "Release of Information,"** and the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**.

e. Because of the nature of the disease, an HIV infected ***employee*** shall have understandable concerns over confidentiality and privacy in connection with medical documentation and other information about his/her condition. Officials who have access to such information are required to maintain the confidentiality of that information. Supervisors, managers, and others included in making and implementing personnel management decisions involving ***employees*** with HIV/AIDS shall strictly observe applicable privacy and confidentiality requirements as noted in **Management Directive 505.26**.

f. The following procedures are to be adhered to regarding ***HIV***/AIDS related information on a state ***employee*** or his/her dependents.

[5] 4-ACRS-4C-10, 5-6A-4354, 5-6C-4396

(1) If this information exists in a written form, it is not to be maintained in the ***employee's Electronic*** **Official Personnel Folder (*eOPF*)**. It is to be maintained in a separate, locked file drawer, compartment, or other secure place with restricted access, under jurisdiction of the party who received the information (medical officer, health care coordinator, supervisor, etc.) or in the personnel office. If maintained in the personnel office, access is to be limited to the personnel officer and a designated custodian of sensitive personnel records. In all cases, the ***employee*** in question shall be informed of what written information is being maintained, where it is kept, and security provisions for its release in accordance with the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**.

(2) Access to ***HIV/***AIDS related information in ***employee*** records is to be limited to only those parties who are the original recipients of that information, those designated individuals in the personnel office, and those who have been pre-approved through written consent by the affected ***employee***, unless there is a medical emergency that requires an immediate response. Copies shall not be made of records, which identify a Department employee's HIV/AIDS status.

(3) HIV/AIDS related information is not to be forwarded to future employers should the ***employee*** change jobs, unless the release of such information has been pre-approved in writing by the affected ***employee***.

(4) Paperwork containing ***HIV/***AIDS related information on an ***employee*** that must be processed through a chain of parties**,** such as work-related disability forms, are to be handled with strict confidentiality. The ***employee*** in question must be informed of how these forms are processed. If possible, agencies shall restrict the routing of these forms, processing them directly from the ***employee's*** immediate supervisor to the personnel office.

g. Confidentiality restrictions on written HIV/AIDS related information also apply to the verbal communication of that information. If a supervisor, co-worker, or other state employee learns information on a Department employee's possible HIV/AIDS condition, that information is not to be communicated to other state employees or members of the public. Unless there is a specific need to do so, verbally communicated information on a state employee's HIV/AIDS status shall not be converted to a written record.

4. ***Identification/Surveillance***[6]

a. There shall be no involuntary HIV testing of an inmate of the Department except as provided in the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**. ***This*** Act establishes criteria for routine and mandated testing. See Department policy **13.1.1, Section 5.**

b. HIV testing shall be offered at the home facility in conjunction with Hepatitis C testing ***on an "opt-out" basis. "Opt-out" testing requirements are as follows:***

[6] 5-6A-4354

(1) ***the inmate is notified that HIV testing will be performed as part of normal intake testing;***

(2) ***he/she is provided the required educational material that includes an explanation of the test, including its purpose, potential uses, limitations, and the meaning of its results; and***

NOTE: A nurse may provide this explanation during routine intake testing with the DC-555, PA Department of Corrections Education for HIV Testing.

(3) ***if the inmate declines testing at that time, he/she is required to sign a DC-462, Release from Responsibility for Medical Treatment.***

c. Otherwise, HIV testing shall only be ordered by a ***practitioner***. The order must be based upon the inmate's current medical history and clinical signs and symptoms. Inmate requests for testing shall be routinely approved, even if the inmate does not admit to high-risk behavior***,*** but testing more frequently than every six months shall be performed only in exceptional circumstances. A program is to be instituted at each Corrections facility to encourage an inmate to voluntarily be tested for HIV ***if there is no documentation of HIV testing during the current incarceration*** so that those who are infected can receive appropriate early counseling and treatment. If an inmate does not request an HIV test, but has exhibited early symptoms of HIV illness or high-risk behavior, the ***practitioner*** may order an HIV test with ***documentation of the inmate's*** consent ***in the DC-472, Progress Note***. The ***practitioner*** shall provide ***an explanation of the test, including its purpose, potential uses, limitations, and the meaning of its results***.[7]

d. The inmate shall receive ***an explanation of the test, including its purpose, potential, uses, limitations, and the meaning of its results (DC-555)*** prior to the HIV test. ***He/she*** shall be offered an interpreter if needed and given ample time to ask questions. The Language Line Services (through the Business Office) will be used for interpretation. The inmate must sign ***a DC-462 if refusing any specific testing***.

e. Testing protocols recommended by the CDC shall be followed. The ***practitioner*** may order additional tests to determine the proper staging and classification of infection.[8]

f. Post-test counseling

(1) ***The results of all HIV screening tests, positive and negative, will be reviewed with the patient. This may be scheduled with either a provider or a nurse who has completed the HIV counseling training from the Department.***

(a) ***For positive results, counseling shall be in compliance with all CDC and Pennsylvania DOH guidelines and protocols, as well as requirements outlined in the Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq. Documentation of this encounter shall be made in the DC-472 of the health record and shall include*** the rationale for testing,

[7] 5-6A-4357, 4-ACRS-4C-10
[8] 5-6A-4357

discussions with the inmate, and plans for management of the condition. ***The patient shall be enrolled in the HIV Chronic Care Clinic where treatment will be ordered by an HIV specialist.***[9]

(b) ***For patients with a negative result, it will need to be determined if the testing occurred during a six-month post-exposure window that would warrant a repeat test.***

(2) ***Psychiatry and/or psychological services shall be offered to inmates with positive test results and documented in the health record.***

(3) ***Pennsylvania DOH shall be notified by the facility ICN of this reportable disease and partner notification services shall be offered.***

(4) Housing plans for an inmate having a positive test result shall be handled on a case-by-case basis, using medical and security considerations. Under ordinary circumstances, an inmate that is known to be HIV positive shall be housed with general population.

(5) If an inmate is paroled or released before the test results are known, when the test results do return, a notation must be made in the medical record by the physician reviewing the test results. The test results shall be forwarded to the Pennsylvania DOH who shall provide ***appropriate notification/***counseling.

5. Treatment[10]

a. Department programs serving those with HIV/AIDS infection ***shall*** address the special needs of this population. The inmate may face stigma and discrimination. He/she may be coping with physical deterioration and the psychological and social impact of having a fatal disease. The Department has an obligation to provide adequate medical care for every inmate including those with HIV/AIDS, including following the latest CDC and other federal guidelines and protocols, where available, for patient diagnosis and treatment.

b. The ***practitioner*** shall complete his/her assessment using professional judgment and current HIV diagnostic procedures. Past and present historical data from the inmate and from the inmate medical record shall be consulted. Information that the ***practitioner*** shall consider includes:

(1) demographic data;

(2) risk factors (IV drug abuser, homosexual and heterosexual high-risk sex, hemophilia transfusions, other transfusion history, history of infections: hepatitis, mononucleosis, herpes, TB, gonorrhea, syphilis, etc.);

[9] 5-6A-4357
[10] 5-6A-4354

(3) history of symptoms: fatigue, fever, anorexia, malaise, depression, dyspnea, persistent diarrhea, night sweats, weight loss, lymphadenopathy, and shortness of breath;

(4) particular attention shall be paid to history and/or current evidence of:

(a) drug abuse;

(b) assaultive behavior;

(c) indiscriminate sexual behavior; and/or

(d) victimization.

(5) the ***practitioner*** performing a physical exam shall give special attention to:

(a) lymphadenopathy;

(b) oral changes;

(c) candidiasis;

(d) mental status changes;

(e) rashes and/or skin changes;

(f) rales in lungs;

(g) weight loss;

(h) fever;

(i) jaundice; and

(j) track marks.

6. Inmate Care Statement

a. There is no evidence that the risks in providing direct care to an inmate infected with HIV are any greater than those associated with caring for any other sick person. Therefore, a healthy HCW shall not be excused, on his/her own request, from providing care to these inmates. A HCW, who believes he/she may be at increased risk because he/she is immunosuppressed or have other clinical conditions that may confer an increased risk of acquiring an infection, shall discuss his/her concerns with his/her supervisor. These cases shall be evaluated on an individual basis in consultation with correctional administration and the HCW's physician. Claims by the HCW must be supported by written medical documentation.

b. Specific guidelines for the care of an inmate infected with HIV are outlined in ***Section 16-QI Plan, Appendix 16-B, Chapter 02 HIV of this procedures manual***.

7. HIV/AIDS in the Workplace

a. The provisions of this section are in accordance with **Management Directive 505.26**. If more detailed information is needed, the Directive may be referenced.

b. A Department ***employee*** and a job applicant with HIV/AIDS infection, or those perceived to have these conditions, shall not be discriminated against with regard to appointment, transfer, promotion, or any other employment or personnel action. Under no circumstance can an appointing authority require a current or prospective state ***employee*** to receive an HIV antibody test, or reveal the results of a previous test or diagnosis, as a condition of employment. Should the Department learn of a current or prospective state ***employee's*** HIV/AIDS infection, that information shall not be used regarding employment or personnel actions except where the ***employee*** concurs.

c. In the event a Department ***employee*** with HIV/AIDS is unable to physically carry out his/her job duties, ***he/she*** shall be afforded the same considerations as any other ***employee*** whose illnesses prevent him/her from fully performing his/her job. Because of the episodic nature of the secondary illnesses which affect persons with AIDS, an ***employee*** may request reasonable accommodations which shall allow him/her to work with his/her handicap. Such requests shall be supported by appropriate documentation from the ***employee's*** physician. These requests are to be honored where operationally feasible, based on the job setting involved and the resources of the facility. An ***employee*** with HIV/AIDS infection who requests a transfer or a lateral or downward reclassification because of his/her medical condition shall have these requests considered, consistent with facility needs, the Americans with Disabilities Act, and **Management Directive 505.7**.

d. An ***employee*** who refuses or objects to working with a co-worker, inmate, client, or member of the public ***having,*** or perceived to have, HIV/AIDS infection shall be counseled and educated in:

(1) how the virus is, and is not, transmitted in the workplace; and

(2) the Commonwealth's **Management Directive 505.26** and this procedures manual on AIDS in the workplace.

e. Should the ***employee*** continue to refuse to work with those individuals, the ***employee*** may be subject to appropriate progressive discipline, up to and including dismissal.

f. Department policy prohibits discrimination against persons with, or perceived to have, HIV/AIDS infection. Complaints about alleged discrimination against an ***employee or*** prospective ***employee*** may be addressed to the agency Equal Employment Officer.

g. In addition, **the Pennsylvania Human Relations Act 43 P.S. §951 et seq**. has been interpreted to cover discrimination against individuals with, or perceived to have, HIV/AIDS infection. Discrimination based on HIV/AIDS infection is prohibited in

employment in Pennsylvania. Any person wishing to file discrimination complaints with the Pennsylvania Human Relations Commission (PHRC) should contact the PHRC regional office in his/her geographical area.

8. Case Reporting

In the Commonwealth of Pennsylvania, both HIV and AIDS are ***required to be reported to the*** DOH. ***CHCA/designee is responsible for this function***.

9. HIV/AIDS Discharge Care

a. The purpose of HIV/AIDS Discharge Care is as follows:

(1) coordinate effective care and access supportive services for HIV positive individuals as they transition out of correctional facilities back to their communities;

(2) prepare HIV positive inmates for community reintegration and conversely prepare communities (AIDS service organizations, social workers, health care workers, housing, etc.) for transitioning these inmates into needed services; and

(3) the transition shall be achieved through a collaborative relationship between the following agencies, but not limited to: Pennsylvania DOH, Pennsylvania Department of ***Human Services*** (***DHS***), and seven Regional AIDS Planning Coalitions.

b. The procedures below shall be followed regarding HIV/AIDS Discharge Care:

(1) the ICN shall serve as the point of contact between the Department, the Pennsylvania Board of Probation and Parole (PBPP), and the seven Regional AIDS Planning Coalitions;

(2) the ICN/designee shall notify HIV/AIDS positive inmates of the existence of the Discharge Care Initiative Program and eligibility. The ICN shall confirm the inmate's anticipated release date and explain the ***transitional planning*** to the inmate prior to his/her release. Inmate education shall include the following:

(a) the completion of a **DC-108*(a), Authorization for Release of Information*** is required prior to inmate contact with Case Manager (telephone or telemedicine); and

(b) the **DC-108** signed by the inmate, carries a timeframe of ***180*** days.

(3) if the inmate refuses to communicate via teleconferencing or videoconferencing with the Case Manager, the ICN shall document the refusal on the **DC-462**, and on the **DC-472**;

(4) when the inmate agrees to participate in the Discharge Care Initiative, the ICN shall notify the Regional AIDS Planning Coalition representative in the appropriate inmate discharge area;

(5) the Regional AIDS Planning Coalition representative shall send the Regional Agency's discharge planning forms to the ICN for the inmate's signature. The physician must sign the Employability Form. The signed Discharge Planning Form shall be faxed or emailed to the Regional Agency;

(6) ICN facilitates contact with the Regional AIDS Planning Coalition's Case Manager. This contact may be by phone or teleconferencing, as feasible;

(7) the ICN shall confirm with the Regional AIDS Planning Coalition's Case Manager that all forms and service care plans are in place for each inmate;

(8) the ICN shall ***document the results of this encounter on the DC-472***; and

(9) on the day of discharge, the inmate receives ***a supply*** of HIV medications ***dependent upon the type of discharge according to the Inmate Transfer Logistics Grid located in the resources section of the Electronic Health Record (EHR)***.

Section 8 – Communicable Diseases and Infection Control[1]

A. Regulations of Communicable and Non-Communicable Diseases

The Corrections Health Care Administrator (CHCA) shall ensure:

1. compliance with regulations established by the Commonwealth of Pennsylvania governing the reporting of communicable diseases **(Pa Code, Title 28, Chapter 17)**;[2]

2. notification to specific Divisions of Health is made and documented as stipulated in the guidelines;

3. the Infection Control Nurse (ICN) notifies the Bureau of Health Care Services (BHCS) Infection Control staff of the index case;

4. the facility medical department follows the treatment guidelines established by the Pennsylvania Department of Health (DOH);

5. the facility medical staff shall document on the **DC-472, Progress Notes (See 13.1.1, "Management and Administration of Health Care Procedures Manual," Section 5 - Occupational Exposure to Blood-borne Pathogens, Attachment 5-D),** in the inmate's medical record the treatment offered to the inmate, as well as when the DOH was notified; and

6. appropriate isolation and quarantine guidelines are followed.

B. Contagious Disease Notification

1. A contagious disease is an illness that is caused by a specific infectious agent (virus) that can be transmitted by blood and body fluids from an infected person to a susceptible person.

   The following diseases require blood/body fluid precautions:

   a. Arthropodborne viral fevers;

   b. Babesiosis;

   c. Creutzfeldt-Jacob;

   d. Hepatitis B (including HbsAG carriers);

   e. Hepatitis C (positive anti-HCV titer);

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f. Human Immunodeficiency Virus (HIV);

g. Leptospirosis;

h. Malaria;

i. Rat-bite fever;

j. Relapsing fever; and

k. Syphilis (primary and secondary).

2. Responsibilities

The CHCA/designee shall:

a. maintain an accurate list of inmates who have been diagnosed with a contagious disease that requires blood and body fluid precautions;

b. ensure the information is maintained in a secure location;

c. ensure that any employee may be advised, upon request, whether an inmate under his/her care, custody, and control has a communicable disease. This information shall also be provided in cases where there has been an occupational exposure to blood and/or other bodily fluids;

d. maintain a **Contagious Disease List Log (Attachment 8-A)** which documents the nature of each request (for general information or because of a specific incident involving exposure to body fluids), and have the employee who reviews the list sign and date the log;

e. ensure that no employee is permitted to photocopy or hand copy the communicable disease list; and

f. advise each individual who reviews the list that, according to the concept of Universal/Standard Precautions, all human blood and body fluids are treated as if known to be infectious for HIV, Hepatitis B, Hepatitis C, and other blood-borne pathogens. Universal/Standard Precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances where fluid is difficult or impossible to identify (mixture of oil and body fluids), this fluid shall be considered potentially infectious material.

C. Employee Tuberculosis (TB) Control

1. Tuberculosis Information

a. TB is caused by a bacterium, M. tuberculosis, that is transmitted in airborne particles of five microns or less in size. These airborne particles are produced when a person who has TB Disease (TBD) of the lung or larynx shouts, sings, coughs, or otherwise exhales forcibly. TB infection occurs when another person inhales small airborne particles containing the TB organism.

b. Every Department employee has some risk of occupational exposure to TB. This risk is greatest for health care workers and employees working on medical units, transportation, or on hospital coverage.

c. TB infection is effectively prevented by the use of administrative controls, engineering and work practice controls, and by the use of personal protective devices. Administrative controls include policies to ensure the rapid detection, isolation, diagnostic evaluation, and treatment of persons likely to be infected with TB. Engineering controls refer to properly designed and maintained isolation rooms and areas for cough-inducing procedures. Work practice controls are measures, which workers can use to minimize the duration of exposure to a work hazard when rooms are in use. Examples relevant to TB control include keeping isolation room doors closed, organizing tasks to reduce the number and duration of trips into isolation rooms, and the use of personal protective devices. These measures reduce, but do not eliminate, the risk of TB transmission.

d. Most people infected with the M. tuberculosis do not have any symptoms or signs of the disease. His/Her infection can only be detected with the TB skin test. This test, more properly called a Mantoux test, involves the injection of a substance called Purified Protein Derivative (PPD) into the skin. Persons with a positive test are likely to be infected with the TB organism. Such persons receive a direct benefit by learning of his/her infection, because treatment of Latent Tuberculosis Infection (LTBI) can significantly reduce the person's chance of ever progressing to actual TBD.

e. A person with HIV infection or immune system compromise is at increased risk to develop TBD if he/she becomes infected. Any employee with serious health conditions should ask his/her private physician whether he/she has increased risk from TB infection.

2. Responsibilities

a. Central Office

(1) BHCS, Chief of Clinical Services shall:

(a) ensure the development and annual review and revision of the Tuberculosis Control Plan, as well as the Annual Operations Inspection in accordance with Department policy **6.3.1**, **“Facility Security;”**

(b) determine the risk assessment for work areas in the Department;

(c) supervise the BHCS ICC in functions such as:

i. TB control data analysis (any employee suspected of having TBD or is confirmed as having active TBD shall be handled in accordance with this procedures manual);

ii. follow-up on contact investigations;

iii. investigation of clusters of skin test converters; and

iv. monitor care provided to inmates with suspected or confirmed cases of TBD.

(d) advise facility medical staff on clinical management of TB infection and disease, and Department policy matters; and

(e) recommend policy/procedural changes to improve TB control efforts.

(2) BHCS, ICC shall:

(a) ensure that the Department TB policies/procedures are reviewed/revised annually;

(b) ensure that the Department's facilities are in compliance with the Department's Tuberculosis Control Plan;

(c) collect, analyze, and present data required for annual reassessment of the Tuberculosis Control Plan;

(d) monitor employee TB skin test (TST) data and notify the Department Chief of Clinical Services, facility CHCA, and local DOH when skin test data show clusters or unusual numbers of TST conversions, or when evidence of TB transmission is observed. Clusters of TST conversions is defined as two or more skin test conversions in the same work area or housing unit occurring within three months of each other;

(e) work with the DOH to investigate clusters or unusual numbers of TST conversions and incidents of tuberculosis transmission. This cooperation with the DOH shall also address recommending changes in facility practice based on these investigations;

(f) maintain a registry of all known and suspected cases of TBD occurring in inmates or department staff;

(g) track asymptomatic inmate converters using the **DC-496, TB Monitoring Tool for PPD Converters (Attachment 8-B)**;

(h) monitor care provided to an inmate with suspected or confirmed TBD. The BHCS, ICC shall also report all active TBD cases under treatment to the BHCS, Chief of Clinical Services and Assistant Medical Director(s); and

(i) work with the CHCA at the facilities in order to facilitate safe patient care when the facility's isolation rooms are occupied or out of order.

b. Facility

(1) The Facility Manager/designee shall ensure:

(a) responsible facility staff members/designees implement all procedures contained in this procedures manual as well as other referenced policies/ procedures manuals; and

(b) any local procedures drafted in order to comply with this policy/procedures manual are implemented, reviewed, and/or revised on an annual basis.

(2) The CHCA shall ensure:

(a) every employee complies with TST as indicated by the assessed risk for the employee position.[3] Testing must be by the Mantoux method: multiple puncture methods (tine test) are not reliable.[4]

(b) the risk of an employee being exposed is assessed as indicated in **Subsection C.3. below**. If there is a question regarding an employee's risk, the question shall be referred to the Department Chief of Clinical Services and or BHCS;

(c) there is an adequate supply of personal respiratory protective devices available. The facility Safety Manager shall do annual fit testing of employees and maintain names in a log book in accordance with Department Policy **15.1.1, "Safety."**

(d) qualified staff have been identified and selected to monitor the TB Control Program;

(e) an employee who has not completed scheduled TST is reported to the Deputy Superintendent for Centralized Services (DSCS) for follow-up; and

(f) the confidentiality of employee TST records is maintained.

(3) The Facility ICN shall ensure:

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(a) times and dates are scheduled for the medical staff to administer and read employee TSTs;

(b) the CHCA and the BHCS Infection Control staff are notified regarding employees who do not comply with notices of required testing, or who refuse testing;

(c) records of test dates and results are maintained, and this data is recorded on the **DC-469, PA Department of Corrections Tuberculosis Summary (Attachment 8-C)** and is entered into the Automated Employee TB Tracking System;

(d) an employee who refuses TST or annual review shall be managed in accordance with Department policy **4.1.1, "Human Resources and Labor Relations;"**

(e) a **DC-514, Manufacturer and Lot Number of TB Solution Log (Attachment 8-D)** showing the manufacturer and lot number of the PPD solutions used for each employee administered a TST is completed. The **DC-514** shall be used as a reference in the event of a manufacturer recall of test solution;

(f) training/review is provided to health care staff as well as other facility staff in accordance with Department policy **5.1.1, "Staff Development and Training,"** and that a current list of employees who have received training is maintained; and

(g) asymptomatic inmate converters shall be reported as they are identified to the BHCS Infection Control staff by using the **DC-469**.

(4) Department and Vendor Medical Staff shall:

(a) comply with the Department's TB control program to ensure rapid detection, isolation, diagnostic evaluation, and treatment of persons suspected of having TB;[5] and

(b) perform employee TSTs, inform employees of test results, and provide test records to the ICN.

(5) Every Department and Facility Employee shall:

(a) comply with the Department's Tuberculosis Control Plan;

(b) use engineering controls and personal protective equipment when indicated; and

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(c) submit to TST and follow-up evaluation as indicated by the Screening Program and the BHCS Information Control staff/ICN.

3. Risk Assessment – Employee

Assessment of risk of infection/disease shall be based on the time spent with the inmate population. The risk assessment in terms of an employee being exposed or possibly becoming infected with TB is generally broken down into four categories. The categories are:

a. No Risk - No TST needed. This person has NO contact or very limited contact with inmates. Examples are:

(1) a person who fills the vending machine;

(2) a construction worker;

(3) a volunteer who comes into the facility and is with the inmate less than two days/month; or

(4) a consulting physician.

b. Low Risk – Annual TST needed. Examples are:

(1) a volunteer who comes into the facility and works with the inmates two or more days/week and/or several weeks/month; or

(2) contact staff who work with the inmates two or more days/week.

NOTE: Most positions in the Department are associated with a low risk of TB transmission. Positions not designated below as intermediate or high risk are considered as low risk. An employee in a low risk position must have TST results documented no less often then every 12 months.

c. Intermediate Risk – annual TST needed:

Health care workers, security staff permanently assigned to medical units, medical transport personnel, and hospital coverage (outside and infirmary) are in inter-mediate risk. Staff in these positions must have documented TST results no less often than annually.

d. High Risk

Staff working in areas with:

(1) a significantly higher skin test conversion rate compared to other work areas;

(2) a cluster of TST conversions; or

(3) other evidence of transmission of TB.

NOTE: The facility Medical Director in conjunction with the Chief of Clinical Services and the local Department of Health shall determine when conditions for designation as a high-risk area have been met. Staff working in a high risk area must have the TST conducted and results documented every three months until the final significant exposure is determined at which time the risk assessment shall be re-defined.

4. Tuberculosis Screening Program

a. Every employee, as well as others working in Department facilities, must have a TST at a frequency determined by the risk assessment for his/her work area as outlined in the **Risk Assessment Guidelines** in **Subsection C.3. above**.

b. The TST test shall be completed according to the **Skin Testing for Tuberculosis (Attachment 8-E),** and **Classification of Reactions to the Tuberculin PPD (Attachment 8-F).**

c. The test result must be read and recorded 48-72 hours after administration. If the TST is not read within 48-72 hours after administration, the test must be repeated. A positive TST is determined by 10 or more millimeters induration except in those situations outlined on the Classification of Reactions to the Tuberculin PPD, where a reading of ≥5 millimeters induration is read as a positive PPD.

d. An employee with a documented prior positive TST response shall not be retested. He/She is permanently exempt from TB skin testing requirements. If Department staff at a Department site did not perform the prior positive test, the employee must provide, on a one-time-only basis, written documentation describing the date, type, and measured response for his/her positive skin test and chest x-ray (CXR). For purposes of tuberculosis screening, including after a positive TST, a single Posterior Anterior (PA) view is required, a lateral view is not necessary. Only Mantoux test results can be accepted. CXR results are also required for this documentation. Employees unable to provide this documentation shall be retested in order to validate the history.

e. New employees must have a current, valid Mantoux test result at the time of employment.[6]

	Employee Situation		Required Action
(1)	Employee with documented positive TST	-	Acceptable from any date, or provided as outlined above.

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(2) Employee with documented negative TST within the past 12 months - Acceptable - shall require a single step upon employment

(3) Employee with a documented negative TST within the last three months - Acceptable - no further testing required to begin employment

(4) Employee with NO documented TST within the past 14 months - Required to have a two-step TST

(5) Two Step TST Procedure

(a) First test is negative - Second test administered one to three weeks after negative initial TST result is obtained.

(b) Second test is negative - Employee shall have an annual TST as per his/her risk assessment.

(c) First or Second test is positive - Employee shall be required to see his/her family physician. The employee shall be required to present documentation of <u>no disease</u> before employment begins. This will include a CXR report. This employee shall not receive any further TST.

The employee shall have a **DC-469** completed on an annual basis to evaluate an employee who falls into this category. The **DC-469** shall be filed in the employee's medical record.

NOTE: Documentation of TST means:

- Test type (only Mantoux is accepted)
- Date of test
- Date test was read
- Measured result in millimeters

Documentation of <u>No Disease</u>:

- The employee's own physician certifies a negative CXR and freedom from TBD within 14 calendar days on the **DC-554, PA Department of Corrections Tuberculosis Surveillance: Physician's Certification of Freedom from Contagious TBD Form (Attachment 8-G).**

f. A pregnant employee may defer having a TST. An assessment of signs/ symptoms shall be required as an initial or annual review. The **DC-469** must be completed and filed in the employee's medical record.

g. Neither Bacillus Calmette Guerin (BCG) vaccination, nor lactation are contraindications for TST. Mantoux tests shall be considered positive if the test produces an induration of 10 millimeters at the site of injection.

h. In contact investigations, the test shall be considered positive if there is induration of ≥ 5 mm at the site of injection. (**See Attachment 8-F**).

i. The facility medical department shall ensure that employees are informed of needed testing in the month he/she was hired. The BHCS shall notify Central Office staff, Hearing Examiners, and local Community Corrections staff, via inter-office mail of his/her need for TB testing. The staff at the Training Academy shall be notified and tested at the Academy by a designated nurse. Employee test results shall be maintained at the Academy.

j. Mantoux skin tests shall be performed in accordance with current Center for Disease Control and Prevention (CDC) and Pennsylvania State DOH guidelines, including the two-step process for new employees. **Any employee who fails to complete the required testing within seven days of being notified in writing that he/she is delinquent shall be prevented from entering the workplace.** This notification shall be initiated the first working day in the month following the employee's annual testing month. The employee may return to work only after the testing process is completed.

k. An employee who chooses to have indicated skin testing done by a personal physician must do so at his/her own expense and submit documentation of the type, date, and measured response (in millimeters) within two weeks of notice that the test is due.

l. Employees Who Have Had Prior Positive TSTs

The ICN/designee shall interview an employee with prior positive tests annually for symptoms of TB. Documentation on the **DC-469** must be completed and filed in the employee medical record. Any employee who fails to complete the required interview within seven days of being notified in writing that he/she is delinquent shall be prevented from entering the workplace.

m. Employees Who Convert to Positive TST

(1) Latent Tuberculosis Infection (LTBI)

(a) An employee who has a history of past negative TST results, and who, upon annual testing, or at anytime converts to a positive TST, shall not be referred for an annual TST in the future. The employee is now considered a

positive reactor (TST) and shall now be monitored and treated according to the procedures contained in **Subsection C.4.k. above**.

(b) An employee who converts from a negative to a positive TST, shall, in the absence of symptoms of active TBD, be given 14 calendar days to provide documentation from his/her own physician certifying a negative CXR (copy of report) and freedom from TBD on the **DC-554**. Failure to do so shall result in suspension, in accordance with Department policy **4.1.1** unless there are known extenuating circumstances that warrant other action.

(2) Suspect or Active TB

An employee with a new positive TST who exhibits a productive cough or other symptoms of TBD must be excluded from the workplace. This exclusion shall be maintained if his/her physician has diagnosed suspected or confirmed TBD until he/she is deemed to be non-infectious by his/her physician or the DOH. The physician or DOH shall document on the **DC-554 (Attachment 8-G)** that the employee is not contagious and is currently under treatment.

(a) the ICN shall contact the BHCS Infection Control staff;

(b) the BHCS Infection Control staff shall direct the ICN to contact the DOH and report the active case; and

(c) the DOH shall direct the contact investigation at the facility.

5. Employees Involved in a Contact Investigation

a. Anyone who shared the same air with a known case of infectious disease for a sufficient amount of time (minimum eight – 12 hours/day – seven days/week is spent with an inmate) is at risk for tuberculosis infection.

b. The contact investigation concerning the employee or any other individuals shall be conducted in accordance with this policy, and the procedures contained in **Subsection D.9.b. below**.

6. Employee Protection

a. Every staff member coming in contact with a known or suspected case of infectious tuberculosis must wear an N-95 mask approved by the Department at all times while in the same room as the inmate. Staff assigned to these areas shall receive training regarding the fit and use of the filtration/respirator devices in accordance with Department policy **15.1.1,** concerning respirator fitness.

b. Transportation of an inmate with known or suspected infectious TB shall be conducted in accordance with the security precautions in Department policy **6.3.1,** and in

Subsection D.8.d.(4)(b) below. Transporting staff must wear N95 respirators, and the inmate must wear a surgical facemask.

7. Training

   All training shall be in accordance with Department policy **5.1.1**.

8. References

   a. American Thoracic Society - Classification of Tuberculosis

   b. CDC, MMWR, Oct. 30, 1998/Vol. 47/No. RR-20, Prevention and Treatment of Tuberculosis Among Patients Infected with Human Immunodeficiency Virus: Principles of Therapy and Revised Recommendations

   c. CDC, MMWR, Sept. 5, 1997/Vol. 46 (RR 15), Anergy Skin Testing and Preventive Therapy for HIV-Infected Persons: Revised Recommendations

D. Inmate Tuberculosis Control

1. Tasks in TB Control - the facility ICN shall be responsible for the following:

   a. There are four general tasks in the system of TB control. This section considers each task as it applies to tuberculosis infection and to TBD to include:[7]

      (1) prevention;

      (2) detection;

      (3) containment; and

      (4) treatment.

   b. Each facility must designate one staff person to coordinate these activities. This generally shall be the nurse responsible for infection control. This person shall consult and coordinate activities with the BHCS Infection Control staff, and local public health officials.

2. Prevention

   a. Prevention of TB infection is accomplished by detecting and containing an inmate with TBD before he/she spreads the disease to others. This is discussed in **Subsection D.8. below**.

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b. Prevention of TBD in an inmate with infection is covered in **Subsection D.11. below**.

3. New Reception Transfer and TB Control

The BHCS has established guidelines to facilitate the new reception transfer programs and maintain TB control. A Diagnostic and Classification Center (DCC) inmate entering any facility shall be assessed for signs/symptoms of TB upon reception. The following process has the approval from the Pennsylvania DOH/TB Control Program:

a. If symptomatic:

The inmate shall be placed in a negative pressure room and further evaluated in accordance with this procedures manual.

b. If asymptomatic, the inmate:

(1) shall be housed separately;

(2) may go to mainline as part of a group to eat, NOT with general population;

(3) needing medical services:

(a) as many services as possible shall be taken to this designated block;

(b) if the inmate needs to be transported to the medical department for a service (wound dressing, etc.), he/she shall be escorted at a time when there are few general population inmates in the department. No mask shall be necessary for this inmate or staff; and

(c) if the inmate experiences a sudden medical emergency and needs to be transported to the medical department, there is no need for an inmate or staff to wear a mask.

(4) In this new reception transfer group shall receive his/her TST and CXR at the DCC facility.

c. The **DC-544, New Reception Transfer Medical Intake Questionnaire** (refer to **Section 2, Attachment 2-C)** shall include questions on:

(1) a history of TBD;

(2) past positive TST; and

(3) signs/symptoms of TBD.

4. Detection of Tuberculosis Infection with TST

a. Every new reception or parole violator shall be screened for the presence of tuberculin reactivity with a TST upon entry or reentry into Department custody, and at least annually thereafter.[8] An inmate staying in a reception facility less than seven days shall receive initial screening through the **DC-544.** Positive responses on the **DC-544** shall result in referral to the Medical Department. The inmate shall be isolated in respiratory isolation until cleared by the Medical Department.

b. A new reception inmate staying in a facility more than seven days shall receive a full medical evaluation in accordance with Section 2, Initial Intake and Screening and Medical Clearance for Transfer of this procedures manual, including a TST and a CXR.

c. Initial screening shall consist of a two-step Mantoux TST and a screening CXR. For purposes of tuberculosis screening, including after a positive TST, a single Posterior Anterior (PA) view is required, a lateral view is not necessary. Further testing may be indicated upon contact with a known case of tuberculosis. Single step testing is acceptable if there is documentation of a negative TST within the past 12 months.

5. Housing and Group Movements for newly Received Inmates During Screening for TB Infection or Disease (includes PVs and Authorized Temporary Absences [ATAs])

a. If the inmate is symptomatic (dyspnea, cough, hemoptysis, fever, or diAphoresis) he/she shall be placed in a negative pressure room and further evaluated in accordance with this procedures manual.

b. If asymptomatic, the inmate:

(1) shall be housed separately until cleared for general population. (Each facility shall establish a local housing policy for a new inmate who is not medically cleared as to TB, based upon security issues and physical layout of the facility);

(2) may go to mainline as part of a group to eat, NOT with general population;

(3) needing medical services:

(a) as many services as possible shall be taken to this designated block;

(b) if the inmate needs to be transported to the medical department for a service (wound dressing, etc.), he shall be escorted at a time when there are few general population inmates in the Department. No mask shall be necessary for this inmate or staff;

(c) if the inmate experiences a sudden medical emergency and needs to be transported to the Medical Department, there is no need for the inmate or staff to wear a mask;

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(d) if it is decided the inmate is medically cleared to travel to SCI Camp Hill, he shall receive the appropriate TST at SCI Camp Hill. This shall be one step or two steps depending on the length of time since his last documented PPD. He shall also have a CXR performed; and

(e) if the inmate must remain at the receiving facility to be medically cleared, and shall not be leaving for an extended period of time, he shall receive the appropriate PPD (one step or two steps) depending on the length of time since his last documented PPD. He shall also have a CXR performed.

(4) If newly received (includes PVs and ATAs) and being screened for TB by a two-step, Mantoux TST, may be moved to general population after the:

(a) first step PPD is negative; and

(b) the screening CXR is within normal limits and there is no suspicion of TB as indicated by x-ray.

c. In general, newly received inmates may be transferred to SCI-Camp Hill or Muncy if:

(1) the first step PPD is negative; and

(2) the screening CXR is within normal limits and there is no suspicion of TB as indicated by x-ray.

6. Testing Frequency

a. Routine TST is performed annually, except as specified below:

(1) an inmate working in a health services area shall have TST every six months; and

(2) an HIV positive inmate shall have TST every six months.

b. An inmate transferring to a Community Corrections Center (CCC) shall have TST two weeks before transfer, if he/she has not been tested within 12 months prior to transfer. If the inmate is found to be out of compliance by the ICN/designee at the support facility, the ICN/designee must contact the CCC Director or the CCC Contract Facility Coordinator at the regional office to report the need for the inmate's annual TST. It is acceptable to have an alternate certified health care facility conduct the test. The CCC Director or Contract Facility Coordinator at the regional office is responsible for sending the results of the test to the ICN at the support facility for input into the TB tracking system. In the event that an inmate is received in the CCC from a State Correctional Facility who is in need of his/her annual TST, it is acceptable to have the inmate return to the support facility for testing or an alternate certified health care

facility. Documentation of that result must be forwarded to the support facility's Medical Department.[9]

c. If an inmate out on ATA was held in another facility, he/she shall not need a CXR upon return to his/her home facility. TB screening shall be performed as appropriate according to the schedule already established for the inmate. Housing and group movement procedures shall be followed in accordance with **Subsection D.5. above**.

d. A facility must immediately skin test any inmate who arrives on transfer without a TST result within the previous 12 months, or documentation of a past positive. Housing and group movement procedures shall be following in accordance with **Subsection D.5. above**.

e. Only an inmate with a health care professional's written documentation of prior Mantoux skin test reactivity or TBD shall be excused from testing. Documentation from the DOH or the Department is acceptable. This inmate shall be required to have an annual review.

f. The TST shall be done according to the guidelines in **Skin Testing for Tuberculosis** and **Classification of Reactions to the Tuberculin PPD**.

g. The test result must be read and recorded 48-72 hours after application. If the TST is not read within 48-72 hours, it must be repeated.

h. A pregnant inmate is required to have a TST. An assessment of signs/ symptoms is required for a pregnant inmate who is past positive, by history, on her TST testing. The **DC-469** must be completed and filed in the medical record.

i. Neither BCG vaccination, nor lactation are contraindications for TST. These inmates shall receive an annual PPD.

j. Any inmate with a positive TST shall be encouraged to be tested for HIV infection.

k. Known TST reactors need not undergo repeated testing or annual CXRs. The health care professional (physician, physician assistant [PA], registered nurse [RN], licensed practical nurse [LPN]) shall question the inmate regarding symptoms of TB on an annual basis. The findings shall be documented on the **DC-469** in the medical record and entered in the automated inmate TB tracking system. The health care professional shall counsel the inmate to promptly report any symptoms of TBD to the medical department.

7. ***Refusal of Testing***

a. ***An inmate who refuses to have TST or symptom review is to be counseled about the importance of the test. If he/she continues to refuse, he/she MUST be***

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kept in Administrative Custody (AC) in accordance with Department policy DC-ADM 802, "Administrative Custody Procedures" (total time in AC is 30 days). When the 30 days have elapsed, the inmate shall be educated in the importance of the TST, he/she shall be examined, a symptom review completed, CXR done and chest auscultation before release to the general population. This is an administrative decision, not a medical one.

b. ***A DC-462, Release from Responsibility for Medical Treatment (refer to Section 1, Attachment 1-F) must be completed and filed in the medical record.***

c. ***An inmate who refuses TST need not be placed on medical hold; however, he/she can only be transferred between Department facilities if he/she is documented to be without symptoms of TB at the time of transfer. Receiving Department facilities must be informed that the inmate being transferred is in AC status and is refusing TST.***

d. ***A CXR shall be performed prior to transferring the inmate into AC status. A single Posterior Anterior (PA) view is required, a lateral view is not necessary.***

e. ***An inmate in AC status must be asked by nurses to reconsider having the test every day for the first week, then once a week for the remainder of the 30 days. An inmate in AC status can agree to have the test at any time, and does not have to wait until he/she is next scheduled to be asked to reconsider. Each encounter must be recorded in the medical record.***

f. ***The inmate shall be educated in the importance of the annual TST. He/she shall be handled as a past positive and receive an annual TB review.***

g. ***An inmate that continues to refuse the symptom review or physical exam at the end of the 30 days shall be referred to BHCS for further instructions.***

8. Detection of Tuberculosis Disease (TBD)

a. The determination for the management of a suspect case of TBD is to be based solely on the likelihood of the presence of exposure and/or active disease. Psychiatric or other medical specialty diagnoses do not override the management of any case or suspected case of TB exposure or disease, and an exception to this is only to be made by the BHCS, Chief of Clinical Services or Assistant Medical Director(s). The on-site Medical Director has the responsibility and authority to make treatment decisions for each case under this policy unless an exception to the policy is indicated.

b. If there is a need to screen an inmate for pulmonary or laryngeal TB, as determined by the on-site Medical Director, the inmate is to be placed in respiratory/airborne isolation in a negative pressure room. Three morning sputum specimens shall be collected and sent for Acid-Fast Bacillus (AFB) smear and culture. The use of aerosolized saline may be needed to produce an adequate specimen.

c. The initial evaluation of an inmate suspected of having TBD shall consist of a **2-view CXR (posterior-anterior and lateral views are necessary)** and at least three morning sputum specimens sent for AFB smear and culture. Sputum collection may only occur in respiratory/airborne isolation rooms, early morning specimens, and done on consecutive days. Staff assisting in the collection must wear an N-95 mask approved by the Department at all times while in the same room as the inmate. A court order must be sought to compel a CXR and sputum collection, if necessary.

d. Cultures shall be obtained on any specimen sent for an AFB smear.

e. Sensitivity studies shall be requested for all cultures positive for Mycobacterium tuberculosis (M. tuberculosis).

f. Adequate sputum samples must be obtained on any inmate with suspected or known TBD, even if the only known site of infection is extrapulmonary. A significant number of inmates with extrapulmonary disease also have pulmonary disease.

g. Healthcare staff must judge the adequacy of sputum samples. Sample collection must be observed. The observer shall encourage the inmate to breathe deeply and cough forcefully to produce a good specimen. Asking the laboratory for a gram stain on questionable samples may assist judgment of sample adequacy. The presence of few epithelial cells and many white blood cells indicates that the sample is adequate.

h. Induced Sputum Samples: The acquisition of good sputum samples may be assisted by the use of nebulized saline, but this procedure must be done with the inmate in respiratory/airborne isolation. Sputum induction is required for inmates suspected of having active TB who are unable to produce sputum on his/her own.

i. Sputum samples that are reported by the laboratory as QNS (quantity not sufficient) or overgrowth on culture are not always negative for AFB. New specimens must be submitted when these results are obtained. Three consecutive new sputum specimens shall be obtained.

j. Mycobacterial Laboratory Services

(1) Each medical vendor, or, in the absence of a vendor, each facility, must identify and maintain a relationship with a laboratory able to provide AFB smear results within 48 hours of sample submission, and preliminary positive culture results within 10-21 days of specimen collection using liquid culture media and rapid identification methods. Facilities unable to find a laboratory that can provide this turn-around time shall notify the BHCS Infection Control staff for assistance.

(2) Prior knowledge of infection with MDR (Multiple Drug Resistant) -TB must be reported to the laboratory with specimen submission.

(3) Induced sputum specimens are usually quite watery. The laboratory must be informed that a specimen is induced sputum or it may be mistaken for saliva.

(4) Only level II or III TB laboratories shall be used. Specimens found to show AFB on smear at a community laboratory must be sent to a level II or III laboratory for further analysis. Further, a new specimen is to be obtained and sent directly to the level II or III laboratory.

(5) All specimens that grow M. tuberculosis or **other mycobacteria** shall be sent to the reference laboratory for drug susceptibility testing.

9. Containment Procedures

a. Indications for TB Isolation (Respiratory/Airborne Isolation)

Respiratory/Airborne isolation is indicated for any inmate who has evidence of contagious TB. This includes, but is not limited to, inmates with:

(1) confirmed or suspected pulmonary or laryngeal TB; and

(2) a clinical indication of TB that includes:

(a) symptoms of TBD (cough, hemoptysis, fever, chills, night sweats, and weight loss). An inmate with a productive cough lasting more than 14 days, despite treatment for a respiratory infection, shall be considered to have a symptom of TBD. An inmate with a productive cough and none of these other symptoms may be treated out of respiratory/airborne isolation if the working differential diagnoses do not include TBD;

(b) abnormal CXR, excluding stable non-inflammatory lesions unchanged from previous films;

(c) undiagnosed laryngeal lesions;

(d) a positive TST; and

(e) sputum smears that are AFB positive.

b. Starting TB Isolation (Respiratory/Airborne Isolation)
TB Isolation (respiratory/airborne isolation) must be instituted as soon as the indication for it is recognized, and must continue until the criteria for discontinuing respiratory/airborne isolation are met, in accordance with **Subsection D.8.e. below.** The **DC-494, Respiratory/Airborne Isolation Flow Sheet (Attachment 8-H)** must be used for all occasions of respiratory/airborne isolation. The **DC-495, AFB Bacteriology Sheet (Attachment 8-I)** shall be used to record sputum results. Refer to **Respiratory Isolation Algorithm (Attachment 8-J)** to facilitate this process.

c. Maintenance of TB Isolation (Respiratory/Airborne Isolation)

(1) An inmate in respiratory/airborne isolation shall be housed continuously in a negative pressure room designated for this purpose and maintained in accordance with current public health guidelines. Whenever an inmate is housed in respiratory/airborne isolation, a clearly visible sign must be posted indicating the necessary precautions.

(2) An inmate may leave respiratory/airborne isolation only for medical treatments, which cannot be provided within respiratory/airborne isolation. Showering outside the isolation room is not permitted unless the shower area is within a separate physical space with adequate negative air pressure and air exchanges. Sponge baths may be used if the isolation room does not have a shower. An inmate must wear a regular surgical mask if he/she leaves the isolation room for a medical treatment. All staff coming in contact with this inmate shall wear an N-95 mask.

(3) Outdoor recreation of the isolated inmate is permitted provided the inmate wears a regular surgical mask to and from his/her destination, and the outdoor area is isolated from others. Staff will wear the N-95 mask.

(4) Legal visits are the only visits permitted to an inmate in respiratory/airborne isolation. Legal visitors must be notified that the inmate is being housed in respiratory/airborne isolation, must be informed of proper respiratory precautions he/she should take, and must be given an approved particulate respirator for use during the visit. Legal visitors must be asked to sign the **DC-513, Disclaimer for Visitors to Inmates in Respiratory/Airborne Isolation (Attachment 8-K),** but may visit without signing the disclaimer. If the legal visitor refuses to sign the visitor disclaimer, the form shall be completed and signed by two witnesses. The legal visit disclaimer shall be filed in the miscellaneous section of the inmate's medical record.

(5) Department employees, consultants, and any other persons entering or sharing a closed space with an inmate in respiratory/airborne isolation must properly and continuously wear an approved N-95 mask while in this space. Any person who enters respiratory/airborne isolation rooms in the performance of his/her job must have training in particulate respirator use. Medical health staff supervising respiratory/airborne isolation must ensure that Department employees, consultants, and others exposed to the isolated inmate use these particulate respirators (Ref: fit testing) in accordance with Department policy **15.1.1**.

d. Transfer of Inmates in TB Isolation (Respiratory/Airborne Isolation)

(1) An inmate in respiratory/airborne isolation must be placed on medical hold and may not be transferred between facilities without authorization from the BHCS.

(2) The following steps must be taken when a facility has more inmates in need of respiratory/airborne isolation than it has available isolation rooms.

(a) each inmate in isolation must be reviewed to determine whether he/she meets the criteria for release from isolation; and

(b) if no inmate meets the criteria for discharge from isolation, facility staff must contact the BHCS Infection Control staff and the inmate shall be transferred to the nearest facility with an available negative pressure isolation room.

(3) Physicians and nurses from a facility transferring an inmate in respiratory/ airborne isolation must contact his/her counterpart at the receiving facility to review the case. The contact must occur before the inmate leaves the transferring facility. This applies whether the receiving facility is a Department correctional facility, another criminal justice agency, or a hospital.

(4) Employee Protection During Transfer of Inmates in Respiratory/Airborne Isolation:

(a) Anyone likely to share the same breathing space with an inmate in respiratory/airborne isolation must be informed of that inmate's status.

(b) Transport staff for a respiratory/airborne isolation inmate must have completed training and fit testing; these staff members must wear the approved particulate respirators continuously while in the same breathing space as the inmate. Any respirator with an N-95 level of respiratory protection is acceptable for transporting an inmate with suspect or active TB.

(c) Transport staff are encouraged to keep his/her vehicle's windows open, weather permitting, whenever transporting an inmate in respiratory/airborne isolation status. The vehicle’s heating and air-conditioning system shall not be set on the recirculating cycle.

(d) A respiratory/airborne isolation inmate must wear a surgical mask (NOT N-95 masks) continuously while out of respiratory/airborne isolation rooms.

e. Release from Respiratory/Airborne Isolation

Respiratory/airborne isolation shall be maintained until one of the following conditions is met **(DC-494, Attachment 8-H, DC-495, Attachment 8-I, and Respiratory Isolation Algorithm, Attachment 8-J):**

(1) An inmate with a positive AFB smear may only be released from respiratory/ airborne isolation if (a), (b), and (c) are all true:

(a) has completed two weeks of appropriate therapy;

i. appropriate therapy for most inmates is the four-drug regimen recommended in **Subsection D. 12.** below; and

ii. appropriate therapy for an inmate with known or suspected TBD requires a minimum of two drugs to which the organism is sensitive, or which the inmate has never received.

(b) is clinically improving; and

(c) three consecutive (collected on different days) sputum smear and culture results are AFB negative.

NOTE: An inmate with confirmed or suspected TBD may not be released from respiratory/airborne isolation with positive AFB smears.

(2) All sputum smears are negative and symptoms have improved on therapy directed toward another disease (bronchitis, pneumocystis pneumonia).

(3) All culture results are known and show no growth of M. tuberculosis. Record results on the **DC-495**. Mavium or other mycobacteria do not require respiratory/airborne isolation.

10. Public Health Containment Measures

a. Public health tasks of facility staff and the BHCS Infection Control staff.

(1) Facilities are responsible for the direct inmate care aspect of the communicable disease program. This includes, among other things:

(a) routine TST;

(b) detection of cases;

(c) diagnosis and treatment of cases;

(d) prophylactic and active TBD case follow-up at a minimum of every 30 days through a TB chronic care clinic with chronic care flow sheet documentation;

(e) reporting of suspected and confirmed cases to the state and/or county public health office, and to the BHCS Infection Control staff;;

(f) maintenance of respiratory/airborne isolation rooms and other containment procedures;

(g) notification of TB diagnosis and treatment status to receiving providers if an inmate must be transferred;

(h) conduct contact investigations; and

(i) provide results of investigations to the DOH.

(2) Facilities must update the **DC-512, Active/Confirmed TB Cases Log (Attachment 8-L)** of active and confirmed TB cases under their care.

(3) The BHCS shall assist facilities in the organization and administration of their communicable disease control efforts. The BHCS Infection Control staff shall:

(a) advise facilities about the Department's communicable disease control policies;

(b) help organize group testing for surveillance or contact investigations;

(c) help facilities find information about treatment or management of inmates;

(d) facilitate the accurate and timely reporting of a suspect and active case to public health officials;

(e) assist in developing the departmental lesson plan for TB; and

(f) assist in discharge planning for an inmate receiving direct observed therapy who is about to be released from custody or transferred to a CCC.

b. Contact Investigation Guidelines

This policy section presents a system for evaluating persons exposed to an inmate with active TB. Anyone who shared breathing air with a known or suspected case of contagious disease for a significant amount of time is at risk for TB infection (work, activities, religious services, neighboring cells) in accordance with **Subsection C.3. above**.

(1) Round One

(a) A contact investigation is comprised of two rounds of testing 10 to 12 weeks apart. An inmate, Department staff, contract staff, visitor, and any other possible contact must be considered for evaluation (PPD and review of symptoms).

(b) Facility medical staff shall conduct the contact investigation with the guidance and assistance of BHCS Infection Control staff and DOH.

i. The decision to test a contact shall depend on the diagnosis of suspected or confirmed TB and positivity of sputum smears in the index case, estimates of the infectivity of the index case, the proximity and duration of contact with the index case, and the presence of host factors that could increase the chance of a contact becoming infected.

ii. The investigation shall begin with close contacts and shall be extended in stages (also called circles) to progressively lower-risk groups until the rate of skin test conversion in a tested group is less than 6%.

iii. Induration greater than or equal to five **(5)** mm shall be considered a positive TST for all contacts investigated. This standard applies to staff as well as inmates.

iv. Every contact who is either a known HIV seropositive, is at high risk for HIV infection, or is known to be immunocompromised, with less than five mm induration on the TST, shall be assessed for the risk of TB infection or disease on a case-by-case basis by the facility Medical Director.

(c) TST in conjunction with a contact investigation is voluntary with the following exceptions:

i. if the inmate demonstrates signs or symptoms consistent with possible TB; and

ii. there are conversions of PPD status to positive among other inmates or staff during contact investigation. Anyone refusing shall be counseled about the benefits of testing. The BHCS and Infection Control staff <u>must</u> be consulted concerning the enlargement of the circle(s).

(d) Any identified contact shall be asked whether he/she has symptoms of TB. Appropriate isolation precautions shall be taken for an inmate with these symptoms. Employees with symptoms of TB must be excluded from the workplace in accordance with **Subsection C. above** of this procedures manual.

(e) Employee contacts with a new positive TST shall be referred to his/her private physician or local public health office for further evaluation. A normal CXR report and a statement certifying freedom of TBD is required to be forwarded to the ICN prior to the employee's return to his/her job assignment.

(f) All inmate contacts with a positive PPD shall be evaluated as outlined in **Subsection D.7.c. above**.

(g) An inmate contact with induration less than five mm on TST shall receive a CXR (a single Posterior Anterior [PA] and lateral view is necessary) if:

i. he/she has symptoms of tuberculosis;

ii. the circumstances of his/her contact make him/her very likely to have been infected;

iii. other contacts with a similar degree of exposure have a high prevalence of infection; and

iv. he/she is known or suspected to be immunocompromised.

NOTE: An employee who meets these criteria shall be referred to his/her private physician or local public health office for further evaluation.

(h) HIV counseling and testing shall be made available to each identified contact that is uncertain of his/her HIV serostatus. An employee who is uncertain of his/her HIV status shall be referred to his/her private physician.

(I) Unless a course of treatment for LTBI is known to have been completed**,** treatment for LTBI shall be offered to all contacts who receive a CXR, and to every HIV infected inmate identified in a contact investigation as having a significant exposure (see Subsection D. 9. b. above.) An individual with known HIV infection shall be counseled specifically on how TSTs may be affected in people with compromised immune systems. Treatment for LTBI shall be started as soon as active disease is ruled out.

(2) Round Two

Any person who was negative in Round One (either PPD or review of symptoms) shall be evaluated in Round Two between 10 and 12 weeks of the initial plant or review. Contacts whose first TST showed less than 5 mm induration shall receive a second Mantoux test 10 to 12 weeks after the end of his/her exposure to the index case.

(a) The facility shall maintain a log of all contacts considered for testing using the **Tuberculosis Case Epidemiological Control Record (Attachment 8-M)**. This log shall list the contacts who accept or refuse testing and the results of TSTs. The BHCS Chief of Clinical Services and Infection Control staff shall determine if the contact investigation circles shall be extended. The BHCS Infection Control staff shall direct the facility ICN if the circle is to be extended. Any person refusing testing shall be counseled. The ICN must also submit a summary report at the conclusion of the investigation, and flag all suspected incidents of transmission on the **DC-512**. The DOH shall receive a copy of this log.

(b) The **DC-496** is to be completed for all converters.

11. Reporting to the DOH

a. Facility health staff must report every confirmed or suspected case of active TBD to the BHCS Infection Control staff via telephone 24 hours of diagnosis or suspicion.

b. Local Public Health Office notification must be made by telephone and by submission of the reporting forms **Report of Verified Case of Tuberculosis (Attachment 8-N)** by the ICN/designee.

12. Treatment of TB (Infection or Disease)

All TB therapy in the Department, including treatment for LTBI, shall be Direct Observed Therapy (DOT).

a. Direct Observed Therapy (DOT)

(1) DOT requires that an LPN, RN, physician, or PA observe the inmate place the medication in his/her mouth and then swallow. The inmate's mouth shall then be inspected for unswallowed pills.

(2) DOT must be documented for each dose. This shall be documented on the Medication Administration Record (MAR).

(3) Inmate DOT Refusal

(a) If an inmate initially refuses DOT for active disease, he/she shall remain in respiratory/airborne isolation until he/she agrees to complete the therapy.

(b) If an inmate refuses to complete the full course of treatment for active disease, he/she shall be evaluated by a physician, three sputums obtained for AFB smears, and a physician shall make a determination for further treatment in consult with the BHCS, Chief of Clinical Services and Assistant Medical Director(s). The DOH shall be notified of all refusals by the BHCS Infection Control staff.

(4) If the inmate is in a CCC and is non-compliant with DOT for active disease, the BHCS, Chief of Clinical Services, Assistant Medical Director(s), and the DOH shall be consulted.

(5) **Title 28, Pennsylvania Code, Chapter 27, Communicable and Non-communicable Diseases** requires treatment of TBD. Refusal by an inmate is grounds for seeking a court order requiring therapy. The facility Medical Director shall consult the BHCS, Chief of Clinical Services and Assistant Medical Director(s). If a court order is determined to be necessary, the facility Medical Director and BHCS shall consult with the Office of Chief Counsel.

(6) An inmate receiving DOT for TBD shall not be transferred to another facility until it is determined that:

(a) he/she shall remain in a Department facility until anticipated completion of treatment;

(b) a comprehensive discharge plan is completed. The discharge plan must identify the name, address, and phone number of the provider who shall assume care when the inmate is released or enters pre-release. The plan must include an appointment date for the inmate to be seen by the provider after release. The BHCS Infection Control staff shall assist in this discharge planning if requested by the ICN/designee; and

(c) the plan for continuing therapy must be discussed with the receiving health care provider whenever an inmate on DOT is transferred. This applies to transfers to a CCC as well as to a community provider who may care for a released or pre-release inmate. An inmate transferred to community providers shall continue to receive DOT.

b. Indication for Treatment for LTBI

(1) Any inmate with a positive TST shall be offered the opportunity to receive treatment for LTBI unless written documentation is received to show that such therapy has been previously completed.

(2) An inmate with CXR findings consistent with prior TBD or silicosis shall be offered prophylaxis according to current CDC, Morbidity and Mortality Weekly Report (MMWR), and American Thoracic Society (ATS) guidelines and updates at the following website: **http://www.cdc.gov*.***

(3) An immunocompromised inmate who had contact with a known case of active TB shall be offered prophylactic INH for nine months.

(4) LTBI Therapy Among HIV-Positive, PPD-Positive Inmates
Unless specifically contraindicated, LTBI therapy shall be provided to a HIV-positive inmate as cited in **Subsection D.11.b.(2) above**:

(a) who has a positive TST (greater than or equal to **5** mm of induration);

(b) who has not already been treated for TB infection; and

(c) whose test results exclude active TB.

NOTE: This LTBI therapy is indicated even if the date of TST conversion cannot be determined.

(5) LTBI Therapy for HIV-Positive, PPD-Negative Inmates

(a) When assessing an HIV-infected inmate who has negative PPD (TST results), the most important factors in considering LTBI therapy are the likelihood of exposure to transmissible active TB and the likelihood of latent M. tuberculosis infection. LTBI therapy shall be considered for an HIV-infected inmate who does not have a documented positive PPD-tuberculin

response but who has had recent contact with an inmate who has infectious pulmonary or laryngeal TB. Repeat TST of initially PPD-negative contacts three months after cessation of contact with infectious TB may be used to assist in decisions about duration of LTBI therapy. However, most of these inmates shall complete a full nine-month course of LBTI therapy in accordance with **Subsection D.11.b.(2) above**. Refer all questions to the BHCS Infection Control staff.

(b) LTBI therapy for an inmate who is not PPD positive also may be considered. Such therapy may be beneficial for:

i. children who are born to HIV-infected women and are close contacts of a person who has infectious TB; and

ii. HIV-infected adults who reside or work in facilities and are continually and unavoidably exposed to inmates who have infectious TB. Some experts recommend continuing Isoniazid LTBI therapy indefinitely for HIV-infected persons who have an ongoing high risk for exposure to M. tuberculosis (inmates of prisons in which the prevalence of TB is high).

c. Refusing LTBI Therapy

An inmate may refuse LTBI therapy, but must be instructed in the rationale for and expected benefits of LTBI therapy before his/her refusal is acknowledged. Refusal of LTBI therapy must be documented in the medical record and automated inmate TB tracking system. In addition, an inmate shall be asked to attest to his/her refusal on a **DC-462,** (refer to **13.2.1, Section 1- Inmate Health Care Plan, Attachment 1-F**). The inmate must be recalled by nursing staff for annual review to document the presence or absence of symptoms of tuberculosis. Preventive therapy must be re-explained and re-offered at each recall visit.

d. Contraindications to LTBI Therapy

(1) No inmate shall be started on prophylactic therapy until active disease is ruled out by interview, examination, CXR, and (if indicated) sputum smears and cultures.

(2) An inmate over 35 years old or with pre-existing liver disease may still be treated with INH therapy. He/She may safely receive the benefits of LTBI therapy, but shall have a baseline Liver Function Test (LFT) prior to initiating INH and repeated LFTs at four weeks and at eight weeks during this therapy. If INH toxicity occurs and treatment must be discontinued, some benefit is obtained from even a partial course of therapy. Rifampin may be used as a second line of therapy after LFTs return to normal.

e. Multi-Drug LTBI Therapy

An inmate converting to a positive TST result after known or suspected contact with a case of MDR-TB shall be considered for multi-drug LTBI therapy.

(1) The inmate shall first have his/her risk of infection with MDR-TB estimated.

(2) The decision to use multi-drug LTBI therapy shall then be based on the **DC-495**.

(3) Physicians identifying an inmate for whom multi-drug LTBI therapy is indicated shall contact the BHCS, Chief of Clinical Services or Assistant Medical Director(s) to discuss therapy.

f. Monitoring LTBI Therapy

(1) The inmate shall be seen periodically by the nurse or physician/PA and evaluated by obtaining liver function testing at two, four, and eight months and concerning symptoms of hepatic dysfunction (nausea, vomiting, abdominal pain, jaundice, biliuria, clay colored stools). INH must be immediately stopped if these signs or symptoms are present. The symptoms must be evaluated and not simply attributed to INH therapy.

(2) Any inmate who develops symptoms of TBD while on DOT must be immediately placed into respiratory/airborne isolation and evaluated as outlined in **Sub-Section D.5. above**.

g. Interrupted LTBI Therapy

(1) If an inmate starts DOT and then becomes non-compliant he/she shall be counseled about the benefits of therapy and then given the opportunity to resume DOT. A second episode of non-compliance shall be considered a refusal of therapy. In addition, the inmate shall be asked to attest to his/her refusal on a **DC-462,** (refer to **13.2.1, Section 1- Inmate Health Care Plan, Attachment 1-F**). The inmate shall have his/her DOT stopped and be counseled to promptly report any symptoms of tuberculosis to his/her facility health staff. He/She shall then be managed as a past positive as stated in **Subsection D.6.q. above**.

(2) The following guidelines shall be used for the resumption of therapy if an interruption of preventive therapy should occur:

(a) for an inmate who received DOT for less than three months and interrupted treatment **more** than 30 days, start over at day zero and complete the indicated length of therapy; and

(b) for an inmate who received DOT for more than three months and interrupted treatment less than 30 days, resume therapy where he/she left off.

(c) **the required number of doses must be administered within 3 months after the anticipated date of completion.**

13. Therapy of TBD

a. Treatment Procedures

(1) Every inmate with suspected or confirmed active tuberculosis MUST be isolated as outlined in **Subsection D.7. above**.

(2) All treatment of TBD should be undertaken with consultation with the BHCS Infectious Disease Specialist, or Pulmonologist knowledgeable in the treatment of TB and according to current CDC, MMWR, and ATS guidelines and updates at the following website: **http://www.cdc.gov.**

b. Monitoring Treatment Effectiveness

(1) One sputum smear shall be obtained weekly after the diagnosis has been established. Once a negative smear is obtained, additional smears and cultures shall be obtained on consecutive days until three consecutive smears are AFB negative. Sputum smears and cultures shall then be obtained monthly until completion of therapy.

(2) The inmate may be released from isolation when all culture results are known and none show growth of *M. tuberculosis*. The facility Medical Director shall consult with the BHCS, Chief of Clinical Services or Assistant Medical Director(s) for approval of this release.

(3) At least monthly, the inmate shall be evaluated by a physician or PA until therapy is completed. This evaluation must include a review of symptoms of TB and side effects of the inmate's medications. A focused physical examination shall be performed. CXR and laboratory studies must be obtained when indicated. Documentation shall be completed on the **DC-472,** (refer to **13.1.1, Section 5-Occupational Exposure to Blood-borne Pathogens, Attachment 5-D**) and other appropriate medical records forms when indicated.

(4) The following data shall be recorded at each physician visit:

(a) presence or absence of symptoms;

(b) weight;

(c) temperature;

(d) presence or absence of physical findings;

(e) abnormal laboratory values;

(f) dates and results of sputum collections; and

(g) date and result of CXRs.

(5) If the sputum culture fails to become negative after three months of therapy:

(a) compliance with DOT must be reviewed;

(b) the laboratory shall be notified that MDR-TB is suspected. Any changes in therapy must be based on updated sensitivity data; and

(c) consult with the DOH.

(6) The **DC-497, Tuberculosis Chemotherapy Flow Sheet (Attachment 8-O)** shall be used to monitor medication use.

(7) Monitoring of adverse effects of medications must be consistent with guidelines found in the **First-Line TB Drugs (Attachment 8-P)** and as cited in **Subsection D.11.b.(2) above**.

c. Nursing Review of Tetanus History/Tetanus Vaccinations

(1) A nurse shall complete the **DC-486, Inmate Immunization Record (Attachment 8-Q),** whenever an inmate is immunized.

(2) If the inmate is known to be allergic to the tetanus vaccine, no vaccine shall be administered and the inmate's allergy to the vaccine shall be documented in the progress notes. In addition, documentation must be provided on the **DC-445, Drug Sensitivity Label**, which is affixed to the front of the inmate's medical record.

(3) Administration of the tetanus/diphtheria vaccine is contraindicated during pregnancy. In the event an inmate is pregnant, the nurse conducting the tetanus history review shall document the inmate's condition and progress in the **Progress Notes Section** of the inmate's medical record.

(4) The physician or nurse administrating the vaccines shall record on the **DC-486**, the following information for all tetanus/diphtheria immunizations given:

(a) date and time;

(b) vaccine lot number;

(c) manufacturer; and

(d) initials of the health care provider administering the immunization.

(5) Tetanus/diphtheria (Td) vaccination shall be administered as follows:

(a) 0.5 ml, IM on intake to the Department. This shall be documented on the **DC-486**, in the inmate's medical records.

(b) A booster dose, 0.5 ml, IM shall be administered every 10 years. This shall also be documented on the **DC-486**.

(c) In the event of a wound, a booster dose of Td vaccine shall be administered in the following amounts:

i. minor wound and not contaminated - Td 0.5 ml, IM given only every 10 years; and

ii. other wounds - Td 0.5 ml, IM is appropriate if the inmate has not received tetanus toxoid within the preceding five years.

(d) Tetanus Immunization: If the inmate has not received any immunization, the recommended schedule for children equal to or greater than seven years of age and adults is a primary vaccination with Td to include three doses:

i. initial dose - Td 0.5 ml, IM;

ii. second dose - Td 0.5 ml, IM four to eight weeks after first dose; and

iii. third dose - Td 0.5 ml, IM six to 12 months after second dose;

NOTE: Td rather than DT (Diphtheria/tetanus) is the preparation of choice for vaccination of all persons greater than or equal to seven years of age because side effects from higher doses of diphtheria toxoid are more common.

(e) progress notes shall only be written if the inmate experiences an allergic reaction or other complications as a result of the immunization; and

(f) after completing the Tetanus History/Tetanus Vaccinations review, the nurse shall file the **DC-486**, under the TB/Immunization Section of the inmate's medical record.

E. Sexually Transmissible Diseases Treatment (STD)

1. Identification of STDs Upon Reception

a. The BHCS has identified the need to expand testing of our inmates to include testing for Chlamydia and Gonorrhea. Risk factors for an inmate are:

(1) below 33 years old;

(2) multiple sexual partners; and

(3) past history of other STDs.

b. Every inmate shall be tested on intake (parole violators and new receptions) to identify these organisms and appropriately treat them.

c. The importance of this testing is based on the fact that the presence of both ulcerative and suppurative disease (areas that are open and draining) places the inmate at increased risk of HIV transmission and acquisition.

d. The Leukocyte Esterase (LE) shall be performed in accordance with **Section 3, Physical Examinations** of this procedures manual.

2. Staff Responsibilities

a. Facility Medical Director

The facility Medical Director/designee shall ensure that all physicians and clinical staff are familiar with the Sexually Transmitted Diseases Treatment Guidelines. Please refer to the "U. S. Department of Health and Human Services Centers for Disease Control and Prevention Guidelines for Treatment of Sexually Transmitted Diseases" that was sent to the ICNs.

b. Corrections Health Care Administrator (CHCA)

The CHCA/designee shall ensure:

(1) that all physicians and clinical staff are familiar with the Sexually Transmitted Diseases Treatment Guidelines; and

(2) that all confirmed cases of sexually transmissible diseases diagnosed within the facility are reported to the appropriate State DOH District Office.

F. Management of Hepatitis A, B, and C[10]

1. Inmates shall be tested for Hepatitis C (HCV) antibodies upon arrival at the home facility rather than at reception, but no later than four months after reception into the Department. Inmates already known to have HCV antibodies need not be retested but may be entered directly into the Hepatitis C protocol (refer to **13.2.1, Section 16, QI Plan, Appendix 16-B, Chapter 01)**. Testing for HCV at any time remains an option at the clinician's discretion.

2. Testing for Hepatitis B surface antigen (HBSAg) can be offered at the same time as HCV testing, and testing for HIV should be offered. Inmates immunized against HBV may

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nevertheless be infected and should not be considered uninfected unless a previous HBSAg is negative.

3. Hepatitis A

   a. Transmission

      Hepatitis A virus is transmitted via fecal to oral route.

   b. Identification – Symptoms of Acute Hepatitis A

      (1) jaundice;

      (2) fever;

      (3) malaise;

      (4) anorexia; and/or

      (5) nausea.

   c. Surveillance

      (1) When the inmate presents to the Medical Department with the above symptoms, he/she shall be placed in contact isolation. Blood testing to confirm the diagnosis will be at a minimum:

         (a) liver function tests;

         (b) HAV antibody (HAV IgM); and

         (c) HB_sAg unless known positive.

         NOTE: Positive IgM indicates recent infection.

      (2) The ICN shall investigate the inmate's cellmate(s) and workplace to determine the source of the infection. This investigation may also identify any other cases.

      (3) If the index case works in Food Service, the ICN shall notify the BHCS/ICC and receive direction on further action.

      (4) The BHCS/ICC and DOH will review the Hepatitis A situation by an inspection of Food Services, hand wash stations, etc. A report will be presented with the findings and the action follow-up to the BHCS and DOH.

   d. Immunization (Hepatitis A Vaccine)

(1) This Hepatitis A vaccine will be given without antibody testing for past infection (HAV IgG).

(2) Every Hepatitis B and C positive inmate, as well as those who have chronic liver disease are offered Hepatitis A vaccine, if not already immune or vaccinated.

e. Treatment

The DOH shall be notified by the BHCS/ICC. The DOH will advise/direct if immune globulin will be indicated for the treatment of an exposed inmate or staff. Treatment for acute Hepatitis A is supportive. This is based on the inmate's clinical assessment.

f. Follow-up

There is no further follow-up after the acute case of Hepatitis A has resolved.

g. Isolation

An inmate who is a suspected or confirmed case of Acute Hepatitis A shall be placed in contact isolation precautions.

h. Every inmate designated for Food Service shall be evaluated for symptoms of Hepatitis A. If the inmate has acute Hepatitis A, he/she shall not work in Food Service.

4. Hepatitis B

a. Transmission

Hepatitis B virus is transmitted via infected blood and body fluids.

b. Identification – Symptoms

(1) jaundice;

(2) fever;

(3) flu-like illness;

(4) malaise;

(5) arthralgias; and/or

(6) nausea.

c. Surveillance

In most cases the patient does not know he/she is infected with Hepatitis B. When the inmate presents to the Medical Department with the above symptoms, blood testing to confirm the diagnosis will be as follows:

(1) Acute Hepatitis B

(a) Hepatitis B Surface Antigen – HbsAG positive indicates the presence of the virus:

i. chronic active; or

ii. persistent uncleared.

(b) Hepatitis B Surface Antibody - HB_sAb positive - past infection and protective antibodies;

(c) Hepatitis B e Antigen - HB_eAg positive - acute infection, highly contagious;

(d) Hepatitis B core Antibody - Hb_cAb positive - past infection, protective antibodies;

(e) Presence of IgM antibodies - new infection; or

(f) Presence of IgG antibodies - previous infection of any duration.

(2) Chronic Hepatitis B is defined as the patient who is Hepatitis B surface antigen (Hb_sAg) positive for greater than six months.

d. Risk Reduction

(1) The physician/PA/ICN shall review the inmate's risk factors/behaviors.

(2) The inmate shall receive education concerning Hepatitis B transmission and prevention.

e. Immunization – Hepatitis B vaccine is offered to:

(1) every staff member and inmate, unless medically contraindicated, already vaccinated or immune; and

(2) a Hepatitis C Virus (HCV) positive inmate as part of the HCV protocol is highly encouraged to receive the Hepatitis B vaccine series.

f. Treatment and Follow-Up

Questions concerning Hepatitis B treatment will be directed to the Department Infectious Disease (ID) Specialist. They will be reviewed on a case-by-case basis.

g. Isolation

The precautions to be taken shall be Universal/Standard Precautions.

h. An inmate with chronic Hepatitis B is cleared to work in Food Service. An inmate with acute Hepatitis B cannot work in Food Service until he/she is medically stable and cleared to work by his/her treating physician. An inmate working in Food Service is not contagious to others unless he/she has the symptoms of the disease.

5. Hepatitis C

a. Transmission

Hepatitis C virus is transmitted via infected blood and body fluids.

b. Identification/Surveillance

Every inmate is tested for Hepatitis C virus upon arrival at the home facility. Every HCV-positive inmate shall be evaluated and treated in accordance with the HCV protocol as outlined in **13.2.1, Section 16 - QI Plan Appendix 16-B Chapter 01** and evaluated periodically in chronic clinic.

c. Immunization

There are no vaccines for Hepatitis C; however, Hepatitis A and B immunization*s* are encouraged.

d. Treatment

Inmates with HCV infection are evaluated as part of the HCV protocol to determine need for drug treatment.

e. Follow-up

A Hepatitis C positive inmate shall be seen in Hepatitis C clinic according to the Hepatitis C protocol.

f. Isolation

The precautions to be taken shall be Universal/Standard Precautions.

g. An inmate with Hepatitis C is cleared to work in Food Service. An inmate working in Food Service is not contagious to others.

G. Management and Reporting of HIV Infection[11]

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1. Responsibilities

   a. Supervisors, Managers, and Coordinators[12]

      Department supervisors, managers, and coordinators are to ensure that every Health Care Worker (HCW) under his/her jurisdiction receives appropriate Acquired Immunodeficiency Syndrome (AIDS) education, follow applicable federal and state public health requirements on AIDS in the workplace, follow all appropriate Commonwealth AIDS and HIV infection policies and procedures, and adhere to confidentiality provisions for AIDS/HIV information on state employees and inmates. General questions on AIDS can be addressed directly to the Pennsylvania DOH's AIDS Factline at **1-800-662-6080**.

   b. The Department HIV/AIDS Education Coordinator shall:

      (1) act as a liaison with the Governor's Office of Administration, the Department's BHCS, Bureau of Human Resources (BHR), and Bureau of Inmate Services (BIS) on HIV/AIDS workplace issues and concerns;

      (2) recommend appropriate Department and facility HIV/AIDS workplace policies and procedures in consultation with the ICC at the BHCS;

      (3) provide technical assistance to Department managers, supervisors, and HCWs on HIV/AIDS questions and concerns;

      (4) coordinate the Department's HIV/AIDS education programs for HCWs and inmates. Conduct annual training needs assessment to ensure appropriate education is offered and provided at the facility; and

      (5) coordinate efforts with the BHCS, BHR, BIS, Office of Equal Employment Opportunity, and medical personnel in the Department to ensure issues and concerns are resolved.

   c. The Facility HIV**/**AIDS Workplace Coordinator shall:

      (1) act as a single point of contact for facility HCWs as defined by:

         (a) Department policy **13.1.1**;

         (b) **Management Directive 505.26, HIV/AIDS in the Workplace**;

         (c) **Management Directive 505.7, Personnel Rules**; and

         (d) the Americans with Disabilities Act.

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(2) act as a liaison with the Department's HIV/AIDS Education Coordinator and the Department's ICC on HIV/AIDS workplace issues and concerns;

(3) provide a program of health and safety education and act as an advisor to HCWs; be available to ensure that the HCWs who refuse or object to working with an HIV/AIDS positive HCW or inmate have basic knowledge on:

(a) the nature of the virus, how the virus is and is not transmitted in the workplace, and its impact on individuals with the disease; and

(b) the Department's and the Commonwealth's policies on HIV/AIDS in the workplace.

(4) ensure that managers and supervisors are aware of federal and state public health guidelines and requirements on HIV/AIDS in the workplace regarding:

(a) Universal/Standard Precautions;

(b) discrimination;

(c) reporting procedures and documentation of Blood and Body Fluid Spill Clean-up Occupational Exposure contained in **Subsection H.5. below**; and

(d) the Americans with Disabilities Act.

(5) coordinate his/her efforts with his/her local personnel office and medical personnel. When an existing coordinator is reassigned or resigns, facilities are to provide the Department's HIV/AIDS Coordinator with the name of the replacement within two weeks;

(6) ensure that confidentiality is maintained in accordance with the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq. (Attachment 8-R)**;

(7) act as a resource during Post Exposure Protocol procedures. Follow-up with the HCW who was involved in an occupational exposure to ensure that:

(a) the HCW's questions are directed to the appropriate personnel;

(b) copies of reports are collected, including medical and other information regarding an occupational exposure to blood-borne pathogens. This information is maintained in a locked file in a secure area separate from personnel files;

(c) in accordance with the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq.**, the HIV/AIDS Workplace Coordinator shall explain procedures for obtaining certification of significant occupational exposure for HCWs who are First Responders or Health Care Providers;

(d) subsequent to the HCW's exposure and medical department appropriate intervention and referral, the HIV/AIDS Workplace Coordinator shall provide the HCW with general information on occupational exposures to HIV in accordance with Department policy of **13.1.1**, and make referrals to appropriate community resources;

(e) the HCW shall not be charged with medical expenses or leave for time incurred in HIV testing and counseling based on a documented workplace exposure. Should there be a charge for the related medical expenses and leave for test and/or counseling, the Department shall assume responsibility for the costs. If further testing or post-test counseling is recommended by the testing center or physician, costs and leave time shall be handled by the Department in the same manner as during the original test. Employees/ HCWs are to make every effort to schedule follow-up testing or counseling during non-working hours;

(f) after consulting with the medical department, the Facility HIV/AIDS Workplace Coordinator shall inform the exposed HCW if the source individual's Hepatitis B and C serostatus is known. Disclosure of the source individual's HIV test results shall be in accordance with the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**. There is no need to perform HIV testing on the source if the HIV serostatus is known and documented on the medical record;

(g) the Facility HIV/AIDS Workplace Coordinator shall seek the source testing after the HCW has submitted to HIV testing; and methods to obtain source blood testing for HIV:

i. good faith effort to seek voluntary signed informed consent;

ii. source refuses HIV testing, available blood may be used for the HIV test. This shall be documented on the source medical record; and

iii. if there is no available blood and the source refuses HIV testing, the HCW may request through the facility HIV/AIDS Workplace Coordinator that the correctional facility obtain a court order to have blood drawn from the source. If such a request is made, the facility HIV/AIDS Workplace Coordinator shall contact and consult with the BHCS. The BHCS shall then contact the Office of Chief Counsel to determine whether to initiate legal proceedings.

(8) maintain a current and updated list of emergency facilities, community HIV/AIDS support groups and services;

(9) act as a resource for all the facility HIV/AIDS issues (staff, inmate, etc.) and coordinate activities with other key facility staff. Work in conjunction with the Department's ICC at the BHCS regarding questions concerning medical policy

issues. Contact the Department's HIV/AIDS Education Coordinator regarding questions concerning the availability of HIV/AIDS education programs and training for facilities;[13] and

(10) report an in-house problem to the Facility Manager/designee.

NOTE: For additional HCW information regarding exposures, refer to **Management Directive 505.26** and the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**.

d. Facility HIV/AIDS Resource Coordinator for Inmates:[14]

(1) shall function as a resource for inmates. This shall include speaking for the inmate to promote his/her health while at the same time maintaining security and confidentiality;

(2) act as a resource during Post Exposure Protocol procedures. Work in conjunction with the Facility HIV/AIDS Workplace Coordinator to ensure that Department policy **13.1.1** is followed and the source inmate receives correct follow-up as per the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**;

(a) If the inmate (source individual) is known to be infected with HIV, repeat testing is not required.

(b) If the source individual's serostatus is unknown, he/she shall be counseled and offered testing for HBV, HCV and HIV.

(3) maintain a list of staff trained to provide HIV/AIDS Prevention (Pre-Post Test) Counseling;

(4) provide educational materials as needed for the inmate population;[15]

(5) conduct direct observation of prevention counseling sessions with the inmate. These observations are to ensure that counseling sessions are performed in a way that provides strict confidentiality for the inmate. The observation shall be random to ensure accuracy and compliance with the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq.**;

(6) maintain a copy of all inmate HIV/AIDS correspondences;

(7) provide a program of health education to inmates who are:

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[15] 1-ABC-4E-41

(a) in general population (in conjunction with the Inmate HIV Peer Education Program); and

(b) leaving the facility (CCC, paroled to the community, served maximum sentence). The coordinator shall encourage the inmate to disclose HIV/AIDS related information to the Parole Officer to ensure appropriate follow-up care.[16]

(8) maintain a current list of community HIV/AIDS support groups and services[17]; and

(9) work with the appropriate departments within the facility to ensure the inmate's needs are met (housing, food services, employment, etc.).

2. Transmission of HIV

a. There is **no evidence** that HIV is transmitted by casual social contact with infected individuals. While HIV has been isolated in many body fluids, only blood, semen, vaginal fluid, and breast milk have been implicated in its transmission. Therefore, the routes of transmission are via:

(1) intimate sexual contact;

(2) sharing of needles and syringes contaminated with blood;

(3) blood and blood products containing HIV;

(4) prenatal transmission from mother to neonate (mother-to-newborn) transmission; and

(5) possible transmission through mother's milk to infant.

b. HIV is transmitted primarily through direct sexual contact involving exchange of implicated body fluids or through the exchange of blood from a person who is infected with HIV. HIV infection is also transmitted by shared needles contaminated with blood. Other evidence for transmission through blood products has been found in the occurrence of AIDS in hemophilia patients receiving clotting factors made from infected blood. Although HIV has occasionally been found in very small quantities in the saliva, urine, feces, and tears of a few people with HIV infection, current evidence indicates that these body fluids are not vehicles of transmission unless they contain visible blood.

c. There is no evidence that HIV has been transmitted by casual, non-sexual, person-to-person social contacts as would occur in normal business or household

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settings with people who are infected with HIV, who are diagnosed as having AIDS, or who participate in high risk activities. Persons who do not engage in high-risk behavior are not at risk of acquiring the virus.

d. Significant exposure consists of exposure of blood or potentially infectious body fluids from a source individual to the blood (needle stick), mucous membranes (eye, mouth, genital, rectal), or non-intact skin (lacerations, open sores) of another individual.

e. Potentially infectious human body fluids include semen, vaginal secretions, cerebrospinal, synovial, pleural, saliva contaminated with blood, and all body fluids where it is difficult or impossible to differentiate between the types of body fluids involved.

f. An HCW with AIDS, as an HCW with any disease, shall continue his/her normal work duties unless his/her medical condition, as determined by his/her physician, precludes it or his/her presence in an area with inmates presents a security or safety concern. HCWs are not at risk of contracting HIV from infected co-workers or inmates, or in the absence of shared needles contaminated with blood, or direct sexual contact involving the exchange of body fluids. Talking to people with AIDS or to persons infected with the HIV or being in close proximity is no cause for concern.

g. There is no evidence that HIV is spread by:

(1) biting, sneezing, coughing, or spitting;

(2) contact with urine or feces, unless there is visible blood;

(3) handshakes or other non-sexual physical contact;

(4) toilet seats, bathtubs, or showers;

(5) utensils, dishes, or linens used by an infected person;

(6) food prepared or served by an infected person;

(7) articles handled or worn by an infected person; and

(8) being around an infected person, even on a daily basis over a long period.

3. Inmate Confidentiality[18]

a. Any HIV-related inmate information of a medical nature may not be revealed by a HCW or volunteer of the Department, unless authorized by the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq.,** or other state or federal statute or regulation. Any written consent to disclosure of confidential HIV-related

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information shall include the various items and requirements as enumerated in **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**.

b. Communication within the correctional facility shall not divulge a patient's HIV/AIDS diagnosis or medical condition, except to those who are authorized by **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**. If written, such information is to be maintained in locked file drawers, compartments, or other secure space in accordance with Health Care Worker Confidentiality, **Subsection F. 8.b. below**.

c. As a matter of policy, Universal/Standard Precautions shall be applied to every individual treated by the medical staff/Department HCW. The CDC recommends the use of Universal/Standard Precautions. Public health policy indicates that knowledge of an individual's antibody status is not helpful for infection control and protection of either patients or staff. The basic tenets of this procedure manual are to treat everyone as if he/she is infected.[19]

d. An inmate request for voluntary HIV testing shall be ordered by a physician/PA.

e. A list of inmates with AIDS or those infected with HIV shall not be posted, in accordance with this procedures manual.

f. The Department's rules, regulations, and directives governing confidentiality shall apply in accordance with Department policy **DC-ADM 003, "Release of Information,"** and the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq.**

g. If an inmate is paroled or released before the test results are known, when the test results do return, a notation must be made in the medical record by the physician reviewing the test results. The test results shall be forwarded to the Pennsylvania DOH who shall, in turn, notify the inmate and provide proper counseling and services.

4. Diagnosis/Assessment/Treatment

a. Department programs serving those with AIDS or HIV infection address the special needs of this population. The inmate may face stigma and discrimination. He/She may be coping with physical deterioration and the psychological and social impact of having a fatal disease. The Department has an obligation to provide adequate medical care for every inmate including those with AIDS or HIV infection, including following the latest CDC and other federal guidelines and protocols, where available, for patient diagnosis and treatment.

b. There shall be no involuntary HIV testing of an inmate of the Department except as provided in **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq.** the Act establishes criteria for routine and mandated testing. See Department policy **13.1.1, Section 5.**

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c. HIV testing shall be offered at the home facility in conjunction with Hepatitis C testing. Otherwise, HIV testing shall only be ordered by a physician. The order must be based upon the inmate's current medical history and clinical signs and symptoms. Inmate requests for testing shall be routinely approved, even if the inmate does not admit to high-risk behavior**,** but testing more frequently than every six months shall be performed only in exceptional circumstances. A program is to be instituted at each Corrections facility to encourage an inmate to voluntarily be tested for HIV so that those who are infected can receive appropriate early counseling and treatment. If an inmate does not request an HIV test but has exhibited early symptoms of HIV illness or high-risk behavior, the physician may order an HIV test with consent of the inmate. The Physician/PA shall provide pre-test counseling. A nurse may provide this counseling after completion of training for HIV counseling from the Department.[20]

d. The inmate shall receive pre-test counseling prior to the HIV test. He/She shall be offered an interpreter if needed and given ample time to ask questions. The Language Line Services (through the Business Office) will be used for interpretation. The inmate must sign the HIV Consent <u>before</u> the blood is drawn.

e. The physician shall complete his/her assessment using professional judgment and current HIV diagnostic procedures. Past and present historical data from the inmate and from the inmate medical record shall be consulted. Information that the physician shall consider includes:

(1) demographic data;

(2) risk factors (IV drug abuser, homosexual and heterosexual high risk sex, hemophilia transfusions, other transfusion history, history of infections: hepatitis, mononucleosis, herpes, TB, gonorrhea syphilis, etc);

(3) history of symptoms: fatigue, fever, anorexia, malaise, depression, dyspnea, persistent diarrhea, night sweats, weight loss, lymphadenopathy, and shortness of breath;

(4) particular attention shall be paid to history and/or current evidence of:

(a) drug abuse;

(b) assaultive behavior;

(c) indiscriminate sexual behavior; and/or

(d) victimization.

(5) unless clinically contraindicated, it is recommended that the customary testing protocols recommended by the CDC shall be followed; that is, if the first ELISA

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test for HIV is positive, a second test shall be done to verify the results of the first test. If the second test is also positive, a third test, the Western Blot, which is more specific for antibody shall be done. Persons with a repeatedly reactive HIV ELISA test and positive Western Blot shall be considered HIV infected, and the physician may order additional tests to determine the proper staging and classification of infection;[21]

(6) the physician performing a physical exam shall give special attention to:

(a) Lymphadenopathy;

(b) oral changes;

(c) Candidiasis;

(d) mental status changes;

(e) rashes and/or skin changes;

(f) rales in lungs;

(g) weight loss;

(h) fever;

(i) jaundice; and

(j) track marks.

(7) post test counseling:

(a) The test and its results shall be discussed with the inmate by the physician/ PA/designee. In any case, when testing is ordered, the physician shall document the rationale for testing, discussions with the inmate and plans for management of the condition.[22]

(b) The physician or trained medical staff is to provide counseling to all inmates prior to and after results are received for HIV antibody testing. Counseling shall be in compliance with all CDC and Pennsylvania DOH guidelines and protocols, as well as requirements outlined in the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**. A nurse may provide this counseling after completion of the HIV counseling training from the Department.[23]

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(c) Housing plans for an inmate having a positive test result shall be handled on a case-by-case basis, using medical and security considerations. Under ordinary circumstances, an inmate that is known to be HIV positive shall be housed with general population.

(d) Determination of housing is based upon comprehensive evaluations and medical judgment as to the appropriate level of care for the inmate's physical status and security considerations. Housing determination shall be made on the following criteria:[24]

i. isolation or physical condition such as weakness, incontinence, diarrhea, etc;

ii. psychiatric diagnosis and treatment (uncontrolled behavior);

iii. the inmate's inability to abstain from intimate sexual contact;

iv. the inmate's inability to follow blood/body fluid precautions due to inability to comprehend and/or unable to follow good infection control measures such as good personal hygiene habits; and/or

v. victimization.

(e) The inmate's management plan shall be updated based on positive HIV test results or diagnosis with AIDS.

(f) The management plan shall outline the methods to be used, encompassing the medical, psychiatric, and psychological needs of the patient.[25]

(g) If an inmate is paroled or released before the test results are known, when the test results do return, a notation must be made in the medical record by the physician documenting the results of the tests. The lab report must be initialed by the physician and filed in the record. The test results shall be forwarded to the Pennsylvania DOH who shall, in turn, notify the inmate and provide proper counseling and services.

(h) Transfers between correctional facilities and CCCs of the Department and Forensic Treatment Centers (FTC) shall have updated medical summaries that include HIV information if that information is pertinent to the future care of the transferee.

5. Inmate Care Statement

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a. There is no evidence that the risks in providing direct care to an inmate infected with HIV are any greater than those associated with caring for any other sick person. Therefore, a healthy HCW shall not be excused, on his/her own request, from providing care to these inmates. An HCW, who believes he/she may be at increased risk because he/she is immunosuppressed or have other clinical conditions that may confer an increased risk of acquiring an infection, shall discuss his/her concerns with his/her supervisor. These cases shall be evaluated on an individual basis in consultation with correctional administration and the HCW's physician. Claims by the HCW must be supported by written medical documentation.

b. Specific guidelines for the care of an inmate infected with HIV are outlined in the procedures section of this document.

6. AIDS and HIV Infection in the Workplace

a. The provisions of this section are in accordance with **Management Directive 505.26**. If more detailed information is needed, the Directive may be referenced.

b. A Department HCW and a job applicant with AIDS or HIV infection, or those perceived to have these conditions, shall not be discriminated against with regard to appointment, transfer, promotion, or any other employment or personnel action. Under no circumstance can an appointing authority require a current or prospective state HCW to receive an HIV antibody test, or reveal the results of a previous test or diagnosis, as a condition of employment. Should the Department learn of a current or prospective state HCW's AIDS or HIV infection that information shall not be used regarding employment or personnel actions except where the HCW concurs.

c. In the event a Department HCW with AIDS or HIV is unable to physically carry out his/her job duties, the HCW shall be afforded the same considerations as any other HCW whose illnesses prevent him/her from fully performing his/her job. Because of the episodic nature of the secondary illnesses which affect persons with AIDS, an HCW may request reasonable accommodations which shall allow him/her to work with his/her handicap. Such requests shall be supported by appropriate documentation from the HCW's physician. These requests are to be honored where operationally feasible, based on the job setting involved and the resources of the facility. An HCW with AIDS or HIV infection who request a transfer or a lateral or downward reclassification because of his/her medical condition shall have these requests considered, consistent with facility needs, the Americans with Disabilities Act, and **Management Directive 505.7**.

d. An HCW who refuses or objects to working with a co-worker, inmate, client, or member of the public with or perceived to have AIDS or HIV infection shall be counseled and educated in:

(1) how the virus is, and is not, transmitted in the workplace; and

(2) the Commonwealth's **Management Directive 505.26** and this procedure manual on AIDS in the workplace.

e. Should the HCW continue to refuse to work with those individuals, the HCW may be subject to appropriate progressive discipline, up to and including dismissal.

f. Department policy prohibits discrimination against persons with or perceived to have AIDS or HIV infection. Complaints about alleged discrimination against a HCW and prospective HCW may be addressed to the agency Equal Employment Officer.

g. In addition, **the Pennsylvania Human Relations Act 43 P.S. §951 et seq**. has been interpreted to cover discrimination against individuals with or perceived to have AIDS or HIV infection. Discrimination based on AIDS or HIV infection is prohibited in employment in Pennsylvania. Any person wishing to file discrimination complaints with the Pennsylvania Human Relations Commission (PHRC) should contact the PHRC regional office in his/her geographical area.

7. Health Care Worker Confidentiality

a. Because of the nature of the disease, an HIV infected HCW shall have understandable concerns over confidentiality and privacy in connection with medical documentation and other information about his/her condition. Officials who have access to such information are required to maintain the confidentiality of that information. Supervisors, managers, and others included in making and implementing personnel management decisions involving HCWs with AIDS or HIV shall strictly observe applicable privacy and confidentiality requirements as noted in **Management Directive 505.26**.

b. The following procedures are to be adhered to regarding AIDS related information on a state HCW or his/her dependents:

(1) If this information exists in a written form, it is not to be maintained in the HCW's **Official Personnel Folder (Form STD-301)**. It is to be maintained in a separate, locked file drawer, compartment, or other secure place with restricted access, under jurisdiction of the party who received the information (medical officer, health care coordinator, supervisor, etc.) or in the personnel office. If maintained in the personnel office, access is to be limited to the personnel officer and a designated custodian of sensitive personnel records. In all cases, the HCW in question shall be informed of what written information is being maintained, where it is kept, and security provisions for its release in accordance with the **Confidentiality of HIV-Related Information Act, 35 P.S. §§7601 et seq**.

(2) Access to AIDS related information in HCW records is to be limited to only those parties who are the original recipients of that information, those designated individuals in the personnel office, and those who have been pre-approved through written consent by the affected HCW, unless there is a medical

emergency that requires an immediate response. Copies shall not be made of records, which identify a Department employee's AIDS or HIV status.

(3) AIDS or HIV related information is not to be forwarded to future employers should the health care worker change jobs, unless the release of such information has been pre-approved in writing by the affected HCW.

(4) Paperwork containing AIDS related information on an HCW that must be processed through a chain of parties**,** such as work related disability forms, are to be handled with strict confidentiality. The HCW in question must be informed of how these forms are processed. If possible, agencies shall restrict the routing of these forms, processing them directly from the HCW's immediate supervisor to the personnel office.

(5) Confidentiality restrictions on written AIDS or HIV related information also apply to the verbal communication of that information. If a supervisor, co-worker, or other state employee learns information on a Department employee's possible AIDS/HIV condition, that information is not to be communicated to other state employees or members of the public. Unless there is a specific need to do so, verbally communicated information on a state employee's AIDS or HIV status shall not be converted to a written record.

8. Case Reporting

a. In the Commonwealth of Pennsylvania, both HIV and AIDS are DOH reportable diseases.

b. For purposes of epidemiologic surveillance, any inmate who is HIV positive and/or has a medical diagnosis of AIDS shall be reported to the Division of Epidemiology, DOH, in accordance with the Commonwealth's Regulations of Communicable and Non-communicable Disease reporting of AIDS and HIV. The CHCA/designee is responsible for this function.

c. In addition to these requirements, the CHCA/designee shall maintain a cumulative listing of every inmate who tests positive for HIV. This list shall consist of the following information:

(1) inmate name;

(2) inmate number;

(3) diagnosis;

(4) date of diagnosis;

(5) housing location; and

(6) disposition.

d. Strict confidentiality of all information related to these cases shall be maintained in accordance with the requirements identified in this procedures manual.

9. HIV/AIDS Discharge Care

a. The purpose of HIV/AIDS Discharge Care is as follows:

(1) coordinate effective care and access supportive services for HIV positive individuals as they transition out of correctional facilities back to their communities;

(2) prepare HIV positive inmates for community reintegration and conversely prepare communities (AIDS service organizations, social workers, healthcare workers, housing, etc.) for transitioning these inmates into needed services; and

(3) the transition shall be achieved through a collaborative relationship between the following agencies but not limited to: Pennsylvania Department of Health (DOH), Pennsylvania Department of Public Welfare (DPW), and seven Regional AIDS Planning Coalitions.

b. The procedures below shall be followed regarding HIV/AIDS Discharge Care:

(1) The ICN/designee shall serve as the point of contact between the Department, the Pennsylvania Board of Probation and Parole (PBPP), and the seven Regional AIDS Planning Coalitions.

(2) The ICN/designee shall notify HIV/AIDS positive inmates of the existence of the Discharge Care Initiative Program and eligibility. The ICN/designee shall confirm the inmate's anticipated release date and explain the Discharge Care Initiative to the inmate six months prior to his/her release. Inmate education shall include the following:

(a) the completion of a **DC-108** (refer to **DC-ADM 003, Attachment A**) is required prior to inmate contact with Case Manager (telephone or telemedicine);

(b) the completion of the **DC-108** is also necessary prior to completion of the **DC-584, Release Planning Form (Attachment 8-S)**;

(c) the **DC-108** signed by the inmate, carries a timeframe of 30 days (Mental Health) and 90 days (Medical information). The inmate in the six month Discharge Planning Program may need to sign several **DC-108** forms to comply with the timeframes and if updates in his/her care are to be recorded on the **DC-584**;

(d) upon completion of the **DC-584**, the form shall be filed under the TB/Immunizations Section of the medical record;

(e) the inmate agreement to participate in teleconferencing to communicate with the Case Manager;

(f) an explanation of the **DC-584**;

(g) ongoing education – prevention, treatment, good health habits; and

(h) discharge with 30 days of medication.

(3) If the inmate refuses to communicate via teleconferencing or videoconferencing with the Case Manager, the ICN/designee shall notify the Regional AIDS Planning Coalition of the inmate's refusal. The ICN/designee shall document the refusal on the **DC-462**, Inmate Health Care Plan, and on the **DC-472.**

(4) When the inmate agrees to participate in the Discharge Care Initiative, the ICN/designee shall notify the Regional AIDS Planning Coalition representative in the appropriate inmate discharge area.

(5) The Regional AIDS Planning Coalition representative shall send the Regional Agency's discharge planning forms to the ICN/designee for the inmate's signature. The physician must sign the Employability Form. The signed Discharge Planning Form shall be faxed or e-mailed to the Regional Agency.

(6) ICN/designee facilitates contact with the Regional AIDS Planning Coalition's Case Manager. This contact may be by phone or teleconferencing, as feasible.

(7) The ICN/designee shall confirm with the Regional AIDS Planning Coalition's Case Manager that all forms and service care plans are in place for each inmate.

(8) The ICN/designee shall complete the **Discharge Planning Checklist (for HIV positive inmates) (Attachment 8-T).**

(9) On the day of discharge, the inmate receives 30 days of HIV medications and a copy of the final **DC-584**.

c. The following is a Summary of the Referral Process:

(1) The ICN/designee shall initiate the outcome report of the referral process.

(2) The Regional AIDS Planning Coalition Case Manager assigned to each inmate shall provide the facility's ICN with a summary report of the placement activities for the respective inmate 30 days after discharge.

H. Infection Control[26]

1. Infection Control Program Authority and Responsibility

   The Department's Infection Control Program is designed to provide a plan for the surveillance, prevention, and control of infection.[27]

   a. Authority

      Overseeing the Infection Control Program and Responsibility is the Department's BHCS.[28]

      ↓

      Chief, Clinical Services, BHCS

      ↓

      Infection Control Coordinator (ICC), BHCS

      ↓

      Facility Corrections Health Care Administrator (CHCA)

      ↓

      Facility Infection Control Nurse (ICN)

      The BHCS Chief of Clinical Services has the authority to institute any surveillance prevention or control measures or initiate studies when an inmate or staff member might be at risk. The ICC shall communicate/coordinate any directions from the Chief of Clinical Services to the facilities.

   b. Procedures

      Each facility shall maintain a current copy of the Department's Infection Control Manual. It shall be the responsibility of the ICC to ensure that the manual is reviewed annually and remains current.

2. Universal/Standard Precautions

   Universal/Standard Precautions shall be used in all patient care practices, regardless of the known infection status of the inmate.

   a. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

   b. Personal Protective Equipment (PPE) shall be provided for any employee and/or inmate who perform jobs that expose him/her to blood and body fluids.

   c. PPE includes, but is not limited to:

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[26] 4-ACRS-4C-09
[27] 4-4354
[28] 1-ABC-4E-43

(1) gown, apron, lab coat - shall be worn when there is a possibility the HCW could contaminate his/her clothing with blood and body fluids;

(2) goggles, full-face shield - shall be worn when an eye splash is anticipated;

(3) gloves (latex, vinyl, reusable rubber) - shall be worn anytime the HCW could contaminate his/her hands with blood and body fluids; and

(4) mask - shall be worn to prevent a splash in the HCW's mouth.

3. Hand Washing

Guidelines for hand washing shall be established in order to minimize or eliminate transmission of organisms.

a. Any worker (employee and inmate) must wash his/her hands immediately, or as soon as possible:[29]

(1) after removal of gloves or other PPE;

(2) after caring for a patient (HCW) or after situations in which there has been contact with mucous membranes, blood, and other potentially infectious materials;

(3) after using the restroom;

(4) prior to performing invasive procedures; and

(5) before meals;

NOTE: The facility may choose either an antimicrobial agent or plain lotion soap as the type of hand cleaner to be used.

b. Recommended hand wash procedures shall be performed for a minimum of 15 seconds:

(1) wet hands under running water and apply liquid antimicrobial (pump dispenser) soap;

(2) scrub vigorously using running water and creating a lather. Scrub all areas of your hands (knuckles, cuticles, both sides of fingers, and under nails). Move or remove rings to clean underneath;

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(3) rinse hands with fingers pointing downward to make sure contaminants go down the drain, not up the arms;

(4) dry hands completely with a clean paper towel or under hot air; and

(5) turn off faucet with a dry paper towel.

4. Housekeeping, Medical Department

The Department/BHCS shall provide a clean medical department for both inmates and staff.[30]

a. Cleaning Goal

Regular cleaning with an Environmental Protection Agency (EPA) approved disinfectant removes the organisms from the surface, therefore decreases the environmental load.[31]

b. Procedures

(1) All cleaning shall be performed using protective equipment.

(a) gloves - at all times (latex, vinyl, or reusable rubber gloves);

NOTE: If the reusable rubber gloves are cracked or have holes they shall be disposed of in the trash. A biohazard waste bag (Red Bag) shall be used only if the gloves are visibly contaminated with blood.

(b) gown/apron - optional; and

(c) mask and goggles - optional.

(2) An EPA approved disinfectant shall be used for hard surfaces, but not limited to:

(a) counter tops;

(b) examination tables;

(c) goose necked lamps;

(d) Mayo stands;

(e) wheelchairs;

[30] 1-ABC-4D-05, 1-CTA-3E-05
[31] 4-4354

(f) medication carts;

(g) litters;

(h) back boards; and

(i) kick buckets.

NOTE: The surface being disinfected must remain wet with the disinfectant solution for at least 10 minutes for full disinfectant action to occur.

(3) Special electronic equipment shall be disinfected according to the manufacturer's directions, (electronic thermometer, glucometer, etc.).

(4) Each facility shall develop a regular cleaning schedule for the medical department in accordance with this procedures manual.

(5) Attention shall be paid to high areas where dust may accumulate. This is particularly important in an area where suturing or trauma care is provided.

(6) If medical equipment needs repaired, it must be decontaminated prior to being shipped, or it must be labeled with a biohazard sign as to which parts remain contaminated.

5. Blood and Body Fluid Spills

Department staff, as well as inmates, must use Universal/Standard Precautions whenever there is a risk of exposure to blood and/or body fluids. ALL blood and certain body fluids have the potential of transmitting one or more communicable disease.

a. Staff Responsibilities

(1) The Facility Manager will ensure at least six inmates are properly trained and assigned to an Inmate Blood and Body Fluid Detail to cleanup significant blood and body fluid spills within the facility.

(2) Based on the size and complexity of the facility, additional Inmate Blood and Body Fluid Details may be needed. Determination will be by the Facility Manager and CHCA.

(3) Requests for the Inmate Blood and Body Fluid Detail will be through the Shift Commander, who will activate the detail.

(4) Upon activation of the Inmate Blood and Body Fluid Detail, the Department Head/Unit Manager/designee of the affected area will have the responsibility for supervising the Inmate Blood and Body Fluid Detail and any documentation required.

(5) Until the blood and body fluid spill area is cleaned up, the area will be secured, to the extent possible, to reduce potential exposure to staff and inmates.

b. Infection Control Nurse

(1) The ICN or Shift Nursing Supervisor shall monitor all blood and body fluid incidents via the following reports:

(a) the **Blood and Body Fluid Clean-up Report (Attachment 8-U);** and

(b) the Employer's Report of Occupational Injury or Illness.

(2) The ICN will also act as a resource or a consultant to Department Heads/Unit Managers and Shift Commanders in a blood and body fluid spill.

c. Reporting

(1) The Shift Commander will be contacted for all significant blood and body fluid spills immediately by the Department Head/Supervisor of the affected area.

(2) The Department Head/Unit Manager or Supervisor will complete the Blood and Body Fluid Clean-up Report when any staff or inmate is required to clean up blood and body fluids. The completed form must be submitted to the ICN/designee by the end of his/her shift that day.

(3) Blood and Body Fluid Reports will be maintained and filed by the ICN in the Medical Records area.

(4) If cleanup does not result in exposure, blood and body fluid forms will be filed and maintained by the ICN for seven years or 30 years if exposure occurs.

d. Blood and Body Fluid Waste

(1) Handling and transporting of blood and body fluid waste will be in accordance with, at a minimum, the OSHA Standards, 29 CFR, §1910.1030 Occupational Exposure to Blood Borne Pathogens.

(2) The following is a summary of OSHA Standards, 29 CFR, §1910.1030 Occupational Exposure to Blood Borne Pathogens:

(a) Universal/Standard 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 will be considered potentially infectious materials.

(b) Appropriate PPE includes, but is not limited to, gloves, gowns, face shields or masks, mouthpieces, resuscitation bags, pocket masks, or other

ventilation devices. PPE will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach 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.

(c) Appropriate PPE in the appropriate sizes is readily accessible at the work site.

(d) If blood or other potentially infectious materials penetrate a garment, the garment shall be removed immediately or as soon as feasible and the area of the skin in contact with the potentially infectious material should be washed thoroughly with soap and water as soon as possible.

(e) All personal protective equipment shall be removed and bagged appropriately prior to leaving the work area.

(f) Affected surfaces shall be decontaminated with disinfectant after completion of procedures immediately or as soon as feasible when surfaces are subject to any spill of blood or other potentially infectious materials.

(g) Universal/Standard Precautions shall be practiced when transporting blood and body fluid soiled laundry.

(3) Adult Disposable Briefs and Colostomy Bags

(a) Pennsylvania Code, Title 25 Environmental Protection, under certain conditions considers adult disposable briefs and colostomy bags an exception to infectious waste. The items can have feces and no visible blood and be an exception to infectious waste. Title 25 defines infectious waste as human blood and body fluid waste. Body fluid waste includes semen, vaginal secretions, and amniotic fluid. It may also include the following items if blood is visible: feces, sputum, urine, and vomitus.

(b) Inmates will not be issued infectious waste bags for colostomy bags or adult disposable briefs disposal. These items are to be placed in the regular trash for disposal and not in the Biohazard Waste Freezer, however, if a soiled disposable brief or colostomy bag contains visible blood, it is to be considered infectious waste and the inmate must report to the Medical Department with the item for proper infectious waste disposal and for an appropriate medical review/exam.

(c) Inmates' adult disposable briefs or colostomy bags should be handled using universal precautions.

e. Equipment/Materials

To provide consistency throughout the Department, labeled Blood and Body Fluid Clean-up Kits and equipment are to be provided. The following is a description of Blood and Body Fluid Clean-up Kits, their intended use, and suggested locations. This equipment is the minimum requirement. It is understood that the facility size and complexity may require additional quantities. Any additional items added to any Blood and Body Fluid Clean-up Kit must be approved by the ICN.

(1) Area Blood and Body Fluid Clean-Up Kit and Equipment - This kit is to be labeled “Blood and Body Fluid Clean-Up.” Contained in the kit is equipment and materials needed to respond to a situation where blood and body fluid cleanup is a concern. This kit must be made readily accessible.

(2) Areas where these kits should be available include, but are not limited to Housing Units, Maintenance Areas, Education, Dietary, Medical, Treatment, Correctional Industries, and Community Corrections.

(3) Area Blood and Body Fluid Clean-Up Kit contents include the following:

(a) kit labeled "Blood and Body Fluid Clean-Up;”

(b) medical grade gloves;

(c) eye splash protection;

(d) paper towels;

(e) absorbent agent/solidified;

(f) non-metallic scoop and scraper;

(g) bio-hazard bags (small and large);

(h) disinfectant (as specified by the Department housekeeping plan);

(i) instruction sheet for **Blood/Body Fluid Clean-Up Procedure (Attachment 8-V);** and

(j) inventory sheet.

(4) Inmate Detail Blood and Body Fluid Clean-up Kit and Equipment - This kit is labeled "Inmate Detail Blood and Body Fluid Clean-Up Kit.” Contained in the kit are materials needed by inmate details for cleaning significant blood and body fluid spills. The kit shall be maintained in the Control Center or other secure controlled area and accessed through the Shift Commander.

(5) Placement, Inventory and Inspection of Inmate Detail Blood and Body Fluid Clean-up Kits

(a) The ICN/designee shall ensure that all appropriate Inmate Detail Blood and Body Fluid Clean-up Kits are placed in the recommended areas throughout the facility.

(b) Assembled kits will have a security seal and tag attached (extinguisher type seal and tag) to assure inventory of kit.

(c) The Department Head/Unit Manager, through the weekly fire/safety/ sanitation inspection form, shall ensure kits are in place and seals intact.

(d) During the monthly sanitation inspection, blood and body fluid clean-up kits shall be inspected for proper placement and seals, and documented accordingly.

(e) A broken seal will require an inventory of items. The Department Heads/Unit Managers shall assure the inventory and reseal kit. A seal shall be obtained from the ICN.

(f) Upon request from the Department Head/Unit Manager, supplies for restocking the blood and body fluid clean-up kits are the responsibility of the ICN/designee. Spare kits shall be kept on hand to replace used clean-up kits.

(g) CCCs should request kits through their support facility.

f. Inmate Blood and Body Fluid Detail Clean-up Kit contents

i. kit labeled Inmate Detail Blood and Body Fluid Clean-up Kit;

ii. medical grade gloves (minimum eight pair);

iii. long-sleeved disposable gowns, impervious to fluids (minimum eight);

iv. eye splash protection;

v. paper towels;

vi. bio-hazard bags (small and large);

vii. disinfectant - (as specified by the Department housekeeping plan);

viii. absorbent agent/solidifier;

ix. non-metallic scoop and/or scraper;

x. inventory list; and

xi. instructions and hand washing notice.

g. Blood and Body Fluid Clean-Up Training for Inmates

(1) The ICN shall ensure that every inmate assigned to the Inmate Blood and Body Fluid Clean-up Detail will receive initial training and annual refresher training on Universal/Standard Precautions for blood and body fluid clean-up.

(2) An inmate shall be provided with training for blood and body fluid clean-up if his/her assigned work duties require cleaning of blood and body fluids.

(3) Hepatitis vaccines shall be offered to an inmate who is required to clean blood and body fluids.

(4) Length of commitment to be served should be a consideration for the selection of an inmate for cleaning of blood and body fluids due to training requirements and the need for hepatitis vaccinations.

6. Transmission Based Isolation Precautions

There are two tiers of the isolation precautions. In the first and most important tier are precautions designed for the care of all patients in general population or in the infirmary. This is regardless of his/her diagnosis or presumed infection status. Implementation of these Universal/Standard Precautions is the primary strategy for successful nosocomial infection control. The second tier precautions are designed only for the care of specified inmates who may be housed in isolation. These additional Transmission Based Precautions are for patients known or suspected to be infected by epidemiologically important pathogens spread by airborne or droplet transmission or by contact with dry skin or contaminated surfaces.[32]

a. Universal/Standard Precautions

(1) Synthesize the major features of Universal/Standard Precautions (designed to reduce the risk of transmission of blood-borne pathogens) and Body Substance Isolation (designed to reduce the risk of transmission of pathogens from moist body substances). It then applies them to any inmate in general population or receiving care in the infirmary regardless of his/her diagnosis or presumed infection status.

(2) Universal/Standard Precautions apply to:

(a) blood;

(b) all body fluids, except sweat and tears, regardless of whether or not they contain visible blood;

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(c) non-intact skin; and

(d) mucous membranes.

(3) Universal/Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in the infirmary or in the facility.

b. Transmission Based Precautions

(1) Transmission based precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Universal/Standard Precautions are needed to interrupt transmission in the infirmary. There are three types of Transmission Based Precautions: Airborne Precautions, Droplet Precautions, and Contact Precautions. They may be combined for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to universal/standard precautions.

(2) Transmission Based Isolation Precautions shall be used in the care of any inmate with a known or suspected infection. Accommodations shall be provided for any inmate requiring transmission-based precautions with the intent to prevent the spread of infection. The inmate may be housed in isolation or his/her own cell based on physician discretion. A color-coded card system, as recommended by the CDC is used to facilitate the barrier patient care procedures as an enhancement to the use of Universal/Standard Precautions.

c. Isolation Procedures

(1) The physician/PA may order the following types of precautions:

(a) contact;

(b) airborne; and/or

(c) droplet

(2) The inmate may be placed into the designated isolation room and the appropriate isolation sign shall be placed on the room door.[33]

(3) Every medical staff, physician, nurse, technician and others, are responsible for complying with isolation precautions and for tactfully calling observed infractions to the attention of the offenders. A physician shall observe the proper isolation precautions at all times; he/she must teach by example. The responsibilities of the medical staff carrying out isolation precautions cannot be effectively dictated

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but must arise from a personal sense of responsibility. An inmate also has a responsibility for complying with isolation precautions. A physician and nurse shall explain the appropriate measures to the inmate. An important general inmate responsibility is hand washing after touching infective material and potentially contaminated articles.

(4) Fundamentals of Isolation Precautions.

(5) Rationale and Responsibilities for Isolation Precautions.

d. Synopsis of Types of Precautions and Patients Requiring the Precautions

(1) Universal/Standard Precautions

Universal/Standard Precautions shall be used for the care of every inmate.

(2) Airborne Precautions

(a) Airborne Precautions are designed to reduce the risk of airborne transmission of infectious agents. Airborne transmission occurs by dissemination of either airborne droplet nuclei (small particle residue two to five microns in size), evaporated droplets that may remain suspended in the air for long periods, or dust particles containing the infectious agent. Microorganisms carried in this manner can be widely dispersed by air currents and may become inhaled by or deposited on a susceptible host within the same room or over a longer distance from the source patient, depending on environmental factors; therefore, special air handling and ventilation are required to prevent airborne transmission. Airborne Precautions apply to an inmate known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

(b) In addition to Universal/Standard Precautions, use Airborne Precautions for an inmate known or suspected to have a serious illness transmitted by airborne droplet nuclei. Examples of such an illness include:

i. Measles;

ii. Varicella (including disseminated Zoster); and/or

iii. Tuberculosis.

(3) Droplet Precautions

(a) Droplet precautions are designed to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large particle droplets (larger than five microns in size)

containing microorganisms generated from a person who has a clinical disease or is a carrier of the microorganism. Droplets are generated from the source person primarily during coughing, sneezing, or suctioning and bronchoscopy. Transmission via large particle droplets requires close contact between source and recipient persons. Droplets do not remain suspended in the air and generally travel only short distances (three feet or less) through the air. Because droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission. Droplet precautions apply to any patient known or suspected to be infected with epidemiologically important pathogens that can be transmitted by infectious droplets.

(b) In addition to Universal/Standard Precautions, use droplet precautions for an inmate known or suspected to have a serious illness transmitted by large particle droplets. Examples of such an illness includes:

i. Invasive Haemophilus Influenzae Type B disease, including Meningitis, Pneumonia, and Sepsis;

ii. Invasive Neisseria meningitidis disease, including Meningitis, Pneumonia, and Sepsis;

iii. other serious bacterial respiratory infections spread by droplet transmission include:

(i) Diphtheria (pharyngeal);

(ii) Mycoplasma pneumonia;

(iii) Pertussis; and/or

(iv) Pneumonic plague.

iv. serious viral infections spread by droplet transmission include:

(i) Adenovirus;

(ii) Influenza;

(iii) Mumps;

(iv) Parvovirus B 19; and/or

(v) Rubella.

(4) Contact Precautions

(a) Contact precautions are designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Direct contact transmission involves skin to skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn a patient, give a bath, or perform other patient care activities that require physical contact. Direct contact transmission can also occur between two patients (by hand contact) with one serving as the source of infectious microorganisms and the other as a susceptible host with a contaminated inanimate object usually in the patient's environment. Contact precautions apply to patients known or suspected to be infected or colonized with an epidemiologically important microorganism that can be transmitted by direct or indirect contact.

(b) In addition to Universal/Standard Precautions, use contact precautions for an inmate known or suspected to have a serious illness easily transmitted by direct inmate contact or by contact with items in the inmate's environment. Examples of such an illness includes:

i. gastrointestinal, respiratory, skin, or wound infections or colonization with multiple resistant organisms that have special clinical and epidemiologic significance;

ii. enteric infections with a low infectious dose or prolonged environmental survival include:

(i) clostridium dificile; and

(ii) for diapered or incontinent patients: Enterohemorrhagic Escherichia Coli 0157:H7, Shigella, or Hepatitis A.

iii. skin infections that are highly contagious or that may occur on dry skin including:

(i) impetigo;

(ii) major (non-contained) abscesses, cellulitis, or decubiti;

(iii) pediculosis;

(iv) scabies;

(v) zoster (disseminated or in the immuno-compromised host); and

(vi) viral/hemorrhagic conjunctivitis.

NOTE: For further information, refer to Clinical Syndromes or Conditions Warranting Additional Empiric Precautions; Key to Types of Precautions and Isolation Precautions Needed for Selected Infections and Conditions maintained by the BHCS.

7. Simple Protective Isolation

This particular type of precaution shall be initiated for the immuno-compromised patient. The patient is generally at increased risk for bacterial, fungal, parasitic and viral infections. The majority of the time the patient is infected with his/her own organisms. The following procedures shall be followed:

a. Universal/Standard Precautions shall be used for all patients.

b. Transmission-based precautions are recommended for specific patients as follows:

(1) contact - wounds, etc.;

(2) airborne - airborne organisms two - five microns in size;

(3) droplet - airborne organisms five microns or larger;

(4) staff and the patient shall practice hand washing;

(a) teach the patient good hygiene to include:

i. wash hands after using the toilet; and

ii. wash hands before eating.

(b) staff shall perform good hand washing (recommended time is 15 seconds) to include:

i. after removing gloves;

ii. after using the restroom;

iii. between patient care;

iv. before eating; and

v. hands shall be washed frequently; therefore shall not be limited to the situations listed above.

(5) Personal Protective Equipment (PPE);

(a) Mask

Guidelines for wearing a mask include, but are not limited to, the following:

i. a mask is not needed by everyone entering the patient's room;

ii. a mask shall be worn by anyone entering the patient's room who has a minor sore throat or upper respiratory infection;

iii. a mask is required by all staff if the patient is in either airborne or droplet precautions; and

iv. the patient shall wear a mask when transported out of his/her room.

(b) Gown, Gloves and Goggles

As per Universal/Standard Precautions.

NOTE: Hair covers and shoe covers on the staff do not contribute to any protection for the patient. There is no need for their use.

(6) Patient care

(a) Bath - A daily bath shall be provided. The patient may take his/her own bath. Special attention shall be paid to the axilla, groin, and rectal areas.

(b) Oral care

i. The nurse shall inspect the patient's mouth daily for open areas or bleeding.

ii. The patient shall clean his/her mouth twice a day with a soft toothbrush or a soft swab and toothpaste.

iii. A gentle mouth rinse may be used (water or saline solution).

iv. DO NOT FLOSS.

(c) Nutrition

i. Patient shall not receive fresh fruit or raw vegetables.
NOTE: Organisms can be carried to the patient on these foods.

ii. Avoid foods with acid (juices, tomatoes) if the patient has sores in his/her mouth.

8. Specimen Collection

The facility shall collect and send specimens safely, and in compliance with community standards. The following procedures shall be followed:

a. Every employee involved in specimen collection and processing shall follow Universal/Standard Precautions.

b. Appropriate PPE shall be utilized as follows:

   (1) gloves - 100% of the time;

   (2) gown/apron - if clothing may be contaminated; and

   (3) mask/goggles - if splashing is anticipated.

c. The specimen is collected from the inmate maintaining safety for both the patient and the staff.

   (1) Used needles shall be disposed of into a puncture resistant container.

   (2) When collecting sputum for AFB, the HCW shall wear an N-95 mask; and the procedures contained in this procedures manual shall be followed.

   (3) If the specimen is sent out to a laboratory, it shall be placed in an appropriate container. The specimen shall be correctly labeled with at least the inmate's name and number. In the case of HIV testing, the laboratory slip will be completed as directed by the DOH reporting of AIDS and HIV. A special laboratory plastic bag with a biohazard symbol shall be used for transporting the specimen.

   (4) You may double bag the specimen using the same type of laboratory plastic bag if there is a possibility the specimen may spill and put other people at risk.

9. Sterilization of Reusable Medical Items

The Department/BHCS shall provide sterile equipment for use during treatment or procedures as appropriate. Please note there is a separate Dental Infection Control Manual that differs slightly from this procedure manual. Please refer to **Section 4, Dental Services** of this procedures manual.

a. There are three categories of medical items based on the degree of risk of infection.

   (1) Critical items

   Objects that enter sterile tissue or the vascular system and present high risk of infection if contaminated with any organism. They must be sterile (surgical instruments, cardiac and urinary catheters, implants and needles).

(2) Semi-critical items

Objects that come in contact with mucous membranes or with non-intact skin. These items must be free of all microorganisms with exception of spores. Semi-critical items require high-level disinfection (gluteraldehydes, other chemical germicides). Semi-critical items are respirator therapy equipment, anesthesia equipment, endoscopes, and hydrotherapy tanks.

(3) Non-critical items

Objects that come in contact with intact skin. They can be cleaned with a low-level disinfectant where they are used. Examples of non-critical items are blood pressure cuffs, crutches, bed rails, bedside tables, etc.

b. There are three methods of decontamination.[34]

(1) Mechanical

Wear gloves and hand scrub the item with soap, water, and a brush.

(2) Ultrasonic washer

Removal of soil from the item by the generation of vibrations (ultrasonic waves) in the water.

(3) Enzyme use

Enzymes developed specifically for decontaminating instruments; this chemical aids in liberating protein from the surface of the item, (crevices, rough areas, etc.).

c. There are two types of sterilization used within the Department.[35]

(1) Steam

Autoclave (tabletop sterilizer)

(2) Chemical

Use of a gluteraldehyde for 24 hours exposure time to achieve sterilization. These chemicals are toxic and must be used following the manufacturer's directions.

d. Every employee shall use PPE during the cleaning process.

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NOTE: a surgical mask shall be worn under the full-face shield.

e. Decontamination can be achieved by the use of any one or combination of the following:[36]

   (1) scrub brush, soap and water;

   (2) soaking in the ultra sound cleaner; and

   (3) soaking in the ultra sound cleaner with an enzyme in the water.

f. Visual inspection of the items while rinsing well under cool running water. If soil is found, repeat the decontamination process.

g. When the items are free of all soil or debris, they are dried and packaged for steam sterilization. Scissors and hemostats shall be sterilized in an open position to facilitate steam exposure to all surfaces.

h. Wrapping instruments.

   (1) The guidelines for the wrapping of instruments include the following:

      (a) instruments can be placed into special autoclave bags;

      (b) wrap instrument sets with special autoclave paper wrap. Secure the wrapped instruments with two pieces of sterilizer indicator tape;

      (c) all instrument packs shall be tagged with a date and load number; and

      (d) a log shall be kept of all sterilization loads.

   (2) Sterilizer indicators can be tape, colored strip on pouch, or indicator placed inside the pack. The indicator verifies the steam has penetrated the package or pack.

i. Place the items into the sterilizer. DO NOT OVERFILL. Follow the manufacturer's directions for your autoclave. Steam sterilizer temperature should achieve 250F. Follow manufacturer’s directions for pressure and time.

j. When cycle is complete, follow the manufacturer's directions for opening the autoclave. Allow bagged items to dry before removing.

k. If the items are wet, they are not sterile. They shall be rewrapped and re-sterilized.

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l. Sterile items must be stored in a clean, dry area with attention to rotation of items, (first in, first out). Items are considered sterile as long as the wrap is intact. The procedures contained in Department policy **6.3.1** shall be followed.

m. The facility tool control policy shall be followed. Care shall be taken by security during instruments search not to compromise the sterile packs.

n. Biological Monitoring

(1) Proper functioning of the sterilizer is verified by the use of biological indicators (attest, kill it).

(a) A weekly spore test shall be performed on each autoclave and sent to an outside provider.

(b) A record of this weekly monitor is maintained. It shall be available for inspection at any time. This record shall contain date/time/result/initials of staff conducting test.

(c) The manufacturer's directions shall be followed concerning the spore test.

(2) Preventive Maintenance on the Autoclave

Consult with the facility engineer or manufacturer’s recommendations concerning preventive maintenance and establish a schedule for autoclave maintenance.

Reference:

(a) APIC - Infection Control and Applied Epidemiology

(b) Asepsis, The Right Touch

o. Biological Monitoring Procedure when the Autoclave Fails

The Department/BHCS shall establish procedures to be used when instruments are not sterilized due to equipment failure.

(1) A weekly spore test shall be sent to an outside provider. The ICN must maintain a log of test results and action follow-up.

(2) If the spore test result is positive, this means the spore was not killed in the sterilizer. Repeat the spore test to confirm the result.

(3) The ICN notifies the ICC at the BHCS of the problem. If the second spore test is positive, shut down the autoclave. Notify the manufacturer of the autoclave for

service. The ICN notifies the ICC at the BHCS of the shutdown and plans for a backup autoclave.

(4) Every item that has been processed since the last failure shall be re-wrapped or repackaged and re-sterilized. There is no need to rewash these items.

(5) If the facility has a second autoclave, it shall be used for the reprocessing. However, if this autoclave is not in regular use, a spore test shall be run to assure the back up autoclave is operating correctly.

(6) A report shall be made by the ICN describing the incident and the recommended action follow-up. This report shall be kept on-site and available for inspection by Department Administrative staff. The incident shall be reported at the local monthly QI meeting on the monthly CHCA report, and reported at the Quarterly State QI meeting. A copy of the ICN report shall be sent to the ICC at the BHCS.

10. Nosocomial Infection Surveillance Procedure

The facility shall collect, investigate, trend, and report the presence of nosocomial infections on an ongoing basis.

a. Specific facilities shall be involved in monthly surveillance as determined by the ICC. However, if any facility identifies a nosocomial infection, they shall report it to the ICC.

b. The ICN shall either begin by checking culture results or investigate the patients who have been placed on antibiotics.

c. The ICN shall conduct chart reviews based on the culture report or antibiotic usage. Inmate interviews may also be helpful, along with visual inspection of the infection when possible (decubiti).

d. Other sources of reference to facilitate the determination of a Nosocomial Infection are the ICC/BHCS and the facility Medical Director.

e. Upon confirmation that the infection is nosocomial, the ICN shall ensure that the appropriate therapy has been initiated. If the appropriate therapy has not been initiated, the ICN shall bring this to the attention of the Medical Director. Appropriate therapy - an antibiotic that the organism is susceptible to as documented by culture.

f. If a problem or trend is noted, the ICN notifies the ICC/BHCS. The problem is dealt with and the BHCS receives a report of the action taken at the next Regional Quarterly QI Meeting.

g. Statistics are collected and reported by the ICN and sent to the ICC on a monthly basis. The report is due to the BHCS by the last working day of the next month (July report due by the end of August). The ICC reports the statistics quarterly to the BHCS

at the Quarterly Regional QI Meeting. Discussion of problems and/or trends is held at this time.

h. Epidemiological studies are performed when health care workers or inmates have been exposed to a contagious organism (Tuberculosis, Varicella, Meningitis).

i. Focused studies shall be conducted for the following:

(1) if there is a need to further evaluate a trend;

(2) if the facility has a particular issue they want to study (decubiti in long term care, etc.); and

(3) the BHCS decides to target a specific problem (multiply resistant organisms).

11. Data Collection and Tracking System for the BHCS

The Department/BHCS shall establish an ongoing system of data collection and analysis.

a. Purpose

The collection of this data shall be used as follows:

(1) to provide statistics for reports to the BHCS;

(2) to provide information upon which to plan budgets;

(3) as a tool to determine the number and type of occupational exposures;

(4) to provide numbers to compare with other Corrections systems; and

(5) collaboration with the DOH in the collection and sharing of statistics.

b. Determination of Data to be Collected

The BHCS shall determine the information that shall be collected:

(1) diseases that shall impact the Department system;

(2) HCW exposures; and

(3) Nosocomial infections to include:

(a) specific areas as directed by the ICC/BHCS; and

(b) special studies to be determined by the ICC/BHCS.

c. Collection Process and Reporting

(1) The ICC at the BHCS shall be the single point of contact for all questions from the field.

(2) The Infection Control Assistant shall function as a second resource for the field.

(3) A tracking form shall be sent to all ICNs. The Nosocomial form shall be used for data collection.

(4) The ICN shall receive initial education in the method of data collection and definitions to be used system wide. There shall be repeat training sessions as needed.

(5) Data collection shall be performed on a monthly basis.

(6) The information must be sent to the ICC at the BHCS by the assigned day of every month.

(7) The ICC/designee shall analyze and enter the data into the computer.

(8) The ICC shall provide the Program Analyst with the monthly data for further organization (statewide, regional, prevalence of disease, etc.).

(9) The information shall be reported quarterly to the BHCS at the Quarterly Regional QI meetings.

d. Specific Data Collection and Analysis

(1) The Health Services Monthly Statistical Report contains an Infection Control section. The ICN/designee at each facility collects the information on a monthly basis. The BHCS analyzes the data and documents the data in a quarterly report. This report collects information on the following diseases:

(a) Hepatitis A, B and C;

(b) HIV/AIDS;

(c) Venereal Disease to include:

i. Gonorrhea;

ii. Syphilis;

iii. Chlamydia; and

iv. Genital Herpes Simplex (HSV).

(d) other communicable diseases as follows:

i. reportable to the State of PA and were not reported previously;

ii. diseases that have an epidemiological significance;

iii. Example: Varicella, Meningococcal Meningitis, Measles, multiply resistant organisms; and

iv. Tuberculosis - Data shall be collected on the mainframe computer system by a designated person at each facility (Medical Department or Medical Records).

(e) Tuberculosis screening and reporting, to the BHCS Infection Control staff and DOH (if required), shall be performed for inmates and employees in accordance with this procedures manual;

(f) the designated person at each facility shall enter results on the mainframe;

(g) corrections and administrative override can only be performed by the ICC at the BHCS or MIS;

(h) the BHCS shall compile the information concerning Tuberculosis and report it quarterly to the QI Committee.

(2) Staff or Health Care Worker Exposures to Blood and Body Fluids

(a) Data shall be collected by a designated person at each facility and sent to the ICC/designee at the BHCS.

(b) The **Occupational Exposure Record** form shall be sent to the ICC/ designee at the BHCS on the 10th working day of each month.

(c) The ICC shall analyze the exposures and contact the specific facilities if there are questions.

(d) The information shall be reported quarterly to the BHCS.

(3) Collection of Data for Special Studies

(a) The BHCS shall determine the need for special studies.

(b) The BHCS Infection Control staff shall direct and work with the ICN in specific facilities for data collection.

(c) The DOH may collaborate with the Department/BHCS on special studies. The BHCS Infection Control staff and Program Analyst at the BHCS shall

analyze data. The DOH Program Analyst may assist in this process when appropriate.

(d) The results of the study shall be reported to the BHCS and other appropriate departments or facilities.

12. Varicella and Herpes Zoster

The Department/BHCS shall provide guidance on the etiology, transmission, clinical management, and housing of inmates with Varicella (chicken pox) and Herpes Zoster (shingles).

a. Varicella

Varicella (chicken pox) is an acute viral disease most common during late winter and early spring. An inmate may present with sudden onset of fever and skin eruptions, which are maculopapular, vesicular, and leave a granular scab. Lesions occur in stages. Transmission occurs via direct contact, droplet, or airborne spread of secretions. Incubation period is as early as ten or as late as 21 days after exposure. Inmates are most contagious for one day before and five days after onset of lesions.

(1) Isolation shall include:

(a) place index case (inmate with diagnosed Varicella) into airborne and contact isolation until the lesions are dried and crusted;

(b) staff with prior history of Varicella shall care for the inmate;

(c) pregnant staff shall be restricted from the isolation room unless cleared by the Medical Director; and

(d) verification testing includes Antibody - IgM, IgG; and Direct -Immuno-fluorescence Antibody and Culture.

(2) Methods of Control

(a) Varicella contact investigation shall include:

i. interview source case to discover contacts at risk and to determine possible source of infection;

ii. interview the contact to determine if he/she is at risk (no previous history of infection);

iii. assess if signs or symptoms are present. Varicella vaccine is useful if given within 72 hours post exposure. Varicella-Zoster Immune Globulin (VZIG) is not very useful in this situation;

iv. educate the contact concerning signs or symptoms so that he/she can report and be evaluated;

v. special attention to susceptible contacts who are immuno-compromised;

vi. restrict movement of the inmate;

vii. monitor his/her status as he/she may be incubating disease and exposing others;

viii. an inmate may not recreate, eat, shower, or participate in school activities with the general population; and

ix. this identified group shall not come in contact with other inmates for 10 - 21 days.

(b) Action plan after identification of more than one case shall include:

i. second verified case of Varicella on same block - quarantine (no movement in or out of block) the block and follow #1 (two weeks);

ii. staff (or inmate) verified outside of block - curb movement in and out of site (but allow movement within the site) for two weeks;

iii. protect immuno-compromised inmates (HIV) by initiating quarantine in a separate unit (infirmary, intake blocks, etc.);

iv. test every HIV inmate with serology (antibody IgG, IgM);

v. a HIV inmate with no serological evidence of past infection shall be offered acyclovir, valtrex, or famivir for two weeks;

vi. a HIV inmate with recent infection shall be quarantined in the infirmary;

vii. Varicella vaccine shall not be given to HIV inmates;

viii. evaluate any immuno-compromised inmates for signs and symptoms. Pneumonia in these inmates can be serious; and

ix. an inmate worker in the infirmary who is immuno-compromised shall be moved to another job until the index case has recovered and sent back to his/her cell.

(c) Pregnant contacts (no history of Varicella)

i. The Medical Director shall assess female inmate contacts that are or may be pregnant.

ii. Any female employee who is or may be pregnant shall contact his/her physician.

(d) Plan for employee protection

i. Provide education concerning Varicella's mode of transmission and communicability.

ii. If an employee has no history of Varicella, immunization against it, or immunity to it, he/she will be tested on site at the Department's expense for the antibodies against Varicella-Zoster virus (IgG);

iii. Each employee is to maintain his/her scheduled work assignment pending the results of the blood test.

iv. Notification of the results of their blood work will be provided to the employee by the Infection Control Nurse (ICN).

v. If antibodies are absent, the employee will be restricted from inmate-contact work from day eight to day twenty-one exposure, in order to prevent the employee from exposing other inmates should he/she develop the illness.

vi. Should the employee develop the disease, he/she shall be restricted from work until all skin lesions have dried and crusted.

vii. Employees demonstrated to be non-immune (absent antibodies and no history of disease) shall be offered immunization at Department expense.

NOTE: As a condition of employment, all future contact employee candidates, as of November 20, 2006, must demonstrate immunity to Varicella-Zoster virus, either by history of chicken pox, by history of immunization against it, or by demonstrating a serum antibody titer.

(e) Reporting
Every case of Varicella must be reported to the ICC at the BHCS.

b. Herpes Zoster

Herpes Zoster (shingles) is a local manifestation of recurrent or reactivated infection with Herpes varicella-zoster, which causes chicken pox. Vesicles with an erythematous base occur in crops along nerve pathways (dermatomes). They are usually unilateral. Severe pain is common. The vesicles contain live virus and can transmit infection to non-immune contacts (i.e., people who have not previously had chicken pox). Virus is present in the lesions and the fluid that weeps from them until the lesions have dried-up.

(1) Isolation

(a) Immuno-compromised patient who has localized or disseminated Herpes Zoster
Place the patient in Airborne and Contact isolation precautions for the duration of the illness.

(b) Normal patient with disseminated Zoster

Place the patient in Airborne and Contact isolation precautions for the duration of the illness.

(c) Normal patient with localized Zoster

Follow Universal/Standard precautions until all lesions are crusted.

(d) Staff with prior history of Varicella shall care for this inmate.

(2) Methods of Control

(a) Source is a normal patient and lesions are localized - transmission requires touching the lesions.

i. Lesions that are covered pose little risk to a susceptible individual.

ii. The patient shall be instructed in proper hand washing procedures if he/she touch the lesions.

iii. The Medical Director shall determine the patient's ability to work.

(b) Source is immuno-compromised with localized or disseminated Zoster (shingles), transmission is possible via airborne and contact (touching lesions).

i. The source shall be placed into Airborne and Contact precautions for the duration of the illness.

ii. The medical department shall interview any contact to determine if he/she is at risk. The procedures for the control of Varicella shall be referred to when dealing with Herpes Zoster.

13. Resistant Organisms

a. The goal of the Department/BHCS is to control the transmission of multiple resistant organisms. The following resistant organisms are discussed in this policy:

(1) Methicillin Resistant Staphylococcal Aureus (MRSA);

(2) Vancomycin Resistant Enterococcus (VRE); and

(3) Methicillin Resistant Staphylococcal Epidermidis (MRSE) (coagulase-negative Staphylococcus). This is usually a skin contaminant not a pathogen.

Contact precautions are required for an inmate known or suspected to be infected by pathogens transmitted by direct skin-to-skin contact (refer to 13. b. (5) and (6) below.

b. The BHCS program to control the transmission of resistant organisms consists of the following:

(1) educational resources (staff and inmates):

(a) BHCS/ICC; and

(b) CDC.

(2) Identification, isolation (when appropriate), and treatment of infected cases;

(3) documentation and tracking of infections system-wide;

(4) reporting trends for resolution;

(5) Universal/Standard Precautions is an approach to infection control. According to the concept of Universal/Standard Precautions, all human blood and body fluids are treated as if known to be infectious for HIV, Hepatitis B, Hepatitis C, and other bloodborne pathogens. Universal/ Standard Precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances where fluid is difficult or impossible to identify (mixture of oil and body fluids), this fluid shall be considered potentially infectious material; and

(6) contact precautions is the use of barriers (gown and/or gloves) to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact (skin-to-skin contact).

c. Hand Washing

Hand washing is the best method for control of infections (refer to **Subsection H.3. above**).

d. Housekeeping/Cleaning (refer to **Subsection H.4. above**)

(1) An EPA approved environmental disinfectant shall be used. The active ingredient of this disinfectant will be either a quaternary ammonium compound or ammonium compound. It should have a bacteria, tuberculosis, virus, and fungal kill. The following areas shall be cleaned:

(a) Medical Department;

(b) isolation rooms; and

(c) the inmate's cell when he/she has been diagnosed with a resistant organism.

(2) Regular cleaning will be directed to areas the inmate has touched (door knobs, soap dispenser, towel containers, faucets, etc.). The goal is to decrease the environmental load.

(3) An EPA approved disinfectant will be used when cleaning equipment designated for use in contact isolation (stethoscope, blood pressure cuff, etc.). This cleaning/disinfection shall be as follows:

(a) put on gloves;

(b) wipe off blood pressure cuff; and

(c) lay stethoscope on a clean paper towel and spray with the disinfectant. Allow stethoscope to remain wet with disinfectant for 10 minutes.

(4) Terminal cleaning when the inmate is discharged from the infirmary or moved from his/her cell shall be done as follows:

(a) use the environmental disinfectant on all surfaces;

(b) walls are cleaned only if you see drainage on the walls;

(c) curtains around the bed or a privacy screen shall be removed and cleaned as appropriate;

(d) discard all disposable items that are open; and

(e) sterile items that are not opened can be placed in a large paper bag (<u>do not</u> use a plastic bag). The date shall be written on the bag and stored in the infirmary. These items can be used in seven days from the time they are place in the bag. <u>Remember</u> - if there is a concern that the package has been compromised, <u>discard it</u>.

e. Laundry

(1) Resistant organisms, like sensitive organism, are destroyed with normal washing.

(2) All laundry will be handled with Universal/Standard Precautions.

(3) No special processing needs to be followed.

(4) Red biohazard bags are not necessary. Red bags go to disposal.

(5) Every inmate with a skin infection or draining wounds should receive clean clothing daily or as needed.

(6) After an inmate has been successfully treated, he/she will be instructed to launder any soiled clothing in his/her personal property.

f. Transportation of inmates infected with resistant organism

(1) Universal/Standard Precautions shall be followed when transporting an inmate in accordance with Department policy 13.1.1.

(2) There is NO need to disinfect the transport vehicle.

(3) If there is a contamination with drainage, follow the blood/body fluid spill clean up procedures located in **Subsection H.5. above**.

g. Methicillin Resistant Staphylococcus Aureus (MRSA)

(1) MRSA is the most common resistant organism.

(2) Staphylococcus Aureus, a colonizer of humans, can easily become a pathogen under the correct conditions such as disrupted skin or mucosal barriers (central line access, endotracheal tube placement, boils, picking at skin, etc.).

(3) Staphylococcus Aureus can be MRSA or Methicillin Sensitive Staphylococcus Aureus (MSSA). MRSA has not demonstrated the ability to spontaneously evolve from MSSA during the course of therapy.

(4) MRSA is not easily distinguished from MSSA; therefore, the initial antibiotic should be chosen to cover MRSA.

(5) Colonization - The organism is present on skin or environmental surfaces, but without tissue invasion or damage. No treatment for colonization.

(6) Infection - The organism has penetrated into skin or other tissue, now causing tissue breakdown, redness, purulence, and possible invasion into adjacent tissue or the blood stream. Treatment is needed for infection control.

h. Inmate presenting with skin eruptions (eczema, seborrhea, spider bites, etc.)

(1) The patient is at risk for staphylococcal infections (resistant or sensitive to antibiotics) because the integrity of his/her skin is compromised by the underlying condition. Any wounds that are draining pose the risk of skin-to-skin transmission of Staphylococcal infection. The inmate shall be place in contact isolation and Universal/Standard Precaution guidelines are followed. In addition:

(a) wear gloves when entering the room;

(b) change gloves after contact with wound drainage or potentially infected material;

(c) remove gloves before leaving the patient area and place in contaminated trash (red bag);

(d) immediately wash hands with an antimicrobial soap; and

(e) avoid touching contaminated surfaces.

(2) The patient should be identified promptly and referred to the facility physician/PA.

(3) Inmate education must be provided to minimize scratching of lesions and to alert the inmate to seek medical attention as soon as abscesses or furuncles (boils) are detected.

(4) The physician/PA should manage skin eruptions and should be alert to the presence of early abscesses.

i. An inmate presenting with abscesses or other draining skin lesions

(1) Skin infections are most commonly caused by MRSA or MSSA.

(2) Any inmate with a draining skin lesion or abscess must be identified and referred to the facility physician/PA as soon as possible.

(3) If uncertain whether incision and drainage (I&D) is necessary, the physician/PA may aspirate any questionable abscess or draining skin lesion, and perform I&D if pus is present and/or the lesion is too large to manage with moist heat. If I&D is performed, administration of prophylactic antibiotics one hour before the procedure is recommended for patients under specific conditions (valvular heart disease, prosthetic joints, etc.) located in **Subsection H.13.M.** below.

(4) A culture and sensitivity (C&S) should not be obtained routinely, but only if the lesion does not respond to initial therapy or for potentially difficult infections (large or involving deeper structures, or in the presence of prosthetic joints or valves, etc.). Surgical wound infections shall be cultured.

(5) The inmate will not be charged a co-pay.

j. An inmate presenting with other skin infections usually caused by other organisms when Staphylococcal Aureus must be considered a possible cause (cellulites or impetigo).

(1) If a Staphylococcal infection is a possibility when choosing the use of an antibiotic, the antibiotic choice should be effective for both Streptococci and Staphylococci.

(2) Up to 30% of community-acquired Staphylococcus infections are MRSA; antibiotics should be chosen accordingly.

k. Opportunities for identification of skin infections.

(1) Reception

(a) the nurse shall ask the inmate if he/she has any open draining area on his/her skin, or any rash;

(b) the nurse shall inspect these areas and direct the inmate promptly to the physician/PA, as necessary; and

(c) the initial reception screening shall be documented on the DC-471, Initial Reception Screening/PV Returns Greater Than 90 Days.

(2) Sick Call

(a) an inmate is encouraged to report any rash or open areas on his/her skin to the Medical Department; and

(b) any staff member who is aware of an inmate with a rash, or open areas, on his/her skin shall direct the inmate to the Medical Department.

(3) Identification and reporting of resistant organisms

(a) When the inmate presents to the Medical Department with an early abscess, or open draining skin lesion, the physician/PA shall evaluate the need for I&D and appropriate treatment.

(b) Surface cultures will be performed only:

i. when the knowledge of this culture result will impact the inmate's health and treatment; and

ii. when cleared with the BHCS Assistant Medical Director, the contracted health care provider Regional Medical Director, or the ICC.

(c) The inmate shall be placed in contact isolation if simply covering the wound is not expected to provide effective isolation.

(d) All cultures are reported monthly to the BHCS on the **Resistant Organism Monthly Report (Attachment 8-W).** In addition, a copy of every culture report shall be forwarded to the BHCS from the lab.

(e) MRSA cases shall be reported to the BHCS ICC on the Resistant Organism Monthly Report. This form must be sent to the BHCS ICC on the last working day of the month.

l. Contact isolation

(1) Contact isolation shall be followed when giving care to a patient with Staphylococcus aureus in accordance with **Subsections H.13.h.1**. above and **H. 13. L.6**. **below**. Contact isolation precautions are designed to reduce the risk of transmission of microorganisms by direct or indirect contact. For example:

(a) skin-to-skin physical contact;

(b) hand-to-hand contact; and/or

(c) contaminated inanimate objects in the inmate's environment.

(2) Contact isolation (single cell or housed with another patient(s) with like condition and sensitivity) shall be instituted under the following circumstances for any inmate:

(a) unwilling/unable to understand follow-up management or who is non-compliant with antibiotic treatment or therapy;

(b) with a large abscess or draining skin lesion that cannot be adequately covered and kept clean and dry (scalp, decubitus, etc.); and/or

(c) who is immunocompromised or who has cellulites, lymphangitis, or sepsis as a complication. The patient should be hospitalized or placed in an infirmary setting as his/her level of care warrants.

(3) Designated medical equipment

The patient in contact isolation shall have a designated sphygmomanometer (blood pressure machine) and stethoscope. These items shall be used on one particular patent.

(4) Cleaning of designated equipment

All medical equipment (blood pressure machine, stethoscope, thermometer, etc.) shall be disinfected before removal from a contact isolation room. The procedure for disinfecting equipment is as follows:

(a) put on gloves;

(b) spray disinfectant on the piece of equipment;

(c) 10 minute contact time with disinfectant;

(d) wipe dry as appropriate (thermometer, stethoscope, etc.);

(e) remove gloves; and

(f) wash hands.

(5) Contact isolation is not necessary when the infected lesion is:

(a) small;

(b) easily covered; and

(c) the inmate voices understanding of the treatment regimen and is compliant.

(6) An inmate on contact isolation should be assigned to a designated shower rather than showering with the general population. This is not necessarily a separate shower facility. Designated infection showers are differentiated from standard showers in that:

(a) an inmate on contact isolation does not shower at the same time as the general population;

(b) an inmate on contact isolation shall shower alone or with an inmate with like conditions and sensitivity. This shall be determined by the Medical Department;

(c) the shower and dressing areas are cleaned with a EPA approved disinfectant before the general population uses the shower again;

(d) an inmate is issued two towels and is instructed to use one to sit upon as a barrier when using the bench in the dressing area; and

(e) if the inmate is physically able, he/she shall disinfect the shower using the EPA approved disinfectant.

(7) PPE used in contact isolation

(a) wear gloves when you touch the patient;

(b) wash hands after glove removal;

(c) wear a gown to protect clothes from contamination;

(d) masks are not necessary. These organisms are not airborne. However, when suctioning any patient with pneumonia, or when within three feet of a patient who is actively/productively coughing, the use of a surgical mask would be understood as Universal/ Standard Precautions;

(e) soiled/contaminated dressings shall be disposed of in a red biohazard bag; and

(f) provisions shall be made for biohazard/red bag disposal if the dressings are changed in the infirmary or by the inmate.

(8) Contact isolation may be discontinued when:

(a) the infection has responded to the antibiotic; and

(b) there is no longer cellulites, lymphangitis, or drainage from a clinically open lesion (decubitus).

(9) When contact isolation procedures are discontinued the inmate may return to the general population with education concerning:

(a) personal hygiene/hand washing;

(b) the need to notify the Medical Department if he/she has a repeat infection;

(c) terminal cleaning of his/her cell in accordance with **Subsection H.13.d. above**; and

(d) laundry in accordance with **Subsection H.13.e. above**.

(10) Transfer of an inmate with skin infections to another facility.

(a) The sending facility shall call the receiving facility and provide a detailed report of the inmate's care.

(b) The inmate shall be evaluated by the receiving facility for any skin problems (rash open draining areas on his/her skin).

(c) If there is a skin problem present, the inmate shall be seen by the physician/PA for clearance or appropriate treatment.

(d) Inter-facility transfer screening shall be documented on the **DC-479,** (refer to **Section 2 – Initial intake and Screening and Medical Clearance for Transfer, Attachment 2-A**).

m. Treatment

For suspected MSSA or MRSA when treatment with antibiotics is planned:

(1) TMP/SMX (Bactrim-DS®, one BID) is recommended for initial empiric therapy. If the patient is allergic to sulfa or trimethoprim, clindamycin is the suggested alternative for initial therapy.

(2) Because of the prevalence of resistance to these drugs, treatment of suspected S. aureus infections with a cephalosporin or erythromycin is not recommended.

(3) Antibiotic ointments can be used to prevent the wound from becoming infected, but are ineffective in the treatment established infection.

(4) If prophylactic antibiotics are used before I&D, the patient should be given one dose of TM/SMX (Bactrim-DS® or Clindamycin 300 mg orally) if he/she has no known allergies to these drugs.

(5) Anti-Staphylococcal antibiotics may be kept on person or distributed at the pill window at the discretion of the physician/PA.

(6) Duration of therapy is based on clinical judgment, but generally should not be less than seven days, and should extend several days past clinical resolution, once the decision to start antibiotics has been made.

(7) Consultation with the BHCS ICC and the Assistant Medical Director(s) can be sought in select cases.

n. Management of patients with treatment failure or recurrent Staphylococcus skin and soft tissue infections

(1) Recurrent Staphylococcus skin infection

(a) An inmate may be prone to develop repeated skin infections. This may be due to poor personal hygiene. The ICN shall provide education in personal hygiene to every inmate. This education shall be reviewed with the inmate when MRSA is diagnosed.

(b) An inmate/patient shall be considered to have recurrent skin and soft tissue infection when he/she has three or more infections in a six month period.

(c) The current infections shall be reported to the BHCS, ICC.

(d) The recurrent infections should be cultured and treated as per culture and sensitivity report.

(2) Other factors to consider in the management of a patient with recurrent Staphylococcus skin and soft tissue infections. Evaluation of personal hygiene includes:

(a) An inmate/patient should be evaluated for adequacy of showering and bathing; a patient should generally have a daily bath or shower with soap and water.

(b) During therapy, all clothing, including socks, underwear, towels, bath clothes, and items including bedding, should be replaced with clean items daily.

(c) An obese inmate/patient with skin folds needs to keep the skin in these folds dry to prevent maceration of the skin. This may require use of powder applied after bathing. Caution that the overuse of powder may increase the problem with obese patients and skin folds.

(3) Evaluation of an inmate/patient for underlying systemic disease/condition

(a) Staphylococcus skin and soft tissue infections are associated with underlying diseases including diabetes mellitus, obesity, HIV infection, and other diseases and/or drugs causing immunosuppression.

(b) An inmate/patient with recurrent infection should be evaluated for underlying predisposing diseases and conditions as indicated.

i. history and physical exam;

ii. urine glucose, fasting blood sugar;

iii. HIV test;

iv. referral to specialty clinics as indicated; and

v. principles of hygiene should be re-emphasized.

(c) Control underlying disease.

i. obtain good control of blood glucose for diabetics;

ii. encourage weight reduction for obese patients;

iii. optimize therapy for patients with HIV infections/AIDS; and

iv. use alternate drugs in place of glucocorticoids where possible.

(d) Evaluate and treat any existing dermatological diseases.

i. diagnose and treat any underlying skin disease; and

ii. refer to dermatology clinic as indicated.

(e) The Site Medical Director shall consider an infectious disease consultation if an inmate has three or more documented skin infections in a six month period. The BHCS Medical Director and the Contracted Health Care Provider State Medical Director shall be notified prior to requesting this consult.

(f) A one-on-one education counseling session should be conducted with the inmate to minimize the dissemination (spread) of microorganisms by colonized patients.

o. Job assignment considerations for patients with recurrent Staphylococcus skin and soft tissue infection. An inmate who experiences three or more of these infections in six months shall not be assigned to work in the following areas in accordance with **Section 3** of this procedures manual:

(1) Medical Department;

(2) Barber Shop; and

(3) Food Services.

p. Coagulase Negative Staphylococcus (Coag-Negative Staph) or Multiple Resistant Staphylococcus epidermidis (MRSE)

The common everyday variety of this organism results in a culture/sensitivity report that is multiply resistant.

(1) This organism is normal skin flora.

(2) Pathogenicity:

(a) Coagulase Negative Staph becomes a pathogen when there is a prosthetic device in the patient (heart valve, total knee replacement, total hip replacement); and

(b) the organism has established the infection on the device.

(3) Transmission occurs through:

(a) the hands of the care giver; and/or

(b) medical devices (IV catheter, etc.).

(4) Universal/Standard Precautions shall be followed at all times. No isolation is necessary.

(5) Treatment shall include:

(a) wound care; and

(b) antibiotic use based on the culture/sensitivity report.

(6) Reporting

This organism shall be reported to the BHCS ICC when the infection involves a medical device such as, but not limited to:

(a) heart valve;

(b) total hip replacement; and

(c) total knee replacement.

q. Vancomycin Resistant Enterococcus (VRE)

(1) Organism normally found in stool.

(2) The organism becomes resistant when Vancomycin is widely used (when treating MRSA).

(3) Transmission occurs:

(a) through contact with the infected stool;

(b) if the patient has diarrhea, therefore increasing the risk of transmission to staff and inmates; and/or

(c) through contact with a surface (the organism can live on a surface in a dried state for seven days).

(4) Identification - Culture/sensitivity of body fluids (wound drainage, blood, etc.).

(5) Contact isolation shall be implemented as special precautions to include putting on a gown and gloves before entering the room.

(6) Housekeeping

(a) clean with an EPA approved disinfectant; and

(b) special attention to areas the inmate may touch (faucets in the room, etc.).

(7) Laundry - Handle with Universal/Standard Precautions

(8) Education (staff and inmates)

(a) hand washing; and

(b) personal hygiene.

(9) Treatment

(a) antibiotic based on sensitivity report; and

(b) consult wit the BHCS Assistant Medical Director and Contracted Health Care Provider State Medical Director.

(10) Reporting

VRE cases shall be reported to the BHCS ICC on the monthly Resistant Organism Monthly Report. This form must be sent to the BHCS ICC on the last working day of the month.

14. Meningitis

The Department/BHCS shall provide guidance regarding infectious agents, modes of transmission, communicability, and methods of controlling Meningitis.

a. Meningitis is inflammation of the meninges (covering) of the brain. It is classified into two groups (aseptic and bacterial), each of which has several organisms, which can cause disease. Symptomatology may be characterized by sudden onset of fever with intense headache, nausea and vomiting, stiff neck, and frequently a petechial rash with pink macules or very rarely vesicles. Delirium and coma may often appear.

(1) Aseptic Meningitis - Usually caused by enteroviruses. The infective material is feces. It requires standard precautions.

(2) Bacterial Meningitis - Although many agents may cause disease, our principal concern is with meningococcal meningitis. Transmission occurs via direct contact including respiratory droplets from the nose or throat of an infected person. Disease incubation ranges from 1-10 days. The inmate shall be placed in droplet isolation for 24 hours after the start of effective therapy.

b. Methods of Control

Emphasis on control is to reduce direct contact and exposure to droplet infection, early diagnosis, and immediate chemoprophylactic treatment of suspects.

(1) educate medical and security staff concerning the transmission of the organism via direct contact, (mouth to mouth contact);

(2) signs and symptoms of meningitis; and

(3) the importance of immediate treatment if suspect cases.

c. When a case of Meningococcal Meningitis is suspected, the procedures listed below shall be followed:

(1) the physician shall perform lumbar puncture and promptly initiate antimicrobial therapy;

(2) the patient should be placed in droplet isolation for the first 24 hours after start of effective antibiotics; and

(3) the facility ICN shall report the occurrence to ICC/BHCS Infection Control staff upon initiation of isolation and therapy. Guidance shall be provided on contact investigation and chemoprophylaxis.

d. Contact investigation of close contacts shall include:

(1) the ICN shall confirm diagnosis with laboratory results of spinal fluid;

(2) the ICN shall identify close contacts, both inmates and staff; and

(3) the ICN shall provide chemoprophylaxis to those who meet definition of close contacts. Close contact is contact with infected person's oral secretions.

e. Prophylaxis

(1) Staff shall be referred to and treated by his/her family physician.

(2) An inmate shall be treated at the facility.

(3) Preferred regimen for inmate treatment by physician:

(a) Rifampin 600mg p.o. bid for two days.

(b) Provide the following education:

i. the medication will color the patient's urine orange.

ii. the medication will permanently stain contact lenses; and

iii. this medication is not recommended for persons under 18 years of age or pregnant women.

(c) Alternative regimen - Ciprofloxacin 500mg p.o. in one single dose.

(d) Report to DOH.

(e) Document treatment on the **DC-472,** (refer to **Section 5 – Occupational Exposure to Blood-borne Pathogens, Attachment 5-D**) in the inmate's medical record.

(f) BHCS Infection Control staff shall report the case, and follow-up action at the next scheduled quarterly state QI meeting.

15. Pediculosis

The facility shall treat the infested inmate and control transmission of pediculosis. For further information, refer to **Facts About Lice (Attachment 8-X)**.

Section 9 – Medical Management of Inmates with Terminal Conditions

A. Initiating and Activating Advance Directives

1. When an inmate is admitted to the infirmary/personal care unit/long term care unit, Advance Directive information shall be made available to the inmate by the Corrections Health Care Administrator (CHCA)/designee. A reference to Advance Directives shall be made in the infirmary rules/handbook.

2. An inmate of sound mind or his/her designated surrogate has the right to choose to complete an Advance Directive or decline; proper documentation in accordance with Department policy **13.1.1, "Management and Administration of Health Care"** must be completed in the medical record as follows:

   a. the inmate signs a **DC-498, Advance Directive Declaration** (refer to Department policy **13.1.1, Attachment 8-A**), specify which measures are to be taken or not taken to preserve/maintain life;

   b. the inmate signs a **DC-498** specifying that no measures be taken to preserve/maintain life; and/or

   c. a **DC-498** is not completed due to time, health issues, or refusal to complete.

3. In accordance with Department policy **13.1.1**, two physicians certifying that the inmate is in the terminal stages of his/her illness must activate the **DC-498**. The physician must note this on a **DC-472, Progress Notes**. An order may be written by the physician indicating Do Not Resuscitate (DNR). The original **DC-498** shall be sent immediately to the Medical Records Supervisor who shall place it in the **Legal/Correspondence Section** of the medical record, document on the **DC-472** that the **DC-498** was placed in the medical record, and affix the **DC-444, Advance Directive Label** to the front of the chart.

4. If medical staff have moral or religious objections to not providing treatment, even when it is the wish of the inmate, refer to Department policy **13.1.1**.

5. The Medical Director shall place inmates with a terminal condition in the infirmary, if and when there is need for admission, based upon their care requirements ***(i.e., housing, personal, intermediate, or skilled)***. The status of the **DC-498** shall be reviewed with the staff during each shift report. If a physician elects not to admit an inmate to the infirmary, he/she shall document this on the **DC-472**.

6. An inmate with a terminal condition may be referred to the Hospice Care Program for palliative care in accordance with **Subsection C. below**. An inmate being treated in hospice shall follow the guidelines contained in **Subsection C. below**.

7. Each Corrections Officer and line staff shall initiate Cardiopulmonary Resuscitation (CPR) as a first responder, unless directed otherwise by the Medical Department.

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8. Declaration of death or termination of CPR should take place in a secure area or in the infirmary/dispensary without inmates present.

9. Medical practitioners who provide any services shall document them in the **DC-472**.

B. Scenarios for Implementing an Advance Directive for Inmates

1. An inmate in the infirmary has completed a **DC-498** in accordance with Department policy **13.1.1**. The **DC-498** specifies which measures are to be taken to sustain life.

2. When an inmate has completed a **DC-498** and the **DC-498** specifies "no code, comfort measures only:"

   a. all medical staff shall be notified at each shift and infirmary report of the inmate's **DC-498** status. Nursing staff shall also notify the Corrections Officer in the infirmary and/or dispensary;

   b. the RN shall asses the inmate for signs of death;

   c. the RN shall pronounce the inmate dead, per the PA Vital Statistics Law of 1953, 35 PA §450.507, if the following is applicable:

      (1) the RN is involved in the direct care of the patient;

      (2) the declaration of death is made under the Uniform Determination of Deaths Act (5 P.S. §10201 et seq.);

      (3) the death is a result of natural causes; and/or

      (4) the patient is under the care of a physician who is unable to be present within a reasonable period of time to certify the cause of death.

   d. the RN shall notify the Medical Director/designated physician of the death immediately.

3. When there is no **DC-498** on the inmate's chart (this applies to an inmate in the infirmary and on the block/unit):

   a. all medical staff shall be notified at each shift and infirmary report of the inmate's **DC-498** status. Nursing staff shall also notify the Corrections Officers in the infirmary and/or dispensary;

   b. in the absence of ABCs, CPR shall be initiated by first responders (Corrections Officers, nurses, practitioners) and the inmate moved to the infirmary/dispensary;

c. if the physician is present, he/she shall:

(1) direct care;

(2) direct that ambulance/EMS be called; and/or

(3) pronounce death.

d. If the physician is not present and CPR has been started, the RN shall:

(1) assess the inmate for signs of death;

(2) if signs of death are not present, continue CPR and call 911/EMS; or

(3) if signs of death are present, continue CPR and call the Medical Director/designee for instructions (declaration of death or call 911/EMS).

e. If physician is not present and CPR has not been started, the RN shall:

(1) assess the inmate for signs of death;

(2) if signs of death are not present start CPR, call 911/EMS, call medical Director/designee; or

(3) if signs of death are present, call the Medical Director/designee for instructions, (declaration of death or call 911/EMS). No CPR should be started.

C. *Release from Facility Due to Terminal Medical Condition, per State Law (42 Pa.C.S. §9777), Including Admission to Hospice Care Program*

1. ***Application Process***

a. ***To be eligible for Application for Release from Facility Due to Terminal Medical Condition, including transfer to a hospice care program, the inmate must have a terminal condition with a physician's documented life expectancy of one year or less. This documentation shall be based on reasonable medical certainty.***

b. ***Initiation of the Application for Release from Facility Due to Terminal Medical Condition may be made by the inmate, someone to whom the court grants standing to act on behalf of the inmate, or staff at the transferring facility, under the provisions of applicable state law, through the Bureau of Health Care Services (BHCS). These include application for pre-release to a hospital, nursing home or community hospice, and/or modification of sentence. BHCS will consult with the Office of Chief Counsel on issues including whether the***

Application satisfies statutory requirements. Once these options have been examined and approved by the BHCS, the process will proceed.

c. ***BHCS will inform the Office of the Victim Advocate (OVA), the Chief of Security/designee and the Records Administrator/designee when an application is being processed.***

2. Determination of Acceptance

a. If the Medical Director/designee is not the attending physician, he/she shall review the attending physician's assessment and make a final determination whether the inmate's medical condition is terminal, and give a written prognosis based on reasonable medical belief as to the inmate's life expectancy. This information shall include the diagnosis and present course of treatment.

b. The transferring facility shall forward a referral packet to the Director, BHCS. The referral packet shall include the following:

(1) a copy of the inmate's signed **DC-498**;

(2) a copy of the **Consent for Participation in the Hospice Care Program (Attachment 9-A)** if applicable;

(3) a copy of the **Functional Needs Assessment Survey (Attachment 9-B)**;

(4) a copy of the **DC-506, Mini-Mental State Examination (Attachment 9-C)**; and

(5) a copy of the **Narrative Summary of the Inmate's Medical Treatment (Attachment 9-D)**.

c. ***Upon review of the referral packet and consultation with the CHCA at the sending facility, the BHCS Director/designee, shall forward the referral packet to the Office of Chief Counsel, who will advise the BHCS and the CHCA/designee, as to the status of the request, whether the application satisfies statutory requirements and whether court proceedings should be initiated.***

d. The CHCA of the sending and receiving facilities shall ensure that the procedures for health screening for pre-transfer and the procedures for the immediate health screening of all intra-system transfers by qualified health care personnel upon receipt of the transferred inmate(s) are accomplished according to **Section 2** of this procedures manual.

e. ***When a court orders the release of an inmate from the Department because of a serious or terminal medical condition:***

(1) ***the court order shall be sent to the Office of Chief Counsel for review. The Office of Chief Counsel shall provide a copy of the court order to the Records Administrator/designee, BHCS, OVA, and the Chief of Security/designee;***

(2) ***the Records Administrator will work with the facility Records Office to ensure that the inmate's release is processed and coded properly in DOCInfo;***

(3) ***the OVA will notify any registered victim(s) as indicated; and***

(4) ***unless alternative arrangements have been made with the County, the Chief of Security/designee will ensure that the appropriate GPS/electronic monitoring device is placed on the inmate, provide the monitoring parameters and reporting requirements to the medical or hospice facility, and arrange for return of the device upon the inmate's death.***

3. ***Withdrawal of Application for Release from Facility Due to Terminal Medical Condition***

   a. ***If the inmate withdraws from the application process, the withdrawal may be cause to initiate a transfer to another facility, based on the medical needs of the inmate as determined by the facility Medical Director.***

   b. ***The Department shall provide continuity of care from admission to discharge from the facility, including referral to community care when indicated.***

   c. ***The CHCA must notify OVA if an inmate's application is withdrawn.***

4. ***If an offender violates the conditions of the GPS/electronic monitoring the Central Office Security Division will notify: the District Attorney in the county where the order for release was granted; the BHCS; and the OVA.***

5. ***Upon the offender's death, the CHCA shall notify the facility Records Office, the Records Administrator/designee, the Central Office Security Division, the Office of Chief Counsel and the OVA.***

D. Notification of Designated Individuals and Inmate Death

The CHCA shall ensure that the policy and procedures contained in Department policy **13.1.1**, are used to document the incident where an inmate suffers a serious injury, and/or death by natural causes, suicide, and/or the natural progression of the inmate's disease.

Section 10 – Medical Orders for Special Items

A. Procedures Regarding Special Item(s)

1. Upon reception at the Correctional Diagnostic and Classification Center (DCC) or State Correctional Facility, the ***practitioner will*** determine, during the physical examination, the medical necessity of any item(s) brought with the inmate in accordance with **Subsection C. below**.

2. The ***prescribing practitioner*** will be responsible for making these determinations. Medical orders will be made on the Physician's Order ***Form***, and documentation will be made on the **DC-472, Progress Notes** in the inmate's medical record, and the **DC-433, Health Care Items Receipt (Attachment 10-A)**, will be completed.[1] ***Documentation must be filed under the Legal/Correspondence Tab in the medical record when any special item(s) are provided to an inmate on the basis of an ADA determination.***

3. ***The Corrections Health Care Administrator (CHCA)/designee will ensure that the Inmate Status automated application on DOCNet is updated as required.***

4. Medical orders for special item(s) will be reviewed on a timely basis depending on the special item(s) ordered. Items ordered as permanent, such as wheelchairs, hearing aids, prosthetic device, etc., will be reviewed annually. All others will be reviewed quarterly.

5. An inmate who has received special items prior to the effective date of this policy/procedures manual will have these items reviewed during his/her health appraisal. The Medical Director will make a determination whether he/she has to be reviewed annually or quarterly.

6. If an inmate refuses his/her quarterly and/or annual review of a special item, the inmate must come to the medical department to complete a **DC-462, Release from Responsibility for Medical Treatment Form** in accordance with Department policy **13.1.1, "Management and Administration of Health Care."** The Medical Department will then make a determination of the necessity for continuation of the special item.

7. When extra blankets and/or pillows are ***prescribed*** by the Medical Department, the Security Office and the Unit Manager will be informed. ***Extra blankets and pillows will be provided by the Department.***

8. An inmate is responsible for keeping and maintaining the special item(s) assigned to him/her.

9. In accordance with Department policy **DC-ADM 801, "Inmate Discipline,"** the inmate will be financially responsible for the costs incurred for the replacement/repair of a special item damaged or destroyed due to negligence or deliberate destruction.

[1] 4-4144, 4-4375

10. The vendor will be financially responsible for providing special medical items to the inmates, including fitting and repair due to normal wear.

B. Responsibilities

1. Bureau of Health Care Services (BHCS) – Central Office

   The Chief of Clinical Services, BHCS will act as the mediator in situations where the CHCA and the ***prescribing practitioner*** cannot reach an agreement as to whether the inmate requires special item(s) prescribed or if an alternative would better treat the inmate's condition.

2. The CHCA/designee will:

   a. review all ***practitioner*** orders for special item(s);

   b. contact the prescribing ***practitioner*** to discuss any concerns related to the ordering of the special item;

   c. discuss the need for the special item(s) with the facility Security Office and the Unit Manager in order to determine if issuing the special item(s) would jeopardize the security of the facility. Security concerns regarding any special item(s) will be brought to the attention of the Deputy Superintendent for Centralized Services (DSCS)/designee and the Deputy Superintendent for Facilities Management (DSFM)/designee for resolution. If necessary, alternate item(s) may be suggested and provided as long as the alternate item(s) meets both the medical need and security concern;

   d. if this issue is not resolved by the facility staff, contact the Chief of Clinical Services to ***arrange for a consult with the prescribing practitioner. The results of the consultation will be documented in the inmate's medical record on the DC-472 and reported as part of the CHCA's monthly report to the BHCS***;

   e. ***forward a copy of the*** **DC-443** to the Unit Manager for notification of the approved special item;

   f. ensure that the discussion with the facility Security Office and the Unit Manager is documented on the **DC-472** in the inmate's medical record and, if necessary, discussed with the prescribing ***practitioner.***

   g. ensure that all medically necessary orders for special item(s) will be carried out, upon discussion and agreement among the ***prescribing practitioners***, Security Office and Unit Managers;

   h. forward all approved medical orders for special item(s) to the medical services vendor(s) for purchase;

i. coordinate the repair or replacement of the special item with the medical vendor when necessary;

j. establish local procedures for a timely review/inspection of all special item(s) prescribed to the inmate. The date of the review/inspection will coincide with the stop/review date ordered by the ***prescribing practitioner, in accordance with Subsection A.4. above***; and

k. make a decision as to what special item an inmate may keep at the time of discharge/parole. Issuance of a special item does not make the item the property of the inmate.

3. The Facility Unit Manager will:

   a. monitor the inmate's use of special item(s) to ensure the inmate is using the item(s) as instructed. If applicable, instructions will be included on or attached to the **DC-443**;

   b. contact the Medical Department if there is a question regarding the inmate's use of the item(s) or the manner in which the inmate is using or not using the item(s);

   c. ensure that all three shifts of Corrections Officers working the block/housing unit are informed of special item(s) orders that an inmate is permitted to posses or changes to existing orders; and

   d. ensure that specialty items are engraved, when possible, or appropriately marked with the inmate's full name and facility number.

4. The inmate will:

   a. ensure special item(s), when authorized, remain in his/her possession at all times;

   b. report to the medical department as ordered for inspection of the special item(s);

   c. ensure the prescribed special item(s) is properly used, not damaged, not stolen or misplaced during the time he/she is issued a special item(s). Any misuse of a special item(s) may cause the special item(s) order to be rescinded;

   d. be financially responsible for the cost of repair/replacement for damage to the special item(s) resulting from the inmate's actions or negligence. Upon inspection, if appropriate medical personnel believe the inmate's actions or negligence caused damage to a special item(s), a **DC-141, Misconduct Report**, will be issued and the inmate assessed for any and all costs for the repair and/or replacement of the special item(s) in accordance with Department policy **DC-ADM 801**;

   e. be responsible for carrying a copy of the **DC-443** at all times; and

   f. be responsible for updating his/her personal property list.

C. Prescription of Special Item(s)

1. ***For a new reception or transfer reception from another facility, if a prescribing practitioner*** determines that an inmate needs or possesses an item that is not routinely provided by the facility, the ***prescribing practitioner*** will inform the CHCA of the need for, or continued use of, the special item. ***Documentation must be filed under the Legal/Correspondence Tab in the medical record when any special item(s) are provided to an inmate on the basis of an ADA determination.***

2. The ***prescribing practitioner*** will document the following information on the **DC-472** of the inmate's medical record:

   a. the condition requiring the special item(s);

   b. the special item(s) needed to treat the inmate;

   c. a prognosis as to how long the inmate will be required to use the item(s);

   d. a stop/review date for the item(s) being requested; and

   e. an order for discontinuance if it is determined that the item(s) is no longer medically necessary.

3. For the treatment of acute conditions, the ***prescribing practitioner*** treating the inmate will review the inmate's need for a special item(s). The required special item(s) will be noted on the **DC-472** in the inmate's medical record. Priority will be given in order to get the medical order approved and filled as medically necessary.

4. For an inmate suffering from a documented chronic condition where the need for a special item(s) may be continuous or permanent in nature, the review of the special item(s) will be conducted at least annually. The results of the ***physician/PA*** and the CHCA's review will be documented on the **DC-472** in the inmate's medical record.

5. Once the special item(s) is available at the facility, the inmate will be summoned to the Medical Department, appropriate medical personnel will instruct the inmate on the following:

   a. proper use, care, storage, ***and financial responsibility for the special item(s) in accordance with Subsection B.4.d. above***;

   b. if the inmate requests assistance to appropriately fit a special item(s), the ***prescribing practitioner will*** reevaluate;

   c. the inmate will be instructed by the ***prescribing practitioner to keep on person*** a copy of the **DC-443** at all times; and

d. the date the inmate is to return the special item(s) to the Medical Department for inspection and evaluation to continue use.

6. The ***prescribing practitioner who is*** instructing the inmate will ensure the **DC-443** is completed, distributed, and filed in the **Miscellaneous Section** of the inmate's medical record.

7. Ensure the following actions occur when the stop/review date is reached:

   a. notify the Unit Manager/appropriate housing authority when the stop/review date is reached;

   b. request the inmate be sent to the Medical Department at a specified date and time for the purpose of assessing the need to continue the specialty item; and

   c. complete the **DC-443**, specifically the **Returned Items Section**, to notify the Unit Manager of the change in status of the special item ordered.

D. Inspection of Special Item(s)

1. During the scheduled inspection of the special item(s) or whenever an inmate brings special item(s) to the Medical Department to be examined, the appropriate medical personnel will document any damages or wear of the item(s) on the **DC-472** in the inmate's medical record and notify the CHCA of any damage he/she believes was caused by the inmate. If appropriate medical personnel believe the inmate's actions or negligence caused damage to a special item(s), a **DC-141** will be issued by the appropriate staff member and inmate assessed for any and all costs for the repair and/or replacement of the special item(s) in accordance with Department policy **DC-ADM 801**.

2. If the special item(s) requires repair, the ***practitioner will*** write an order for repair/replacement of the special item. The CHCA will complete a new **DC-443** specifically the **Returned Items Section** and forward it to the Unit Manager.

3. In accordance with Department policy **DC-ADM 801**, if the inmate is determined to be financially responsible, a **DC-138A, Inmate Cash Slip, *will be completed*** for the cost of the repairs or replacement. If the inmate is indigent or does not have enough money to cover the cost of the repair, the Inmate Accounts office will handle the monies owed as ***a medical*** insufficient funds situation.

4. Upon receipt of the repaired or replaced special item(s), the inmate will be summoned to the Medical Department to receive the item(s) and sign a **DC-443**. At that time staff will inform the inmate that he/she must carry the **DC-443** at all times or be subject to a misconduct.

E. Procedures for Electric Razors

1. If an inmate requests an electric razor, the inmate must sign up for sick call. The ***prescribing practitioner will*** discuss the matter with the inmate and document the examination of the inmate on the **DC-472** in the inmate's medical record.

2. After completing the examination regarding the electric razor, the ***prescribing practitioner*** will inform the CHCA of the inmate's request for the electric razor. The CHCA will forward the ***prescribing practitioner's*** documentation of the examination, as well as a rationale for the medical necessity for the use of an electric razor to the Chief of Clinical Services, BHCS at Central Office.

3. The Chief of Clinical Services, BHCS will review the request and approve or disapprove the request. The Chief of Clinical Services, BHCS will inform the CHCA of his/her decision. The CHCA will ensure that the ***prescribing practitioner*** is informed of the decision.

4. The ***prescribing practitioner*** who examined the inmate requesting the electric razor will ensure the following:

   a. that the inmate is informed of the decision regarding his/her request for the electric razor; and

   b. that the encounter with the inmate regarding the electric razor and the decision is recorded on the **DC-472** in the inmate's medical record.

5. ***The CHCA/designee will ensure that the Inmate Status automated application on DOCNet is updated as required.***

6. The vendor will be responsible for providing the electric razor to the inmate.

7. The Unit Manager will ensure that all three shifts of Corrections Officers working the block/housing unit are made aware and kept informed of any changes regarding the possession of electric razors or other special item(s) permitted to be retained by an inmate.

8. After receiving the electric razor, the inmate will ensure that his/her property inventory is updated accordingly. The Unit Manager will ensure that the razor is engraved with the inmate's full name and Department number.

F. Discontinuance or Change in Status Regarding Electric Razors

1. The Medical Department will review an order for the use of an electric razor quarterly. The ***prescribing practitioner*** will document the results of the review on the **DC-472** in the inmate's medical record.

2. If the inmate's condition changes and the electric razor is no longer medically necessary, the ***prescribing practitioner*** will document the change on the **DC-472** in the inmate's medical record ***and notify the CHCA***.

3. ***The CHCA/designee will ensure that the Inmate Status automated application on DOCNet I updated as required.***

4. The CHCA will inform the Unit Manager as to the change regarding the inmate's use of the electric razor.

G. Procedures for Pressure Relief Mattresses

1. ***Pressure relief*** mattresses will only be provided upon prescription by a physician for the following reasons:

   a. alleviation and/or prevention of pressure ***ulcers*** on inmate patients whose condition requires confinement to bed for prolonged periods of time;

   b. any other reason or circumstances as documented by a physician on the **DC-472** in the inmate's medical record;

   c. ***the CHCA/designee will ensure that the Inmate Status automated application on DOCNet is updated as required.***

2. The use of this equipment will be restricted solely to the infirmary inpatient care area or to a Long Term Medical Care Unit.

3. Because this item cannot be effectively disinfected, its use will be confined to a single patient and discarded when the patient no longer requires it, or if it becomes deteriorated and/or contaminated.

Section 11 – Review of Diagnostic Reports

A. General Procedures

1. A full time or *locum tenens* medical or psychiatric practitioner-physician, certified registered nurse practitioner (CRNP) or physician assistant (PA) will review all diagnostic test results within three calendar days of receipt of these by the facility and prior to filing in the medical record. If an electronic medical record is in use, **Subsections 2. – 7. below** do not apply.

2. If a psychiatric practitioner is not scheduled to be on-site within the first three calendar days after test results are received at the facility, then the medical practitioner will review these results during that time period. The medical practitioner will sign off these reports and then forward them to the psychiatric practitioner for his/her review and signature prior to filing in the medical record. In situations of abnormal results requiring urgent attention, the medical practitioner will take corrective action and/or contact the on-call psychiatric practitioner for further guidance or action.

3. If a psychiatric practitioner conducting a telepsychiatry evaluation orders diagnostic tests, local nursing staff shall follow the same procedure described in **Subsection 2. above**.

4. Practitioners will initial or sign, date and time all diagnostic test results to signify their reviews, using a Diagnostic Study Stamp.

5. If the result is Normal (N), a progress note entry is not required.

6. If the result is Abnormal and requires follow up practitioner action (A), progress note documentation is required.

7. If the result is situationally or chronically Abnormal, but does not require follow up practitioner action ***(Not Clinically Significant: NCS)***, progress note documentation is not required.

8. Diagnostic test results should be discussed subsequently with the patient, and this will be documented on the **DC-472, Progress Notes** or the **DC-472C, Outpatient Psychiatry Progress Note**.

B. Diagnostic Study Stamp

DIAGNOSTIC STUDY STAMP

PRACTITIONER: _____

DATE: _____

TIME: _____

A	**N**	***NCS***
ABNORMAL	**NORMAL**	***NOT CLINICALLY***
(Requires DC-472 SOAP Note)		***SIGNIFICANT***

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Section 12 – Pharmacy Guidelines[1]

A. Operational Standards

The Bureau of Health Care Services (BHCS) shall ensure that each facility medication room has personnel, space, equipment, and supplies to safely and effectively store and administer medications to the Department's inmate population.

1. ***Staffing***

   a. ***Each facility shall assign a sufficient number of trained licensed personnel necessary for the safe and efficient operation of the medication room.[2]***

   b. ***Medication room personnel shall participate in the Department's basic nursing training orientation to allow for the safe and efficient operation of the medication room.***

2. ***Security***

   The medication room shall remain locked at all times. Access is limited to assigned licensed staff, on-duty nursing supervisors, administrative staff, and auditors.[3]

3. ***Storage***

   a. ***Medications and biologicals are to be stored in an orderly manner to facilitate their safe and efficient administration.[4]***

   b. ***Medications for internal use are to be stored separately from drugs for external use.***

   c. ***All scheduled medication (II-IV), shall be stored in accordance with requirements of Pennsylvania state laws and regulations, the Federal Drug Enforcement Agency and in accordance with Subsection D. below.[5]***

   d. ***The medication room shall not be used to store non-pharmaceutical material such as personal effects, unneeded equipment, archived records or cleaning products.***

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e. ***A cleaning schedule shall be maintained for the medication room. It shall be thoroughly cleaned at least weekly and as needed. Cleaning products shall be stored in a cabinet, separate from pharmaceuticals.***

f. ***Staff shall not store or consume food, beverages, or tobacco products in the medication room.***

g. ***Only food/supplements used in the administering of medications may be kept in the medication room refrigerator and/or on a shelf separate from medications.***

h. ***Expired, outdated, contaminated, or deteriorated medications must be immediately withdrawn from stock and destroyed on site. Destruction methods shall include disposal via secured trash or via sharps container (once rendered "unusable"). Narcotics shall be destroyed on site. Other medication must be returned to the pharmacy contractor for destruction.***[6]

i. ***Pharmaceutical grade refrigerators must be used to store vaccines or medications.***

j. ***Temperature control areas where medications are stored shall adhere to the following:***[7]

(1) ***the room temperature in all areas where medications are stored must be maintained between 59 and 80 degrees Fahrenheit. If the temperatures fall outside the parameters, the Registered Nurse Supervisor (RNS)/designee shall be contacted promptly.***

(2) the temperature of the drug storage refrigerators must be maintained between 36 and 46 degrees Fahrenheit; and

(3) the temperature of the refrigerators, freezers, and where medications are stored (if utilized) must be checked and recorded ***on the Temperature Monitoring Log (Attachment 12-A)*** every shift. ***The log must have the temperature standards listed and deviations from the standard must be reported to the nurse supervisor/designee immediately.***

B. Formulary

The BHCS, medical, pharmacy and mental health service contractors shall jointly develop, publish, and maintain a formulary of the most commonly used and most cost effective medications to be used in the Department. The formulary shall be updated every six months.[8]

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1. ***All other medications shall be available by request through a non-formulary medication approval process approved by the Department and referenced in the Electronic Medication Administration Record (eMAR).***

   a. ***Non-formulary orders shall be processed upon the approval of the assigned non-formulary reviewer in the eMAR system.***

   b. ***For emergencies, immediate fills, or verbal/telephone orders of non-formulary medications, the authorizing regional medical director or statewide Mental Health Director shall contact the contract pharmacy to approve.***

2. ***Generic drug equivalents or non-formulary medications, after being reviewed, shall be dispensed by the contracted pharmacy for medication(s) ordered by brand name in accordance with the provisions of state/federal law, unless the prescribing practitioner (MD/DO/PA-C/CRNP/DDS/DMD) specifically states otherwise.[9] If the prescribing practitioner requires a brand name medication, BMN (Brand Medically Necessary) must be checked on the order.***

   NOTE: When a generic medication is dispensed for a brand name medication, the medication shall be labeled with the generic name such as "Methyldopa" and below it shall be the brand name it substituted and labeled "Substitute for Aldomet."

3. ***Only Food and Drug Administration (FDA) approved medications, biologicals, and other related items ordered by the prescribing practitioner shall be sent to a Department facility. The use of investigational or experimental drugs is not permitted in Department facilities.[10]***

C. Operational Practices

1. Medication Orders

   A valid order is required for all medications dispensed, administered, or distributed. ***The clinically indicated order must be entered in the eMAR system and documented on the DC-472, Progress Notes in accordance with Department policy 13.1.1, "Management and Administration of Health Care," Section 10.[11]***

   a. Verbal/Telephone Orders

      (1) A registered nurse (RN)/licensed practical nurse (LPN) may accept a verbal/telephone order provided the order is understandable to and within the scope of practice of the nurse. The nurse must enter the order in the eMAR system and document on the **DC-472**.

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(2) The verbal/***telephone*** order must be countersigned within 72 hours ***by the ordering practitioner/medical director***.

(3) A verbal/telephone order may be accepted from ***mid-level practitioners.***

b. ***Physician Assistant medication orders shall be entered in the eMAR and reviewed/countersigned by a supervising physician within 72 hours.***

c. ***Orders for controlled medications must be entered in the eMAR system. The prescription must be printed, signed, and faxed immediately to the contract pharmacy. The original prescription must be mailed to the contract pharmacy within 72 hours.***

d. ***The contracted pharmacy shall develop policies and procedures for the processing of medication orders received from all facilities.***

e. ***The contracted pharmacy shall develop policies and procedures for the efficient and timely delivery of ordered medications.***[12]

2. Precautions during Hot Weather

a. An inmate who is prescribed medications that cause heat sensitivity shall be informed of the side effects. (A listing of medications that cause heat sensitivity is contained in the ***pharmacy provider heat related illness pamphlet located on the BHCS website.)***

b. ***An inmate who is prescribed medications that cause photosensitivity shall be informed of the side effects. (A listing of commonly identified medications that cause photosensitivity is contained in the heat related illness pamphlet.) SPF-30 sunscreen shall be made available in the commissary.***

c. The practitioner and nursing staff shall remind inmates of the precautions necessary to avoid episodes of heat stroke and heat exhaustion.

d. The CHCA shall ensure that all facility personnel that supervise inmate workers, especially those who work in the powerhouse, garage, and outdoors, are made aware of the potential for heat stroke and heat exhaustion.

3. Duration of Prescriptions

Prescription duration does not imply frequency of visits for management of a chronic illness. Frequency of visits depends on patient condition, practitioner judgment, and Department policy. At the practitioner's discretion, prescriptions may be entered for up to 210 days for an inmate with a stable chronic illness such

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as hypertension, cardiovascular disease, asthma, convulsive disorder, HIV infection, diabetes mellitus, and chronic mental illness such as major depressive disorder, bipolar disorder or schizophrenia. Exceptions to this limit are as follows:

a. ***TB prophylactic medication(s) may be written for 270 doses of therapy;***

b. ***Hepatitis C treatment medications may be written for up to 48 weeks;***

c. ***schedule III-V controlled substances may be written for up to 180 days per DEA policy;***

d. ***schedule II controlled substances may be written for a maximum of 30 days per prescription order. Refills are NOT permitted on Schedule II controlled substances. A hard copy of the prescription shall be mailed to the control pharmacy;***

e. ***schedule II and III drugs can be written for 30 days for an inmate at the time of release; and***

f. ***inmates transferring with medications included in the 340B Drug Discount Program of the U.S. government may have prescriptions written for longer periods outlined in the 340B agreement.***

4. ***Renewal of a Prescription***

A practitioner shall re-evaluate a prescription prior to its renewal.[13]

5. ***Discontinued Medication***

a. ***Only a practitioner can discontinue a medication order. This order must be entered in the eMAR system and documented on the DC-472.***

b. ***Verbal orders to discontinue medications may be received as a verbal order by a RN or LPN. This order must be entered in the eMAR system and documented on the DC-472.***

c. ***All verbal orders must be countersigned by the ordering practitioner or site medical director within 72 hours.***

d. ***Medication room staff[14]***

The discontinued package shall be placed in a separate designated area of the medication room for proper handling.

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(1) ***A full or partial medication card meeting the following criteria shall be sent to the contract pharmacy for credit consideration:***

(a) ***the card was not self-administered;***

(b) ***the medication expiration date is 90 days or greater;***

(c) ***the medication is not a controlled substance;***

(d) ***the medication is not adulterated; and/or***

(e) ***the medication is allowable for return in compliance with state and federal regulations.***

(2) ***Medication room staff shall electronically scan barcodes on qualifying returns using the inventory module in the eMAR system.***

(3) ***When the scanning of returns is complete, medication room staff shall print two copies of returns, log and use one copy as a packing manifest for the return shipment and the other copy for the facility's records.***

(4) ***Items that can be destroyed at the site (via secure trash or sharps container method) include suppositories, refrigerator items, topicals, otics, ophthalmics, liquids, injections, and any item labeled by the contract pharmacy and administered as a self-carry medication. These items do not qualify for credit.***

(5) ***Any unused controlled substances that remain as a result of an order discontinuation shall be stored at the facility in a securely locked designated area until disposition.***

(a) ***Schedule III-V controlled substance can be destroyed at site level by two licensed persons in accordance with Department policy on controlled substance destruction. Licensed personnel may include an RN, LPN, or Registered Pharmacist.***

(b) ***Schedule II controlled substance shall be destroyed by the contract pharmacist during quarterly scheduled visits.***

(c) ***Controlled substances SHALL NOT be returned to contract pharmacy.***

e. ***The Controlled Medication Destruction Log shall be provided and reviewed by the contracted pharmacy on a quarterly basis and shall be kept securely by the RNS or Corrections Health Care Administrator (CHCA)/designee.***

6. ***Changes in Medication***

   The contracted pharmacy shall provide the facility with "Directions Changed Refer to Chart" stickers. These stickers shall be affixed to the medical packaging that still carries the original unaltered prescription label. Staff shall refer to the eMAR for the current directions for medication bearing such stickers prior to administering the medication to the inmate.

7. Over-the-Counter (OTC) Medications[15]

   OTC medications shall be purchased by inmates in the commissary. ***Exceptions to this practice are the following:***

   a. In the event the inmate has sufficient funds to purchase the OTC medication, a supply of the medication shall be provided to the inmate to last until the next commissary day.[16]

   b. ***In the event the inmate has insufficient funds to purchase the OTC medication, a supply of the medication shall be provided to the inmate.***

8. Administering Medication

   a. ***Administration of Medications from Medline Windows***

      (1) ***The appropriate medpass shall be downloaded from the eMAR before the start of the medline by the assigned nurse who shall pass medications at the given location.***

      (2) ***Medications shall not be prepared prior to the medline.***

      (3) ***Nurses shall scan the inmate ID barcode for each patient upon their approach to the window.***

      (4) ***Nurses shall administer medications due for the inmate during the medpass time in the following manner:***

         (a) ***Each medication card/bottle shall be scanned prior to placing medication into a cup to ensure the appropriate medication is the one prescribed for the selected patient for the specific medpass date and time. Note: Some products without vendor barcodes affixes are not identifiable (i.e. stock medications, vitamins, etc.). The nurse shall visually verify the product is prescribed for the patient prior to placing it in a cup.***

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(b) ***After scanning and placing each medication into a cup or other container, medications are administered to the inmate.***

(c) ***After the nurse observes the patient swallowing medication(s), the eMAR shall be documented to reflect Administered.***

(d) ***If/when the inmate refuses any or all medication(s), the refusal(s) is/are documented in the eMAR.***

(e) ***At the conclusion of medline, the nurse shall determine which medication(s) due for administration at the given medline time were not taken.***

(f) ***Presence of inmates who were due for psychotropic or life-sustaining medication(s) during the medpass and did not show to the medline shall be sought via the Shift Commander/designee.***

(g) ***When the inmate presents to the medline, the eMAR shall be documented as Administered or Refused.***

(h) ***If/when inmates fail to report to medline after being sought by the Shift Commander/designee, the eMAR shall be documented with a No Show result.***

(i) ***All non-psychotropic/non-life-sustaining medications not taken during the medline shall be reflected on the eMAR as Missed.***

(j) ***When documentation of medpass results is completed, the nurse shall end the medpass. This action updates the eMAR for each patient due for medications at that medpass.***

(5) ***Nurses shall take all follow-up actions necessary, immediately following the medline (example, signing patients up for medline, completing DC-462s, etc.) in accordance with Subsection C.10. below.***

b. Administration of Medication in a Housing Unit

(1) A nurse may place medication in a container labeled with the inmate's name and ***number immediately before*** leaving the medication room ***for the purpose of administering medications in a housing unit.***

(2) The nurse who placed the medication in the container ***must lock it and keep it in his/her sight at all times prior to taking the medication*** to the unit for administration. ***A nurse may not administer a medication prepared by another nurse.***

(3) ***The nurse shall immediately document the outcome of medication administration in the eMAR.***

(4) ***Any medications that were prepared, but not given during medpass, shall be destroyed as outlined in Subsection C.11. below.***

c. Procedures for Crushing Medications

(1) ***A list of medications not suitable for crushing (Do Not Crush List) is available in the eMAR. Generally, all sustained and extended release beaded and enteric-coated medications shall not be crushed.***

(2) ***All Schedule II, III, and IV medications shall be crushed at the discretion of the prescribing practitioner except for those medications on the "do not crush list." All tricyclic antidepressants (TCA) must be crushed, floated and opened.***

d. Administration of an Injectable Medication(s)

(1) The medical department shall use safety syringes ***that have been approved by the BHCS except when administering pre-filled manufacturer's medication syringes.***

(2) Only ***a practitioner*** and licensed ***nursing staff*** shall administer injectable medication to an inmate in accordance with the ***pharmacy contractor IV policy and procedures manual.***

(3) Upon completion of an injection, the needle and syringe shall be properly disposed of in a sharps container designed to prevent retrieval.

(4) ***Upon opening any injectable medication, the RN, LPN, or practitioner must affix a date opened sticker, or write on the package the date when the package was first opened. The contract pharmacy shall provide a "beyond use reference guide" to facilities to inform them as to when an injectable item must be discarded.***

(5) An inmate may only self-administer injectable medication, including insulin, during the 30 day period immediately preceding his/her release from the facility.

(6) Nursing staff shall directly supervise and observe the entire process of the inmate's self-injecting medication. This supervision includes providing the inmate with proper instructions on:

(a) use of sterile technique;

(b) identification of appropriate injection sites;

(c) how to draw-up the correct amount of medication;

(d) how to administer the medication; and

(e) ***proper disposal of equipment.***

(7) ***An inmate's ability to self-administer an injectable medication correctly must be documented on the DC-472 in the medical record.***

e. Medications for Inmates being Transferred or Released from the Department

(1) ***Medications for inmates being transferred or released from the Department shall be provided in accordance with the current Inmate Transfer Logistics Grid maintained in the eMAR.***

(2) ***Procedures for transferring or discharging inmates with prescribed medications shall conform to Department policy 6.3.1, "Facility Security," Section 20.***

(3) An inmate receiving prescribed medication(s) shall be issued the ***minimum supply for transfer/release in accordance with the Inmate Transfer Logistics Grid.***

(4) The medical department must be informed at least five days prior to an inmate's release from prison or parole/transfer to a Community Corrections Center (CCC).

(5) The CHCA ***is responsible for ensuring the required*** medication is ordered from the ***contract*** pharmacy, properly ***secured in a*** labeled package, and delivered to the ***receiving*** facility (***or inmate in cases of release***).

(6) ***For Authorized Temporary Absence (ATA) transfers or county jail placement, nursing staff shall notify the contracted pharmacy of placement. Nursing staff shall place the medication(s) in a sealed and properly labeled package and follow local procedure to assure medication transfers with the inmate. This action shall be documented in the eMAR.***

9. Electronic Medication Administration Record (eMAR)

a. The eMAR shall contain:

(1) inmate identification data;

(2) current month and year;

(3) all allergies (including no known allergies);

(4) PRN medications;

(5) start date (month, day, year);

(6) stop date (month, day, year);

(7) medication, dose, frequency, and duration of medication order;

(8) a record of initials under date and hour medication was administered;

(9) ***if an inmate refuses medication, the nursing staff must document the refusal in the eMAR;***

(10) ***if a medication dose is held by a practitioner or the medication is held due to abnormal vital signs, the eMAR shall be documented as Held;***

(11) ***if an inmate is not present at the facility and not available to take the medications, the eMAR shall be documented as Absent; and***

(12) ***if inmate is not present at the medication line, not absent from the facility, and the steps outlined in Subsection C.8. above have been completed, the eMAR shall be documented as No Show.***

b. ***When Keep on Person (KOP) or self-medication is provided to an inmate, practitioners or nursing staff shall document the number of doses provided in the eMAR.***

c. ***The initials, electronic signature, and title of the nurse administering or providing the medications shall be recorded in the eMAR.***

10. Monitoring Medication Compliance[17]

Refusal of Life Sustaining/Chronic Medical Illness and Psychiatric Medications

a. ***The CHCA/designee shall:***

(1) ***review the eMAR medication compliance reports on a daily basis and ensure the contracted health care provider schedules all inmates that have missed three consecutive medication doses or 50% missed doses of medication occurring within a seven day timeframe for evaluation by a practitioner;***

(2) ***monitor on a weekly basis that practitioner follow-up evaluations have occurred;***

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(3) ***request the contracted health care vendors provide updates regarding specific inmate medication compliance problems at the facility Quality Improvement (QI) meetings; and***

(4) ***review the quarterly pharmacy and therapeutic reports for compliance issues.***

b. ***Nursing Staff shall:***

(1) ***ensure each inmate receives medication, as ordered;***

(2) ***notify the facility Medical Director/designee or Psychiatrist when an inmate misses a life-sustaining medication;***

(3) ***notify the facility Medical Director/designee if an inmate with chronic medical illnesses misses three consecutive doses of medication or 50% missed doses of medication occurs within a seven day timeframe. A DC-462 shall be initiated;***

(4) ***for an inmate who is on the PRT or housed in a specialized unit, the nurse shall notify the Psychiatrist if three consecutive doses are missed in succession or 50% missed doses of medication occurs within a seven day timeframe. A DC-462 shall be initiated; and***

(5) ***document non-compliance as a nurse's note in the eMAR.***

c. ***Psychology Department staff shall:***

(1) ***provide a list of inmates on the PRT roster to the CHCA. This list shall include housing unit and assigned Psychology Department member and counselor;***

(2) ***review the eMAR medication compliance reports on scheduled workdays and provide counseling to an inmate who is non-compliant within 24 hours, or as soon as facility operations permit;***

(3) ***discuss medication compliance at each interaction;***

(4) ***discuss the instances of non-compliance at the first scheduled PRT meeting, if staff have identified decompensation associated with non-compliance or discuss instance(s) of non-compliance at the inmate's next regularly scheduled PRT meeting if staff have not identified decompensation associated with non-compliance;***

(5) ***notify the inmate's psychiatrist of medication non-compliance; and***

(6) ***the LPM shall notify the DSCS of significant instances of medication non-compliance, which may place the inmate at risk for relapse of his/her mental illness.***

d. ***The Medical Director/designee shall:***

(1) ***review the DC-462 and counsel the inmate regarding medication non-compliance after being notified of such by nursing staff and document a progress note on the DC-472; and***

(2) ***notify the CHCA where such non-compliance may cause a relapse of the inmate's medical conditions.***

e. ***The Psychiatrist shall:***

(1) ***review the DC-462 and counsel the inmate regarding non-compliance after being notified of such and document a progress note on the DC-472;***

(2) ***discuss medication compliance at each interaction;***

(3) ***attend PRT meetings to review all instances of non-compliance;***

(4) ***direct the PRT in developing a multi-disciplinary plan to address the issue of non-compliance for those inmates with serious mental illness; and***

(5) ***the PRT shall notify the DSCS of all serious instances of non-compliance, which may put the inmate at risk for a relapse of his/her psychiatric disorder.***

f. ***Facility Management and Security Support***

(1) ***The DSCS shall:***

(a) ***notify the Program Review Committee (PRC) of serious instances of inmate non-compliance; and***

(b) ***recommend to the PRC remedial measures to be considered, such as Administrative Custody (AC) status or less restrictive recommendations for the PRT, Unit Manager, or CHCA to address concerns of serious non-compliance.***

(2) ***For inmates housed in the Residential Treatment Unit (RTU) and Special Needs Unit (SNU), medications shall be either delivered to the unit or by an independent medline movement shall be established. All medpasses for these units shall be monitored for medication compliance in accordance with Subsection C.8. above.***

g. ***Monitoring of the Inmate***

Multi-disciplinary members such as the Medical Director, Psychiatrist, Counselor, and Psychologist shall monitor the inmate weekly until the inmate complies with the medication ordered. Documentation shall be written in the medical record.

(1) ***The eMAR system is available to practitioners during clinic visits.***

(2) ***Medication compliance for Direct Observation Therapy (DOT) and the Self-Medication Program shall be in accordance with Section 15 of this procedures manual.***

11. Medication Destruction[18]

a. ***All unused medications that qualify for credit (full and partial cards that are DOT, have 90 days of expiration dating, are not adulterated, damaged, or written upon, and are allowed to be returned by state and federal regulations) shall be returned to the contract pharmacy. Each facility CHCA shall ensure the contract pharmacy's electronic reconciliation program is used to process and track any items returned to the contract pharmacy.***

b. Schedule II medications must be disposed of in the facility by the ***contract*** pharmacy ***during quarterly visits. The contract pharmacy and RNS/designee shall document destruction on the pharmacy provider control destruction log and on the pharmacy provider controlled drug count verification log. A separate destruction log (provided by the contract pharmacy) shall be maintained and held by the RNS or CHCA/designee as record of any controlled substance destroyed at the site.***

c. ***Schedule III-V medications can be destroyed at the facility by two licensed personnel that may include RN, LPN or Registered Pharmacist. Each facility CHCA shall ensure site personnel document and validate destruction by having both persons sign the daily controlled substance flow record and the change of shift record log that shall reflect the change(s) in perpetual inventory. The controlled destruction log shall be provided by the contracted pharmacy vendor.***

d. ***Medications destroyed at the facility shall be:***

(1) ***destroyed via secure trash;***

(2) ***"rendered non-usable" by submerging tablets and/or capsules under water in a sharps container. (The container can then be sealed and returned to the contracted biohazard vendor for disposal); and/or***

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(3) ***for non-tablet and capsule entities, disposition through a sharps container (or secure trash).***

e. ***Medications brought into the facility that are not provided by contract pharmacy:***

(1) ***if the medications are individually packaged (unit dose or bubble packed) and identifiable, these medications may be used until they are gone; or***

(2) ***any medications that are received loose, unlabeled, in a vial, mixed together, or any packaging other than blister pack or unit dose, shall be destroyed.***

12. ***Emergency Kits and Crash Carts***

Medications in these containers shall be managed in accordance with Section 6 of this procedures manual.

13. ***Post Exposure Prophylactic (PEP) Kits***

Medications in these kits shall be managed in accordance with Department policy 13.1.1, Section 5.

D. Controlled Substances[19]

1. ***The policies of the contracted pharmacy shall conform to the Controlled Substance Act of 1970 (Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970) and amendments, and the Drug Enforcement Agency (DEA) Title 21, Chapter 13, Drug Abuse and Prevention Control.***

2. ***Controlled substances are medications with high abuse potential and are subject to special handling, storage, disposal and record keeping.***

3. ***Controlled substances are classified by the DEA into five schedules as listed below.***

a. ***Schedule I (CI) – Highest abuse potential contains medications with no accepted medical purpose, such as Heroin.***

b. ***Schedule II (CII) – Contains medications with an extremely high abuse potential such as Morphine, Demerol, Percocet, Percodan, Ritalin, Methadone, Dilaudid, Cocaine, Amphetamines and most barbiturates, such as Nembutal and Seconal.***

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c. ***Schedule III (CIII) – Contains medications with very high abuse potentials, such as Tylenol with Codeine, Vicodin, etc.***

d. ***Schedule IV (CIV) – Contains medications with a lessor abuse potential then Schedule III and includes Darvocet, Restroil, Phenobarbital, Chloral Hydrate, Valium, Serax and Librium.***

e. ***Schedule V (CV) – Contains seldom abuse drugs, such as the Codeine containing cough syrups (Robitussin DAC) and Lomotil.***

4. ***Orders for Schedule II drugs shall be entered in the eMAR and the standard prescription form shall be generated and printed for signature. The signed standard prescription form shall be immediately faxed and mailed to the contract pharmacy. The contract pharmacy must receive the original signed copy within 72 hours. A practitioner cannot write an order for a Schedule II controlled substance that exceeds 30 days.***

5. ***Schedule III-V controlled substances orders can be ordered for a maximum of 180 days per DEA policy.***

6. ***Medications listed in Schedule II through V shall be stored under double lock, separate from all other medications. Only one pharmacy nurse on duty at the time shall maintain possession of the key to the controlled medication drawer/cabinet.***

7. ***Methadone can only be ordered for the reasons outlined below.***

   a. ***Pain management – Prescriptions of methadone for pain management should have the term "for pain" documented on the original order.***

   b. ***Pregnant women addicted to opioids to prevent abrupt withdrawal and harm/death to the fetus. When such inmates arrive, contact the Department of Drug and Alcohol Programs, Division of Program Licensure (717-783-8675), for referral to a community program licensed to provide methadone detoxification services to pregnant women. A practitioner may write a one-time order for three days until arrangements as outlined above can be confirmed.***

8. ***Records***[20]

   a. ***A nurse shall be assigned to medication inventory reconciliation which shall be completed in the eMAR system.***

   b. ***When receiving and reconciling Schedule II-V medications, the medication room nurse shall complete the DC-453, Narcotic/Controlled Substance Record (Attachment 12-B).***

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c. ***Thereafter, a physical inventory of that medication shall be made at the change of each shift by two licensed nursing personnel who are authorized to administer the medication, in accordance with the procedures for medication administration (usually that shall be the medication nurse going off duty and the medication nurse coming on duty). Each person shall sign the pharmacy provider controlled drug counting verification log to verify a count was performed and the inventory is correct. Medications that have been discontinued shall be documented on the pharmacy provider controlled drug count verification log and kept in a separate location until handled properly.***

d. ***Separate records shall be maintained on all schedule drugs, in the form of declining inventory records on the DC-453. Such records shall be accurately maintained and shall include:***

(1) ***facility;***

(2) ***narcotic/controlled substance;***

(3) ***month/year;***

(4) ***date;***

(5) ***time;***

(6) ***inmate name;***

(7) ***inmate number;***

(8) ***name of the prescriber;***

(9) ***dosage;***

(10) ***amount issued;***

(11) ***administered by;***

(12) ***amount received;***

(13) ***balance; and***

(14) ***shift inventory signature.***

e. ***The DC-453 forms shall be reconciled to a physical count of the remaining medication substances at the end of each shift and shall be retained for at least seven years.***

f. ***The RNS/designee shall investigate and reconcile all reported discrepancies. If a discrepancy is irreconcilable, the RNS/designee shall document the details on the audit record, including the possible shift or persons responsible for the discrepancy, and the efforts made to reconcile it. If a major discrepancy or a pattern of discrepancies occurs or there is obvious criminal activity, the CHCA/designee shall notify the Shift Commander immediately and the consultant pharmacist.***

9. ***Accounting Procedures[21]***

a. ***Schedule II-V controlled substances, including discontinued medication, shall be counted at each change of shift by at least two persons who are legally authorized to administer medications. This shall usually be done by the on-coming and off-going shift nurses and shall be documented on the pharmacy provider controlled drug count verification log.***

b. ***Any discrepancy in the count of controlled substances shall be reported immediately, in writing, to the responsible RNS/designee and a signed entry shall be recorded on the page where the discrepancy is found.***

c. ***The RNS/designee shall institute an investigation to determine whether or not the dose was administered or refused.***

d. ***The contracted pharmacist shall be notified immediately if any discrepancy is detected upon shipment reconciliation for any controlled substance regardless of the classification. The pharmacist shall make regular checks of the handling, storage, recording, and disposal procedures of controlled substances during his/her scheduled quarterly inspections.***

e. ***Each line on the DC-453 shall represent one dose.***

f. ***If a dose is removed from the packaging for administration, but refused by the patient or not given for any reason, it shall be destroyed in the presence of two nurses and the disposal must be documented on the DC-453.***

g. ***The DC-453 and change of shift record logs shall be maintained securely in binders. When completed, the audit and proof-of-use records shall be kept on file in the facility for at least seven years by the CHCA.***

10. ***Release of an inmate with Scheduled/Controlled Medications[22]***

a. ***In accordance with the Inmate Transfer Logistics Grid, scheduled/controlled medications shall be prepared for inmates leaving the system or transferring to another facility.***

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b. ***In accordance with Subsection C.8. above, controlled drugs may be sent with the inmate on discharge or transfer when ordered by the discharging practitioner.***

c. ***A new order shall be required for any Scheduled II-V controlled substance for release from a Department facility.***

d. ***The release records for a controlled substance shall be documented on the DC-453 and pharmacy provider controlled drug count verification log.***

e. ***Remaining controlled substances, not authorized by the practitioner for release or transfer of the inmate, shall not be surrendered to any person (including practitioner) for any reason. These medications shall be destroyed in accordance with Subsection C.11. above. Records of these returns for destruction shall be maintained by the facility medication room for at least seven years.***

E. Facility Procedures for Stock Medications

Stock medications are ordered in the eMAR based upon current facility inventory needs. The site medical director is required to approve all orders for stock medications. Policies and procedures for ordering of stock medications in the following categories shall be developed by the contracted pharmacy:

1. ***universal stock list;***

2. ***bulk OTC stock;***

3. ***control substance stock;***

4. ***psychotropic medication stock; and***

5. ***dental stock.***

F. Sharps[23]

Sharps shall be maintained in accordance with Department policy 6.3.1, Section 7.

G. Contracted Pharmacy Responsibilities

1. ***Backup Pharmacy/Emergency Needs***

All facilities shall have a local backup pharmacy should an emergent (same day, after hours, weekend, holidays) need arise. In some cases, due to geography, the

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contract pharmacy may also serve as the backup pharmacy. Procedures for using backup pharmacy services shall be:

a. ***The contracted pharmacy shall arrange backup pharmacy services to an available local pharmacy in reasonable proximity to the facility (when possible).***

b. ***The backup pharmacy or local pharmacy shall invoice the contracted pharmacy as agreed either electronically or on paper invoice. The facility shall NOT be responsible for payment of emergency RX at the time of delivery or pickup. The contracted pharmacy shall invoice each emergency RX and delivery, if applicable, as a pass thru to the facility on the next scheduled monthly invoice.***

c. ***Emergency prescriptions can be delivered if the local back up pharmacy provides this service. If the local pharmacy does not provide delivery services or the daily delivery has already left for the day, the facility or CHCA/designee shall pick up the prescription so the medication can be utilized in a timely fashion. (Local backup pharmacy services may vary from one facility to another).***

d. ***The contracted pharmacy shall provide the prerequisite emergency prescription order form that includes an emergency fax number. The medication room nurse shall complete the form and forward it to the contracted pharmacy for action.***

   NOTE: The emergency fax number is not the same as the routine fax number.

e. ***The contracted pharmacy shall evaluate the EMERGENCY RX request and contact the backup pharmacy directly. A minimal quantity sufficient to cover the emergency situation shall be processed by the backup pharmacy as directed by the contracted pharmacy.***

f. ***Non-Formulary Emergency prescriptions shall be approved by the respective contracted pharmacy vendor site.***

2. ***Invoices***

The facility CHCA shall verify the accuracy of all invoices sent by the contracted pharmacy. Procedures for reconciling discrepancies are listed below.

a. ***Facility Daily Drug Deliveries[24]***

   (1) ***The contracted pharmacy shall provide a daily packing sheet with each daily drug delivery.***

   (2) ***The Medical Room staff shall verify the contents of each daily delivery with electronic scanning verification.***

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(3) ***Daily notifications on tote container errors/discrepancies/omissions shall be communicated to the contracted pharmacy immediately.***

b. ***Facility Weekly/Monthly Pharmacy Invoices***

(1) ***Weekly or monthly pharmacy invoices shall be sent to the CHCA/designee in electronic or disc format.***

(2) ***Invoice questions shall be handled in a timely manner by the CHCA/designee and either the contracted pharmacy billing representative or if necessary the consultant registered pharmacist (RPH) assigned to each facility.***

(3) ***The CHCA shall review and approve the monthly pharmacy invoices either electronically or by faxing them to the contracted pharmacy no later than the 15th day of the month.***

(4) ***The contracted pharmacy shall submit all facility monthly invoices, as required, in the requested billing format type to the appropriate designee at the PA-Department comptroller's office.***

3. ***Consulting Services***

The contracted pharmacy shall provide consulting services as listed below:

a. ***Performance of an oversight inspection of the pharmaceutical divisions of the facilities on a quarterly basis. The inspection shall ensure compliance of all federal, state, and local laws and regulations in regards to the Pharmacy Act and the Controlled Drug Device and Cosmetics Act.***

b. ***Establishment of policies and procedures consistent with the requirements of the BHCS. The contractor shall assist in the developing, implementing, and monitoring of policies and procedures for the safe and effective distribution, control and use of drugs, including medications in crash carts, emergency kits, and PEP kits.***

c. ***General supervision of facility procedures for the control and accountability of all drugs throughout the facility. Provide an overall inspection of the pharmaceutical division of the facility on a quarterly basis. This shall ensure that all drugs are approved and dispensed in compliance with federal and state laws, as well as the facility's policies and procedures.***

d. ***Retention of all records from the facility under the strictest confidentiality.***

e. ***Continual assessment of recommendations of plans for implementations. This shall be completed through quarterly inspection reports that are provided to the CHCA/designee for follow-up and evaluation of performance.***

f. ***Emergency and routine consultations via toll free telephone number on a 24 hours a day, seven days a week basis.***

g. ***Devote time, energy, and skill as required, including the following:***

(1) ***all time expended preparing reports of activities performed or to be performed; and***

(2) ***time expended viewing provisions and activities relating to pharmaceutical services connected with governmental inspections or voluntary accreditations.***

h. ***The contracted pharmacy shall assist the facility with the following:***

(1) ***recording, accounting, destruction, and reconciliation of unused controlled substances;***

(2) ***providing accountability for the destruction of returned/discontinued medications, in accordance with all applicable federal and state laws and regulations;***

(3) ***providing and updating reference materials (i.e. controlled substance lists, Do Not Crush List, Beyond Use List, metric-conversion, I.V. policy and procedures manual, eMAR user manual, in-service library list, etc.);***

(4) ***attending (and chairing, if requested) Pharmacy and Therapeutics (P&T and Quality Assurance (QA) meetings;***

(5) ***inspecting all areas relating to the pharmacy and report to the CHCA deviant practices that might jeopardize patient care; and***

(6) ***providing training to site personnel as required for the efficient and safe management and dispensing of medications/pharmaceuticals.***

i. ***Provide and maintain an extensive video library pertaining to pharmaceuticals and related topics for each facility and their personnel for loan.***

j. ***Develop and implement a Medication Event Analysis Tool.***

H. Quality Assurance Improvement

The Pharmacy and Therapeutic (P&T) Committee shall meet quarterly. Committee membership shall include, at a minimum, representatives of BHCS, the contracted

pharmacy, the contracted medical care provider, and the contracted mental health services provider. Meetings shall be held no less than quarterly.

Section 13 - Management of Pregnant Inmates

A. Detection, Confirmation, and Notification of Staff

1. If the inmate arrives at the facility and states that she may be pregnant and the results of the intake physical and confirmatory blood test show her to be pregnant,[1] the Corrections Health Care Administrator (CHCA)/designee shall immediately contact the Unit Manager.

2. If an inmate in general population is determined to be pregnant, the CHCA/designee shall notify the Deputy Superintendent for Facilities Management (DSFM) who shall immediately notify the Facility Manager, in writing, and the inmate's counselor.

3. If an inmate in general population is determined to be pregnant, and has not participated in the furlough program, the CHCA shall notify the DSFM/designee, who shall immediately provide the Facility Manager with a written report detailing all pertinent information. The Facility Manager shall initiate an investigation as to the circumstances surrounding the pregnancy.

4. A monthly list of every pregnant inmate, including due date, shall be prepared by the Medical Department. Copies shall be sent to the Facility Manager, DSFM, Deputy for Centralized Services (DSCS), Corrections Classification and Program Manager (CCPM), Unit Managers, Control Center, Food Service Manager, and Parenting Program Director.

B. Medical

1. Prenatal Care

   a. After confirmation of pregnancy, the Medical Department shall provide regularly scheduled obstetrical examinations, prenatal vitamins, and any medication as prescribed by the physician. Prenatal education programs shall be provided to the inmate. The CHCA shall contact the Parenting Program Director, who shall inform the inmate of prenatal classes available at the facility. Included in this is individual basic instruction in prenatal nutrition and general health habits **(Attachment 13-A)**. A prescription for therapeutic/pregnancy diet and snack shall be issued if deemed necessary by the Medical Department and/or the Obstetrician/Gynecologist (OB/GYN).[2]

   b. Specialists in obstetrics provide prenatal care. High-risk pregnancies and chemically dependent pregnant inmates shall be identified by the Medical Director and immediate referrals made to an outside specialist.[3] Immediate medical risk in pregnancy shall also be referred to an outside specialist.

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c. Each facility, through its contracted medical provider, shall be responsible for providing services of an OB/GYN and clinic/hospital for the obstetrical care of the inmates. This care shall include prenatal, delivery, and routine postpartum care.

d. Lab tests to be done on every prenatal inmate, conducted by the OB/GYN, shall include, but are not limited to, the following:

(1) New Commitment Profile: Complete Blood Count (CBC), Chem Profile, Rapid Plasma Reagin (RPR), Urinalysis (U/A);

(2) Rubella Titer;

(3) Hepatitis B Surface Antigen (HBsAg); Hepatitis C Virus-Enzyme Immuno Assay (HCV-EIA);

(4) Antibody Screen - screening test that looks for RH (Erythroblastosis fetalis) and other antibodies. If the inmate has received blood products in the past, she may be carrying antibodies that could:

(a) present a problem when performing a type and cross match on her blood; and

(b) create a hemolytic disease in the baby.

(5) Type and Cross Match;

(6) Indirect Coombs;

(7) HIV Testing after Counseling and Voluntary Consent;

(8) Cultures to include:

(a) Chlamydia;

(b) Gonococcal;

(c) Trichomonas; and

(d) Pap Test

Note: a shift from the normal flora with an increase in coccobacillus or the presence of gardnerella vaginalis could increase the possibility of pre-term labor.

Treatment for any positive cultures as per doctor’s orders.

(9) Urine C & S - at the discretion of the health care practitioner.

e. A pregnant inmate shall be seen by the OB/GYN once a month during the first and second trimester with the exception of high-risk cases that are seen at least every two weeks. During the third trimester, a pregnant inmate shall be seen every two weeks and on a weekly basis during the last month prior to delivery.[4]

f. The health care practitioner shall order further testing during the prenatal time as appropriate. This testing may include: glucose screening, H & H, Group B strep culture - at 35-37 weeks.

g. A pregnant inmate, who is released from her parent facility, shall be provided with a copy of her prenatal chart.

h. A pregnant inmate who receives Disciplinary Custody (DC) time shall be placed in the infirmary with prenatal care.

i. Ten days prior to the due date, as established by the obstetrician, the inmate shall be transferred to the infirmary for housing.

2. Erythroblastosis Fetalis (RH factor)

In some instances, this can lead to the death of the baby. It can be treated in utero (before birth) by medication or intrauterine transfusion. When the child is born, signs may include an enlarged liver and/or spleen, generalized edema (swelling, anasarca), jaundice, and anemia.

a. Prevention:

(1) prenatal care throughout pregnancy;

(2) early care is essential to determine the risk of RH incompatibility;

(3) special anti-RH gamma globulin is given to the mother at 28 weeks gestation and within 72 hours after delivery, miscarriage, ectopic pregnancy, or abortion;

(4) amniocentesis beginning at 28 weeks if indicated by elevated antibody titers in the mother; and

(5) Rho (D) immune globulin shall be administered to a non-sensitized, RH negative obstetrical patient. Dosage shall be 300 mcg (1500 I.U.) at 26-28 week gestation

b. Each of the above medical decisions shall be on a case-by-case basis by the OB/GYN physician.

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3. Delivery and Transfer of Infant Custody

   a. At the first signs of labor, the inmate, if not already housed in the infirmary, shall be transported to the infirmary. Once the medical staff has established true labor, arrangements shall be made to have the inmate transferred to the community hospital.

   b. ***Transportation of pregnant inmates during labor/delivery will be in accordance with Department Policy 06.03.01 Section 22.***

   c. The Corrections Officer providing security for the inmate at the community hospital shall contact the Facility Control Center with notification of the birth. The Facility Control Center shall notify the infirmary of the birth.

   d. Transfer of infant custody shall be accomplished at the hospital through the Social Service Department using the hospital's form.

   e. If the caregiver cannot or will not take the baby upon the baby's discharge from the clinic/hospital, the hospital shall notify the appropriate State childcare agency.

4. Postpartum Care

   The obstetrical specialists also conduct postpartum follow-up.

C. Parenting Program

1. The parenting staff/designee shall contact the inmate within two working days of the confirmation of the pregnancy. The initial session must be used to discuss what options are available to the inmate at that time. The **Inmate Checklist (Attachment 13-B)** shall be used to determine the extent of the inmate's needs and identify any problem areas. After the initial session, at a minimum, the parenting staff/designee shall maintain biweekly contact with the inmate until plans are finalized. These sessions shall be documented in the **DC-14, Cumulative Adjustment Record**.[5]

2. The caregiver (person assuming responsibility for the child) shall be confirmed by the parenting staff/designee at least two months prior to the expected delivery date, if applicable. The caregiver's name, relationship, address, and telephone number shall be maintained in the **DC-14**, and the inmate's medical file for future reference. It is the parenting staff/designee's responsibility to record this information in the **DC-14** and notify the Medical Department, in writing, of the caregiver data and any change regarding this status up to, and including, the date of delivery.

3. Arrangements must be made by the inmate to cover any extraordinary medical expenses for the infant beyond routine postnatal care. This can be accomplished through the Department of Public Welfare, medical assistance, etc., with the assistance of the hospital social worker.

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4. The parenting staff/designee shall inform the inmate that it is her responsibility to arrange for her child's care. Emphasis shall be placed on using the spouse, the baby's father, parents, grandparents, brothers, sisters, close friends, foster care, or adoption.

5. It is the hospital social worker's responsibility to notify the caregiver of the birth. Arrangements for telephone calls from the hospital must be made with the parenting staff/ designee in advance. If the inmate wants a family visit on the day that the baby is discharged, arrangements shall be made with the parenting staff/designee in advance. The inmate is to instruct visitors to bring ID in accordance with Department policy **DC-ADM 812, "Inmate Visiting Privileges."**

6. The inmate is responsible to arrange for caregivers to bring a car seat and necessary clothing to the hospital for the baby (undershirt, sleeper, sweater, and blanket). The hospital social worker calls the caregiver when the baby is to be discharged.

D. Postpartum Education and Counseling Programs

Postpartum education classes and counseling programs shall be provided to the inmate as outlined in the **Pregnancy Plan of Action (Attachment 13-C)** or on an as needed basis. Separation issues and postpartum expectations and abnormalities shall be the focal points of this programming.[6]

E. Visitation

1. An inmate visitor(s) is allowed to be in the birthing room while the birth is taking place if he/she is on the inmate's approved visitors list and are following hospital policy and procedures. Facilities shall encourage bonding between the inmate mother and her newborn child while at the clinic/hospital. An inmate visitor(s) shall follow the hospital visiting hours and be admitted to the inmate's hospital room provided he/she is listed on the facility's approved visitors list for that inmate.

2. Visitation shall be encouraged between the inmate, the caregiver, and her newborn child after discharge from the hospital.

F. Elective Termination of Pregnancy

Elective termination of pregnancy procedures will be provided at the inmate's request.[7]

1. The inmate and her family shall be responsible for all costs related to the diagnostic work-up, assessment, treatment, surgical intervention, medical complications, security officer and transportation costs associated with the elective termination of pregnancy procedures.

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2. The Chief of Clinical Services shall be consulted prior to elective termination of pregnancy procedures being instituted.

3. A physician, in compliance with all applicable laws, including the Abortion Control Act, 18 Pa. C.S.A. §§ 3201-3220, Chapter 2, shall perform elective termination of pregnancy procedures.

4. Elective termination of pregnancy procedures shall be performed by a physician, in conformance with the requirements regarding minors, as referenced in the **Abortion Control Act, 18 Pa. C.S.A. §§ 3201-3220, Chapter 2, Page 10, Subsection II.E.3**.

5. These procedures shall not be performed in Department facilities. They shall be performed off-site in hospitals or OB/GYN physician offices.

Section 15 – Direct Observation Therapy and Self-Medication Program

Inmate patient's medications may be administered either by Direct Observation Therapy (DOT) or by the patients themselves in the Self Medication Program (Keep on Person [KOP]).

A. Direct Observation Therapy (DOT)[1]

1. DOT includes ensuring compliance with prescribed medication therapy through education, direct observation, monitoring and counseling.

2. Some medication(s) must always be administered by DOT. These shall be identified in the current formulary.

3. All DOT medication(s) shall be ***routinely*** delivered to the ***following (but not limited to) housing*** units: Psychiatric Observation Cell (POC), ***Behavior Management Unit (BMU), Diversionary Treatment Unit (DTU), Intermediate Care Unit (ICU),*** Secure Residential Treatment Unit (SRTU), Special Assessment Unit (SAU), Special Management Unit (SMU), Special Observation Unit (SOU), or Restricted Housing Unit (RHU).

4. For inmates housed in a Residential Treatment Unit (RTU) or Special Needs Unit (SNU), medications shall be either delivered to the unit or an independent medication line movement shall be established.

5. Unless specifically prohibited by the Psychiatric Review Team (PRT), an inmate shall be allowed to keep both his/her rescue inhaler and/or nitroglycerine even if other self-medication(s) is not approved. **A *medical* practitioner order for these items shall be documented in the medical record**.

B. Self-Medication Program

1. Criteria for Self-Medication Program

   a. Any inmate in general population may participate in self-medication if ordered by a practitioner.

   b. The inmate must be able to understand the education and importance of compliance.

   c. An HIV patient may be eligible for self-medication(s) at the discretion of the practitioner if the inmate is compliant with the medical regimen(s) and the disease is well controlled.

   d. An inmate currently in the Diagnostic and Classification Center (DCC) may be eligible for the Self-Medication Program at the discretion of a practitioner.

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e. An inmate in the RHU may be eligible for self-medication(s) at the discretion of the facility in accordance with Department policy **6.5.1, "Security Level 5 Housing Units."**

f. An inmate housed in a RTU or SNU may be eligible for the Self-Medication Program at the discretion of the mental health practitioner and PRT.

g. An inmate admitted to an Infirmary, ***State Correctional Institution (SCI) Laurel Highlands Skilled Care Unit,*** POC or Mental Health Unit (MHU), or housed in a ***BMU, DTU, ICU,*** SRTU, SMU, SAU, or SOU shall not be eligible for the Self-Medication Program.

2. Procedures for Self-Medication[2]

a. The medical staff shall provide education to the inmate on self-medication(s) and assess the inmate's ability to understand the program. The inmate shall provide feedback regarding the use of self-medication(s).

b. For self-medication(s) to be initiated, ***a nurse shall access the electronic health record and*** complete the **DC-499, Self-Medication Distribution Program Instructions Form (Attachment 15-A)**. ***The inmate shall sign the DC-499 to acknowledge receiving and understanding instructions for participation in the program. A copy of the DC-499 shall be printed for the inmate.***

c. Education shall be documented ***by the nurse*** on the **DC-472, Progress Notes**, and shall continue as needed, on a one-to-one basis, during ***the inmate's*** incarceration.

d. The prescriber must ***verify a DC-499 is completed before initiating*** the order that enables the inmate to keep medication on his/her person. The Medical Department, in connection with the Security Department, shall identify a process for the secure distribution of self-medication. The Medical Department shall inform the inmate eligible for the Self-Medication Program of the procedures for obtaining refills of his/her medication. The **DC-499** shall contain procedures for an inmate to obtain refills of his/her medication(s).

e. Medication must be kept in the inmate's possession until the order expiration date, which is to be marked on the label, along with the inmate's name, facility number, and start and stop dates of medication.

f. The medical provider shall review non-compliant inmate(s) for possible discontinuation from the Self-Medication Program.

g. The inmate must return all unused, expired, or discontinued medication(s) to the Medical Department.

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3. Criteria to be removed from Self-Medications

   Eligibility for the Self-Medication Program shall be revoked when:

   a. the inmate is hoarding, diverting, or selling medication(s) or drug(s);

   b. the inmate overdoses on KOP medication(s) or any other medication(s);

   c. the inmate attempts suicide or makes suicidal gestures;

   d. there is a positive urine test for illegal substances or any prescription medication(s) for which the inmate does not have a current medication order;

   e. the inmate is unable to understand the importance of medication compliance and the self-medication (KOP) procedures;

   f. repeated non-compliance to take the medication(s) shall result in counseling of the inmate. The inmate may be removed from the Self-Medication Program for persistent non-compliance;

   g. security shall be notified by the Medical Department to confiscate medication(s) from an inmate who has been removed from the Self-Medication Program and return them to the Medical Department; and

   h. ***revocation or subsequent reinstatement*** in the Self-Medication Program ***will be ordered*** by the Medical Director/***psychiatry practitioner*** with input from PRT and the Program Review Committee (PRC) as appropriate.

4. Monitoring the Self-Medication Program

   Monitoring shall include the following:

   a. random cell checks;

   b. specific cell checks by medical staff request;

   c. the inmate brings applicable self-medication(s) to the clinic ***or sick call***. Medical staff checks the medication(s) for remaining pills; and

   d. medical staff verifies compliance by referencing the electronic ***health record***.

5. Procedure for Transfers

   a. When removing an inmate from general population (furlough, routine transfer, RHU, etc.) all of the inmate's prescription medication must be returned to the Medical Department.

b. The medical staff shall secure all medication(s) prior to any transfer.

c. Prior to transferring an inmate, the sending facility shall ensure the inmate scheduled for transfer receives his/her ordered dose of medication(s).

d. Medication(s) must not be packed with the inmate's property.

e. All medication(s) shall be packaged and sent in a secure manner.

f. The nursing staff at the receiving facility shall return the self-medication(s) to the inmate, if appropriate.

6. Reasonable Accommodations

a. In accordance with Department policy **DC-ADM 006, "Reasonable Accommodations for Inmates with Disabilities,"** an inmate requiring DOT shall be granted reasonable accommodations with regard to maintaining his/her medication schedules.

b. Medical clearance for employment or programs shall not be affected by the DOT requirement (outside workers, Community Work Programs [CWP], etc.).

CONFIDENTIAL

13.2.1, Access to Health Care

Section 16 – Quality Improvement Plan

This section is confidential and not for public dissemination.

Section 17 – Inmate Transfers

This section establishes procedures for the transferring and receiving of inmates throughout the system, with providers of health care/mental health services, and with external corrections settings. Medical holds can be applied as clinically indicated, and procedures for their administration are described.

A. Medical Department Responsibilities

1. The type of inmate transfer shall be identified. The types of transfers utilized are as listed below:

    a. Intra-System Transfers: temporary and permanent transfers; the procedures in **Subsection B. below** shall be followed;

    b. Medical Transports and Temporary Medical Transfers: inmates are sent to other Department facilities for care or may be seen by a community health care provider. The procedures in **Subsection C**. **below** shall be followed;

    c. Consolidated Infirmary Transfers: facilities without an infirmary (Frackville, Huntingdon, Laurel Highlands, Pine Grove, Quehanna Boot Camp, and Retreat) may temporarily transfer inmates requiring infirmary care, or 23-hour observation, to their respective consolidated infirmary. The procedures in **Subsection C.2.e**. **below** shall be followed;[1] and

    d. Authorized Temporary Absences (ATA) Transfers and In-Transit Offenders: inmates may be temporarily transferred to other prison/jail settings, or may be moved within the system to facilitate effective release planning. The procedures in **Subsection D**. **below** shall be followed.

2. The Medical Department is responsible to ensure the below listed procedures are completed prior to the non-emergent transfer of an inmate.[2]

    a. A determination of suitability for travel, based on a medical evaluation, is completed by a practitioner, with particular attention given to communicable disease clearance.

    b. Written instructions regarding medication and health interventions required en route, are provided to transporting officers. This is separate from the medical record.

    c. Specific precautions are communicated to transportation officers before transfer of the inmate.

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Effective: 7/26/2017

d. The original medical record is maintained in a confidential fashion and accompanies the inmate to the transferring Department facility.

B. Intra-System Transfers of Inmates (temporary transfer [TT] and permanent)

An intra-system transfer inmate shall receive a health screening by a health trained, or qualified, health care personnel, which commences on his/her arrival at the facility.[3] The transferring facility's Medical Department responsibilities (excludes same day transfers) are as follows.

1. Transferring Facility's Medical Records Department Responsibilities

a. The Medical Records Department shall obtain information from the Department's Offender Management System concerning an inmate's approval for transfer as outlined in Department policy **11.2.1, "Reception and Classification."** The Office of Population Management (OPM) shall provide this listing on a weekly basis via the Automated Transfer Petition System. As required by local procedure, the Medical Records Department shall ensure the list of inmates being transferred is communicated to all pertinent Department staff.

b. The type of transfer is reviewed to determine if the inmate shall be moved as a temporary or permanent transfer.

(1) Temporary Transfer Procedure

(a) When an inmate is a temporary transfer, the current volume of the medical record shall be prepared for movement to the receiving facility.[4]

(b) If the inmate is being transferred to a Mental Health Unit (MHU), or the Forensic Treatment Center (FTC), additional volumes may be sent upon request from the MHU/FTC. Previous MHU record information must be included.

(c) Loose documents/forms for the medical record shall be gathered and filed in the medical record.

(d) The **DC-485, Intra-System Medical Record Transfer Checklist (Attachment 17-A)** shall be completed. If information is not sent, or is unavailable, it must be documented on the **DC-485**. The transferring facility shall follow-up with the receiving facility's Medical Records Department when the information is available.

[3] 4-4363
[4] 4-4414, 4-ACRS-4C-24

(e) The original **DC-485** shall be placed on top of the History and Physical Exams tab of the medical record. A copy of the **DC-485** shall be maintained by the transferring facility's Medical Records Department for six months following the transfer.

(f) The medical record shall be provided to nursing staff for transfer processing.

(2) Permanent Transfer Procedures

(a) When an inmate is a permanent transfer, the entire medical record, and x-ray film file, shall be prepared for movement to the receiving facility.[5]

(b) Loose documents/forms for the medical record shall be gathered and filed in the medical record.

(c) The **DC-485** shall be completed. If information is not sent, or is unavailable, it must be documented on the **DC-485**. The transferring facility shall follow-up with the receiving facility's Medical Records Department when the information is available.

(d) The original **DC-485** shall be placed on top of the History and Physical Exams tab of the medical record. A copy of the **DC-485** shall be maintained by the transferring facility's Medical Records Department for six months following the transfer.

(e) The medical record shall be provided to nursing staff for transfer processing.

(f) Upon return of the inmate's medical record(s) from nursing staff, the Medical Records Department shall ensure the following:

i. medical records for each inmate scheduled/approved for transfer are placed into individual transfer envelopes or boxes;

ii. each transfer envelope or box shall have the receiving facility's full name, transferring facility's name, inmate's name, and identification number legibly documented;[6] and

iii. the Medical Records Department/designee shall deliver the transfer envelopes or boxes to the facility's designated intake/discharge area for transfer with the inmate.[7]

[5] 4-4414, 4-ACRS-4C-24
[6] 4-4414
[7] 4-4414

2. Receiving Facility's Medical Records Department Responsibilities for Temporary and Permanent Transfers (excludes same day transfers)

   a. The Medical Records Department shall obtain information from the Department's Offender Management System regarding inmate transfers to the facility.

   b. Medical Records and x-ray films shall be removed from transfer envelopes or boxes and reviewed.

   c. The **DC-485** form shall be reviewed and completed.

   d. After the **DC-485** has been reviewed and completed by the receiving facility, it shall be filed under the Miscellaneous tab of the medical record.

   e. Any identified, missing record information shall be reviewed with the transferring facility's medical records staff by the receiving facility's medical records staff.

   f. Medical records shall either be made available for the reception nurse or filed.

   g. X-ray films shall be moved to the designated filing area.

3. Transferring Facility's Nursing Responsibilities for Temporary and Permanent Transfers (excludes same day transfers)

   a. A nurse shall complete a **DC-491, Intra-System Nursing Transfer Checklist (Attachment 17-B)** for each inmate scheduled for transfer.[8]

   b. The **DC-491** shall be completed in the following manner:

      (1) the nurse shall review the medical records for answers to all of the transfer checklist questions;[9]

      (2) if any of the numbered questions are answered with a "YES," the nurse shall review the checklist and medical record with the practitioner;

      (3) if the inmate is not approved for transfer, the practitioner shall initiate a medical hold, and the procedures contained in **Subsection E. below** shall be followed;

      (4) if an inmate is being transferred and has unresolved medical problems, the procedures contained in **Subsection B.7. below** shall be followed;

[8] 4-4364, 1-ABC-4E-05
[9] 4-4414

(5) when the inmate is approved for transfer, the nurse completing the **DC-491** shall write a progress note in the inmate's medical record documenting the type of transfer, location receiving the inmate, and completion of the **DC-491**;[10] and

(6) the **DC-491** shall be filed in the first section of the medical record on top of the Therapeutic Diets tab.

c. The nurse completing the **DC-491** shall ensure the inmate's medical record(s) are returned to the Medical Records Department for further processing.

4. Receiving Facility's Nursing Responsibilities for Temporary and Permanent Transfers (excludes same day transfers)

a. The **DC-491** from the transferring facility shall be completed.

b. The **DC-479, Intra-System Transfer Reception Screening (Attachment 17-C)** form shall be completed with the inmate.[11]

c. The nurse shall document the results of his/her interview, and other pertinent information concerning the intake interview, as a progress note contained in the inmate's medical record.[12]

d. Both the inmate and the nurse shall sign and date the **DC-479**. If the inmate refuses to sign, a witness shall sign in the space provided.

e. After completing the **DC-479**, the nurse shall provide an oral and written explanation to the inmate regarding the facility's:

(1) access to health care services in accordance with this procedures manual; [13]

(2) sick call, including inmate co-pay, in accordance with Department policy **DC-ADM 820, "Co-Payment for Medical Services;"** [14]

(3) emergency services, in accordance with **Section 6, Access to Emergency Care/Nursing Protocols – Nursing Evaluation Tools (NETS)** of this procedures manual;

(4) dental care, in accordance with **Section 4** of this procedures manual;

(5) psychiatric/psychological services in accordance with Department policy **13.8.1, "Access to Mental Health;"** and

[10] 4-4414
[11] 4-4363, 4-4364, 4-4370
[12] 4-4363
[13] 4-4344
[14] 4-4345

(6) access to the inmate grievance system.[15]

f. After explaining the facility's health care services to the inmate, the nurse/designee shall document his/her encounter with the inmate in the progress notes.

g. Inmates on the Stability C or D Roster who transfer from one Department facility to another Department facility shall be seen by the intake nurse. Psychology will assess stability, and refer to psychiatry as appropriate (urgent or emergent based on presentation/stability during assessment) by completing the **DC-97, Mental Health Referral** and including reason for referral. All Stability C and D Roster inmates shall be scheduled for follow-up with Psychiatry.

When an inmate that is on psychotropic medication(s) arrives at the receiving facility, the Registered Nurse (RN) or Licensed Practical Nurse (LPN) shall review the electronic health record (EHR) for medication(s) that are going to expire in the next 14 days. If they are expiring within 14 days, the RN/LPN shall consult with the psychiatrist/Psychiatric Certified Registered Nurse Practitioner (PCRNP) as follows:

(1) if during working hours, ***review shall occur with the on-site psychiatrist/PCRNP. The inmate*** shall be scheduled for follow-up with Psychiatry ***within 14 days***; and

(2) if the psychiatrist/PCRNP is not on grounds, or during off hours/weekends, the RN/***LPN*** shall alert the on-call Psychiatrist/PCRNP of the transfer ***with expiring medications***, review the ***medications with the on-call psychiatrist/PCRNP,*** and document verbal orders for medications as deemed clinically appropriate. The inmate shall be scheduled for follow up with Psychiatry ***within 14 days***.

h. Nursing staff shall complete the **Prison Rape Elimination Act** (**PREA) Risk Assessment Tool (PRAT),** and update the **WebTAS,** within 72 hours, in accordance with Department policy **DC-ADM 008, "PREA." (28 C.F.R. §115.41)**

i. The appropriate individuals/departments (this shall include, but not be limited to: Infection Control Nurse, Psychology Department, Food Service Department, etc.) shall be notified of any inmate restrictions or special recommendations.

j. The inmate's name shall be placed on the appropriate treatment, or chronic disease, tracking system, when indicated.

k. The inmate's medication shall be delivered to the Medication Room/Pharmacy.

l. After completing the reception process, nursing staff deliver the inmate's medical record(s) to the Medical Records Department.

[15] 4-4344

m. The nurse shall discuss concerns regarding any problematic transfer with the Nursing Supervisor/designee and the Corrections Health Care Administrator (CHCA). The CHCA/designee shall:

(1) completely investigate the matter; and

(2) notify the Bureau of Health Care Services (BHCS) Regional Quality Improvement (QI) Nurse regarding the problematic transfer, and the results of the investigation.

5. Transferring Facility's Medication Room/Pharmacy Nurse Responsibilities for Temporary and Permanent Transfers[16]

a. In accordance with the Inmate Transfer Logistics Grid, maintained in the electronic medication administration record (eMAR), the inmate shall travel with a minimum of a five-day supply of medication.

b. The Medication Room/Pharmacy Nurse shall prepare the inmate's medications and ensure the following:

(1) the inmate's eMAR is current;

(2) the **DC-492, Intra-System Pharmacy Transfer Checklist (Attachment 17-D),** is completed; and

(3) all inmate medication(s) are sealed in a manila envelope(s)/appropriate container(s) and clearly labeled with the following:

(a) "To: receiving facility's full name, Medical Department";

(b) inmate's name; and

(c) inmate's number.

c. The Medication Room/Pharmacy Nurse shall ensure the medication envelope(s)/appropriate container(s) is prepared and delivered to the facility's designated intake/discharge area for transfer with the inmate.

6. Receiving Facility's Medication Room/Pharmacy Nurse Responsibilities for Temporary and Permanent Transfers

a. Ensure the **DC-492** is reviewed, completed, signed, and dated.

b. Review and update the eMAR as needed.

[16] 4-4378

c. Administer medications to inmates as ordered/prescribed.

d. Upon completion of the **DC-492**, forms shall be filed in the medical record.

7. Criteria for Permanent Intra-System Transfer of an Inmate with Unresolved Medical Problems

a. An inmate shall not be transferred directly from any **infirmary, skilled, or personal care setting** within the system unless there is documentation on the progress note that both the CHCA/designee, and the Medical Director/designee from the receiving facility, have been contacted by his/her counterpart at the transferring facility (contact may be made via email, **if receipt is acknowledged**, and documented on a progress note), and have been made aware of, or acknowledge, the following:

(1) the inmate's current medical problems;

(2) the currently prescribed treatment plan(s);

(3) agreement to accept responsibility for completing the medical management of the identified problem; and

(4) a practitioner shall discharge an inmate from the **infirmary, skilled care, or personal care setting**, and medically clear him/her for transfer.

b. The health care professional, including LPN, RN, Physician Assistant (PA), Certified Registered Nurse Practitioner (CRNP), Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), and Doctor of Dental Medicine (DDM), shall document in the progress notes, that a medical problem shall be addressed at the receiving facility and ensure the following has occurred:

(1) direct communication, regarding serious inmate medical problems, with his/her counterpart at the receiving facility has been completed. The relay of information (verbally/email) shall be documented in the progress notes of the medical record; and

(2) all information has been documented/updated on the **DC-491**.

c. The receiving facility is required to assume medical responsibility for the inmate prior to transfer. In the event of a disagreement on the appropriateness of the transfer between two facilities, or if there are any unresolved medical problems regarding the transfer of the inmate, the Regional QI Nurse at the BHCS, shall be contacted by the CHCA/designee of the transferring facility. The Chief of Clinical Services shall provide final resolution.

d. In the event the nurse reviewing the medical record notes an x-ray, lab, or other diagnostic test abnormality, the medical record shall be referred to the Medical Director/designee of the transferring facility for review prior to approving the inmate for

transfer. The Medical Director/designee shall write a progress note concerning the treatment plan for this finding.

e. Any request for a sick call visit shall be completed prior to transfer. In the event the inmate is en route when the request for sick call is received, the transferring CHCA/designee shall ensure a call is made to the receiving facility's CHCA/designee and the sick call visit shall be scheduled within 24 hours of the inmate's arrival at the receiving facility; this shall be documented in the progress notes.

f. A nurse or the CHCA, prior to clearing the inmate for transfer, shall note on the **DC-491** any pending clinic visit, including chronic care or specialty referral. If known, the date and time shall also be noted. For the purpose of treatment continuity, significant medical concerns shall be communicated to the receiving facility's CHCA/designee by the transferring facility's CHCA/designee. Documentation of the communication shall occur in the progress notes.[17]

C. Medical Transports and Temporary Medical Transfers

1. Facility Security

a. The Deputy Superintendent for Facilities Management (DSFM), Majors, and Shift Commander/designee shall ensure the following:

(1) transporting officers are advised of any specific precautions and special needs (wheelchair, crutches, canes, prescribed medications, etc.), disabilities, and/or limitations to mobility of the inmate. This information shall be documented by the nursing staff on the **DC-487, Transfer Health Information Form (Attachment 17-E)**;[18]

(2) if the practitioner orders a physical restraining device, the escort team shall contact the Shift Commander/designee for approval. Any alternative restraining method proposed by Security for transport must be reviewed with the ordering practitioner, and the plan of action shall be documented in the progress notes;

(3) the escort team is advised that if the practitioner does order restraint removal, or that they not be used, they must obtain in writing, the reason(s) why and document the minimum time period the restraints may not be used. The practitioner shall document a progress note and write an order on the Physician's Order Sheet. A copy of the Physician's Order Sheet and corresponding progress note shall be provided to security; and

(4) if the escort team is advised that while the inmate is lying in a hospital bed, a single one-point restraint shall be applied to the appendage furthest away from the room entrance door. If this is not possible, the Transport/Escort Officers shall

[17] 4-4347
[18] 4-4414

contact the Shift Commander/designee for approval to use another method of restraint.

b. Escorting Officer/Staff Members shall ensure the following:

(1) out-of-facility medical staff are advised of the inmate's disabilities and/or limitations to mobility, and restraint, as identified by the facility's **DC-487,** Physician's Order Sheet, and progress note(s);

(2) out-of-facility medical staff are provided with the information/medication packet prepared by the facility's Medication Room/Pharmacy Nurse;

(3) escorting officer/staff members shall comply, to the extent possible, with instructions from the outside medical practitioner on limitations with mobility and use of restraints during transit or transport;

(4) escorting officer/staff members shall have in his/her possession the inmate's medical record, or information, and any prescribed medications that the inmate shall require upon arrival at the destination;[19]

(5) upon notification by hospital staff that the inmate is being prepared for discharge, the Shift Commander shall notify the facility's Registered Nurse Supervisor (RNS)/RN Team Leader, who will, in turn, immediately (within 20 minutes) contact the Medical Director/On-call provider for approval of the inmate's return to the facility;

(6) the escort team shall return the inmate (to include all Level Five [L5] Housing Inmates) to the facility's Medical Department along with any documentation sent by the outside medical practitioner or treatment center; and

(7) the facility's practitioner shall review all documentation sent by the outside medical provider.[20]

c. Medical Department Responsibilities:

(1) the CHCA/designee shall inform the Facility Control Center, DSFM, and the facility's Transportation Coordinator**/**designee of all scheduled or non-scheduled medical appointments and temporary medical transfers out of the facility;

(2) the facility's CHCA/designee, in conjunction with the contracted health care provider, is responsible for scheduling these appointments, and the escort shall be the responsibility of the referring facility;

[19] 4-4414, 1-ABC-4E-54, 4-ACRS-4C-24
[20] 4-4347

(3) the CHCA/designee shall ensure the procedures set forth in Department policy **13.1.1** are followed for all inmates being transported;

(4) the CHCA/designee shall ensure the **Inmate Medical Trip Form** is completed for all medical transports in accordance with Department policy **6.3.1, "Facility Security**;**"**

(5) in all instances, the inmate shall be notified of the transfer at the last possible moment to ensure the inmate does not have the chance to notify an outside party of his/her pending transfer;

(6) if the hospital attending practitioner orders oxygen therapy during transport, the transferring facility's CHCA/designee shall be responsible, through hospital staff, for educating the inmate on his/her responsibility of maintaining it; this shall be documented in the progress notes. The transferring facility's Medical Director shall determine if an inmate needs medical staff to accompany the inmate during transport;

(7) upon return from an off-site consultation/hospitalization, the practitioner/RN shall review the discharge summary, or the outside medical practitioner's report, paying attention to recommendations, limitations, medications dispensed or prescribed, as well as any other recommendations for managing the inmate's condition;[21] and

(8) medical records, and x-rays, for temporary medical transfers of inmates shall be in accordance with **Subsection B.1.b. above** and Department policy **13.1.1, Section 10**.

2. Types of Medical Transports and Temporary Medical Transfers

a. Sending an Inmate to the Emergency Room/Department

Sending Facility → Emergency Room/Department

Emergency transportation of inmates shall be in accordance with **Section 6** of this procedures manual, and Department policy **6.3.1, Section 22,** and the procedures listed below:

(1) Modes of emergency transportation include, but are not limited to: DOC vehicle, ambulance (Basic Life Support [BLS] or Advanced Cardiac Life Support [ACLS]), or Air Ambulance transportation.

(2) In an emergency, the practitioner/RN, based on the extent of the injuries, the inmate's condition, and in consultation with the Shift Commander, shall

[21] 4-4347

determine the best method of transporting the inmate to the hospital or trauma center.[22] [23]

(3) Once the method of transportation has been determined and summoned, time permitting, the Shift Commander and/or the CHCA/designee shall ensure:

(a) the Contracted Health Care Provider/RN/designee prepares a transfer record for transport and/or reference by the Shift Commander/designee while the injured inmate is out of the facility;[24]

(b) the RN prepares the **DC-493, Emergency Room Transfer Form (Attachment 17-F)** and includes any additional medical record documentation as needed;

(c) the RNS/designee informs the Shift Commander/designee, or the escort team, of the precautions that must be followed while transporting/supervising the inmate. This shall be documented in the progress notes. The RN shall also document the limitations/precautions on the **DC-493**;[25]

(d) if the inmate's condition is serious enough to require immediate transport, the RN/designee shall prepare the information referenced above and fax, or send, the information to the hospital or trauma center, and

(e) as soon as possible, the staff member who was transported with the inmate shall contact the transferring facility in order to brief the Shift Commander/designee regarding the present situation/condition of the inmate and to request additional information or support. This information shall be communicated to the RNS/RN Team Leader, recorded in the Medical Department Daily Communication Log and documented in the progress notes in the inmate's medical record.

b. Returning an Inmate from the Emergency Room/Department

Emergency Room/Department → Receiving Facility

(1) Upon notification by the hospital Emergency Room/Department staff that the inmate is being prepared for discharge, the Shift Commander shall notify the facility's RNS/RN Team Leader, who shall immediately notify the on-site Medical Director/designee. At his/her discretion, the Medical Director/designee shall contact the Emergency Room/Department physician, and receive an updated report **PRIOR** to approving/disapproving the inmate's return.

[22] 4-4349
[23] 4-4351
[24] 4-4347
[25] 4-4348

(2) In the event the Medical Director/designee is not on site, the RNS/RN Team Leader shall immediately (within 20 minutes) contact the hospital Emergency Room (ER)/Department Charge Nurse, and receive an updated medical report. The RNS/RN Team Leader will then contact the Medical Director/on-call physician to provide a medical update. At the discretion of the Medical Director/on-call physician, he/she shall contact the ER/Emergency Department (ED) physician for more information, and to determine if the inmate shall return to the facility. The Medical Director/on-call physician, shall then contact the RNS/RN Team Leader, and provide medical orders for the returning inmate.

(3) After receiving orders from the Medical Director/on-call physician, the RNS/RN Team Leader shall contact the Shift Commander and inform him/her of the inmate's approved/denied return from the ER/ED.

(4) Upon the inmate's return, and by direction of the Medical Director/designee, the inmate shall be placed in the infirmary for 23-hour observation. **NOTE**: All hospital returns (including L5/Specialized Housing Unit Inmates) shall be taken to the Dispensary for evaluation upon return to the facility for a medical assessment/evaluation by the practitioner/RN.

c. Sending an Inmate for Inpatient Treatment at Outside Hospital(s)

Transferring Facility → Hospital

(1) The contracted health care provider shall identify an inmate requiring inpatient hospital treatment, the hospital providing the services, and report the information to the CHCA/designee.

(2) The CHCA/designee shall prepare a schedule, documenting every out-of-facility treatment for inmates, arrange with the facility's Inmate Records Office, and notify the DSFM/designee in order to make arrangements for the inmate's transportation. The CHCA/designee shall send a copy of the report to the OPM.

(3) The CHCA's schedule shall contain the following information:

(a) inmate's full name and number;

(b) name of transporting facility;

(c) effective date of transfer;

(d) the estimated length of stay in the hospital;

(e) reason/rationale for transfer (do not include diagnosis);

(f) name of hospital transferred to; and

(g) the method of transportation.

(4) The CHCA/designee shall notify the DSFM/designee, and the OPM, in the event the inmate is admitted into the hospital; this shall be documented in the progress notes.

d. Returning an Inmate from Inpatient Treatment at an Outside Hospital(s)

Hospital → Receiving Facility

(1) The facility's Medical Director/designee shall consult with the attending physician at the hospital, for any inmate with a serious condition requiring follow-up care at the facility, prior to the inmate being released/returned back to the facility. In the event the attending physician does not respond to the Medical Director/designee inquiries, the Medical Director/designee shall document this in the progress notes.

(2) In the event the inmate's permanent facility cannot provide the prescribed/required follow-up treatment pending hospital discharge; the inmate shall be transferred to another facility that can continue to provide services/continuity of care. The following procedures shall be followed:

(a) the transferring CHCA/designee shall contact the identified, receiving facility's CHCA/designee to ascertain whether the receiving facility can manage the referral; this shall be documented in the progress notes;

(b) the transferring Medical Director/designee shall contact the identified, receiving facility's Medical Director/designee 24 hours prior to transfer, with a medical report of the inmate; this shall be documented in the progress notes;

(c) if the transferring Medical Director/designee is unable to make contact with the hospital's attending practitioner, or the receiving facility's Medical Director/designee, the transferring Medical Director/designee shall contact the Regional Medical Director to consult with the BHCS, Chief of Clinical Services and/or Assistant Medical Director for direction for the transfer and/or hold. All communication, and direction, shall be documented in the progress notes;

(d) after appropriate review, approval/acceptance of the transfer, the transferring CHCA/designee shall notify the BHCS Regional QI Nurse to coordinate the transfer with the OPM.

(e) if at any time the transferring Medical Director/designee is informed, or is knowledgeable of a change in the inmate's medical status prior to transfer, the receiving Medical Director/designee shall be notified immediately; and

(f) if the inmate is being temporarily transferred to another facility, directly from the hospital, the receiving facility's Medical Director/designee shall contact the hospital attending practitioner to resolve any final questions.

e. Sending an Inmate to Another Facility/State Correctional Institution (SCI) for Treatment/Medical Services:

Transferring Facility ⟶ Receiving Facility

An inmate requiring medical services that cannot be provided at the facility in which he/she is currently housed shall be transferred to another facility's Medical Department as outlined below.[26]

(1) The contracted health care provider's on-site staff shall identify an inmate requiring medical treatment that can be provided at another facility's Medical Department, and shall inform the CHCA/designee.

(2) The transferring CHCA/designee shall contact the identified, receiving CHCA/designee to ascertain whether the receiving facility can manage, and approve, the referral; this shall be documented in the progress notes.

(3) The transferring facility's Medical Director/designee shall contact the identified, receiving facility's Medical Director/designee 24 hours prior to transfer to provide a medical report of the inmate (this includes all **personal care, skilled care, infirmary inpatient care, and medically unstable inmates**); this will be documented in the progress notes.

(4) After appropriate review, approval/acceptance of the transfer, the transferring CHCA/designee shall notify the BHCS Regional QI Nurse to coordinate the transfer with the OPM.

(5) The transferring facility's Contracted Health Care Provider is responsible for obtaining a copy of the hospital medical records, and sending it to the receiving facility, within a 30-day period from the date of transfer.

(6) The transferring facility's Medical Records Department/designee is responsible to send the pertinent medical information (progress notes, physician's orders, labs, and diagnostics) to the receiving facility when the inmate is transferred.

(7) An inmate requiring temporary transfer for medical services shall be scheduled for transport on a regularly scheduled bus, unless there is a prevailing medical condition that would prohibit such.

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f. Returning an Inmate to his/her Permanent Facility After Receiving Treatment/Medical Services

Transferring Facility ⟶ Receiving Facility

(1) The transferring CHCA/designee shall contact the receiving CHCA/designee to discuss arrangements for the return of the inmate to his/her permanent facility; this shall be documented in the progress notes.

(2) The transferring facility's Medical Director/designee shall contact the receiving facility's Medical Director/designee 24 hours prior to transfer to provide a medical report of the inmate; this shall be documented in the progress notes.

(3) The transportation arrangements for the return of an inmate to the permanent facility shall be the responsibility of the permanent facility, unless otherwise arranged by the OPM.

(4) As soon as a discharge date is determined, the receiving facility's CHCA/designee shall notify the DSFM/designee so proper arrangements can be made for the return of the inmate.

g. Sending an Inmate to a Consolidated Infirmary at Another Facility

Transferring Facility ⟶ Consolidated Infirmary Facility

An inmate requiring infirmary services/housing/observation shall be transferred to another facility's Medical Department Infirmary as outlined below:[27]

(1) The contracted health care provider's Medical Director/designee shall identify an inmate requiring medical treatment that can be provided at another facility's infirmary and shall inform the CHCA/designee.

(2) The transferring CHCA/designee shall contact the receiving CHCA/designee to ascertain whether the receiving facility can manage the referral; this shall be documented in the progress notes.

(3) The transferring facility's Medical Director/designee shall contact the receiving facility's Medical Director/designee, and provide an updated medical report of the inmate, to ensure the inmate's treatment information and/or treatment plan is reviewed, and understood, in order to ensure continuation of the inmate's care.

(4) The sending and receiving facility's CHCA/designee, shall notify the appropriate staff at their respective sites regarding the outgoing/incoming transfer, so that continuity of care/services shall be maintained.

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(5) After appropriate review, approval/acceptance of the transfer, the transferring CHCA/designee shall notify the BHCS Regional QI Nurse, and designated staff, to assist with the transfer/trip management as needed.

(6) The following information shall be communicated in the notification:

(a) inmate's full name and number;

(b) effective date of transfer;

(c) reason for transfer (do not state diagnosis);

(d) facility receiving the inmate;

(e) method of transportation; and

(f) facility security transporting the inmate.

(7) The **DC-571, Consolidated Infirmary Transfer Form (Attachment 17-G)** shall be completed by both the transferring facility's nursing and Medical Records Staff/designee.

h. Returning an Inmate to his/her Permanent Facility From a Consolidated Infirmary

Consolidated Infirmary Facility ⟶ Permanent/Receiving Facility

(1) When an inmate is scheduled to be discharged back to his/her permanent facility, the treatment/transferring facility's CHCA/designee shall notify the inmate's permanent facility's CHCA/designee to ensure the inmate's treatment information and/or treatment plan is received, and understood, in order to ensure continuation of the inmate's care. This shall be documented in the progress notes.

(2) The transferring facility's Medical Director/designee shall contact the inmate's permanent (receiving) facility's Medical Director/designee, and provide an updated medical report of the inmate to ensure the inmate's treatment information and/or treatment plan is reviewed, and understood, in order to ensure continuation of the inmate's care.

(3) The transferring CHCA/designee shall notify the inmate's permanent (receiving) facility's CHCA/designee to schedule the transportation of the inmate, and return all records that were transferred with the inmate.

(4) The transferring and receiving CHCA/designee shall notify the appropriate staff at their respective sites regarding the outgoing/incoming transfer so that continuity of care/services shall be maintained.

(5) The **DC-571** shall be completed by both the transferring facility's nursing and Medical Records staff/designee.

i. Sending an Inmate to a MHU and FTC

Transferring Facility → MHU/FTC

(1) The Mental Health Coordinator (MHC), or Licensed Psychology Manager (LPM), shall identify an inmate requiring mental health commitment, and shall contact the various MHU Directors, or FTC, to determine if a bed is available.

(2) The MHC or LPM/designee shall prepare a report documenting the inmate's commitment, and provide it to the facility's records office. The MHC/designee's report shall also be immediately sent to the Licensed Psychologist Director (LPD) at Central Office, the respective MHU Director, and the OPM. The report shall contain the following information:

(a) inmate's full name and number;

(b) name of sending facility;

(c) effective date of transfer;

(d) reason for transfer;

(e) name of MHU or FTC transferred to;

(f) method of transportation;

(g) whether the mental health commitment is due to symptomology observed during the interview conducted by psychology staff for the disciplinary process; and if so

(h) the misconduct number and date.

(3) The MHC or LPM, along with the mental health staff of the facility seeking the commitment (transferring facility), shall schedule a conference call with the designated MHU/FTC to inform the receiving treatment center of the inmate's condition. If the inmate's mental illness includes significant medical problems, both the transferring and receiving site's Medical Directors/designees shall be included in the conference call.

(4) In situations where an inmate is experiencing mental distress and requires involuntary admission to a MHU/FTC, the permanent facility's medical/mental health staff shall process the inmate according to the steps outlined above.

(5) Prior to contacting the designated MHU/FTC, the facility's mental health staff and MHC or the LPM shall contact the county mental health administrator in order to assist in obtaining a court order for the commitment of the inmate.

j. Returning an Inmate to his/her Permanent Facility From a MHU/FTC

MHU/FTC → Receiving Facility

(1) When an inmate is scheduled to be discharged to his/her permanent facility, the treatment (transferring) facility's CHCA/designee shall notify the inmate's permanent (receiving) facility's CHCA/designee in order to schedule the transportation of the inmate, and to return all of the records that were transferred with the inmate.

(2) If the inmate is scheduled to be discharged from a MHU/FTC, the unit/center's staff shall schedule a conference call with the inmate's permanent (receiving) facility's mental health staff to ensure the inmate's treatment information and/or treatment plan is received, and understood, to ensure the continuation of the inmate's care. If the inmate's mental illness includes significant medical problems, both the transferring and receiving site Medical Directors/designee shall be included in the conference call.

(3) If the inmate is scheduled to be discharged from a facility's infirmary, or long term care unit, the discharging (transferring) facility's CHCA/designee shall contact the inmate's permanent (receiving) facility's CHCA/designee to ensure the inmate's treatment information and/or treatment plan is received and understood in order to ensure continuation of the inmate's care.

D. ATA Transfers and In-Transit Inmates

1. ATA

a. An ATA can vary in type and length (e.g. ATA to court [for a day], ATA to a county correctional facility, etc.)

b. A nurse at the transferring facility shall complete the **DC-487,** and a copy shall be sent with the inmate. When the inmate is sent ATA and housed with the county jail, the only information that must be sent is a copy of the **DC-487**. The original **DC-487** shall be filed in the Intake/Reception Assessments Section of the medical record.

c. The Medication Room/Pharmacy Nurse shall ensure that a minimum of five days of medication shall be sent with the inmate. Nursing shall update the eMAR by making the inmate status ATA.

d. If the five-day medication order has not been completed in advance, the practitioner shall be responsible for dispensing the medication into a labeled, sealed envelope.

e. When the inmate is sent ATA, but housed at another Department facility, the receiving facility shall have custody of the inmate. The most current volume of the medical record shall be transferred to the receiving facility.

f. Upon reception, if the receiving facility's medical staff determines that more medical record information is needed, the transferring facility's medical staff shall be contacted. The transferring facility's Medical Records Department/designee shall either send information, or forward the entire medical record to the receiving facility. The medical record may be sent by Department bus or traceable mail.

g. When an inmate returns from an ATA, the following is required:

(1) if the inmate is returning from an external correctional facility, or health care provider, medical transfer information is reviewed by nursing staff and practitioner; [28]

(2) a progress note is documented by nursing staff for the ATA return and includes the following information:

(a) reason for the return; and

(b) if the inmate has an immediate medical need, injury, or concern;

(3) the receiving facility's nursing staff shall complete the **DC-510, Suicide Risk Indicators Checklist** (see Department policy **13.8.1, Section 1, Attachment 1-F**) for all inmates returning from court;

(4) the eMAR shall be updated by nursing staff with the inmate status;

(5) medications are reviewed, updated, and ordered by a practitioner; and

(6) nursing staff shall complete the **PRAT** when an inmate returns from an outside transport during which the inmate was not in the custody of Department staff. **(28 C.F.R. §115.41[a])**

2. In-Transit Inmates

a. An In-Transit inmate is an inmate that is moved from one Department facility to another when he/she is scheduled for parole, release, or transfer to a community corrections setting. Usually, the inmate leaves the system within a day or so of arriving at the receiving Department facility.

[28] 4-4347

b. All In-Transit inmates shall receive a health screening by a health trained, or qualified health care professional on reception. The health screens shall be reviewed by the practitioner/nursing staff at subsequent receiving facilities for continuity of care.[29]

(1) Transferring Facility's Requirements

(a) The inmate shall be medically cleared by a practitioner for release and for transfer to the receiving facility.

(b) Medication shall be ordered and prepared for transfer in accordance with the **Inmate Transfer and Logistics Grid,** located in the eMAR. The Medication Room/Pharmacy Nurse shall ensure all medications, to include release medications, are prepared and sent to the receiving facility.

(c) Nursing shall ensure a **DC-481, Medical Release Summary Form** is updated/completed with the inmate within two weeks of departure, and filed in the medical record in accordance with **Section 18** of this procedures manual. A copy shall be made for the receiving facility's medical department and placed in a manila folder which identifies the inmate number and full name.[30]

(d) The manila folder(s) shall be placed in a transfer envelope labeled with the receiving facility's name, sending facility's name, inmate number(s) and inmate name(s). The Department medical record shall not be sent with these inmate movements. If the receiving facility's medical department requires information, the transferring facility's Medical Record's Department/designee can either fax/scan records as needed or transfer the most current volume of the chart to the receiving facility.

(2) Receiving Facility's Requirements

(a) A nurse shall ensure the inmate is/was medically cleared by a practitioner for release. The nurse shall document in the progress notes, the following information:

i. the type of transfer received;

ii. if the inmate was injured during the transport process;

iii. immediate clinical health care concerns;

iv. if the inmate has any suicidal ideation; and

v. if medication(s) were received.

[29] 4-4364
[30] 4-4364

(b) Any clinically indicated problems shall be referred to a practitioner as needed.

(c) Nursing shall complete the **PRAT** and update the **WebTAS** system. **(28 C.F.R. §115.41)**

(d) The Medication Room/Pharmacy Nurse shall maintain and verify the medication(s).

(e) Medical documentation shall be maintained in the manila folder specific to the inmate. When the inmate is released, the Medical Records Department shall ensure the manila folder(s) are returned to the Medical Records Department at the Department facility that originally transferred the inmate. That facility will file any original documentation received into the medical record.

(f) When the inmate is paroled or released, nursing staff shall ensure the **DC-481** is current and updated accordingly as a result of any changes. The inmate shall be provided a copy of the **DC-481,** and medications at release, in accordance with **Section 18** of this procedures manual.

E. Medical/Psychiatric Holds

1. Medical/psychiatric holds may include, but are not limited to:

   a. completion of Tuberculosis (TB) screening to determine that the inmate is free of active TB disease;

   b. a suspected diagnosis which should be resolved or identified;

   c. the presence of acute or unresolved infection;

   d. a clinical work-up indicating the need for immediate surgery at the current location;

   e. post-surgery until released from care;

   f. a determination by the practitioner that the inmate is not physically able to travel;

   g. medical isolation;

   h. serious accident/overdose within 24 hours;

   i. presence of an acute psychotic episode, or evidence of clinical signs/symptoms, of major psychiatric disorder; or

   j. dental emergencies as defined in **Section 4** of this procedures manual.

2. Initiating and Monitoring a Medical/Psychiatric Hold

   a. An inmate identified as being eligible for transfer (new receptions, parole violators, Community Corrections Center [CCC] returns, etc.) and having an unstable, uncontrolled, or acute medical/psychiatric condition, shall have a medical/psychiatric hold initiated. The practitioner shall order the hold on the Physician's Order Sheet and document the following in the progress notes:

      (1) the reason for the hold, and the prescribed treatment plan; and

      (2) any observations concerning the inmate's hold status.

   b. A nurse shall transcribe the order from the practitioner, document, and complete the Medical/Psychiatric Hold section of the **DC-482, Medical/Psychiatric Hold Form (Attachment 17-H)**, and update the patient demographics in the EHR.

   c. The original **DC-482** shall be inserted into the medical record above the Problem List.

   d. When a medical/psychiatric hold is initiated, the Medical Records Department/designee shall immediately notify the facility's Inmate Records Office.

   e. An inmate's hold status shall be re-evaluated by a practitioner upon the expiration date and at least every ten working days thereafter if the hold is continued.

   f. The CHCA/designee, and the Medical Director/designee shall conduct a bi-weekly review of every inmate in "Medical Hold" status to ensure that the inmate's needs are being addressed, and so the inmate can be cleared for transfer as soon as possible.

3. Discontinuing a Medical/Psychiatric Hold

   a. Only a practitioner may discontinue a hold and/or clear an inmate for transfer. The following is required:

      (1) an order shall be documented on the Physician's Order Sheet to discontinue the hold and/or clear the inmate for transfer; and

      (2) complete a progress note addressing continuity of care and treatment for the inmate.

   b. A nurse shall transcribe the order, complete the Hold Discontinued and Inmate Cleared for Transfer section of the **DC-482,** and update the patient demographics in the EHR.

   c. Upon discontinuation of the hold, the **DC-482** shall be maintained in the Miscellaneous Section of the inmate's medical record.

d. When a medical/psychiatric hold is discontinued, the Medical Records Department/designee shall immediately notify the facility's Inmate Records Office.

Section 18 – Health Care Release Planning and Reentry

A. General

The Corrections Health Care Administrator (CHCA)/designee shall be notified when an inmate is scheduled for a Community Corrections Center (CCC) placement, parole, or sentence complete in order to obtain medical clearance for transfer.

B. Responsibilities

1. The CHCA/designee shall ensure that the **DC-481, Medical Release Summary (Attachment 18-A)** is updated two weeks prior to the actual release or transfer, and forwarded as part of the **DC-13A, Reclassification Summary**.[1]

   a. The **DC-481** shall be completed by nursing staff (Registered Nurse [RN] or Licensed Practical Nurse [LPN]). Non-medical personnel at the CCC, parole staff, and inmates shall use this form, therefore, medical terms shall be simplified, and abbreviations not used, in order to provide a clear understanding for non-medical users.

   b. Once the **DC-481** has been completed, a RN shall schedule/call the inmate up to the Medical Department to review the information with the inmate, and to assess the inmate for any recent health/medical issues. The RN shall schedule the inmate to see a practitioner if a change in the inmate's health/medical status has been noted. This shall be documented as a progress note. A change in the inmate's health/medical status could include, but is not limited to, the following:

      (1) acute medical problem(s);

      (2) recent hospitalization/surgery;

      (3) open consults;

      (4) recent (within the past three months) infirmary/Psychiatric Observation Cell (POC) admission; and

      (5) is actively receiving a treatment(s) (active Treatment Administration Record [TAR]).

   c. If there are no noted, recent health/medical issues, and upon information review, the inmate shall sign and date the form, acknowledging its completion. After the inmate has signed the **DC-481**, the RN shall affix his/her signature, title, and date that the **DC-481** was completed.

[1] 4-4446

d. When any HIV/AIDS information has been written on the **DC-481**, a **DC-108, Authorization for Release of Information** form must be completed and signed by the inmate in accordance with Department policy **DC-ADM 003, "Release of Information."**

e. The original copy of the **DC-481** shall be inserted under the Release Planning or Miscellaneous tab of the medical records. Copies shall be distributed to the appropriate personnel and given to the inmate.

f. For every inmate discharged to the CCC, the CHCA/designee shall ensure that the completed **DC-481** is sent to the Bureau of Community Corrections (BCC) prior to the inmate being released.

g. In accordance with the Inmate Transfer Logistics Grid, located in the electronic Medication Administration Record (eMAR), the CHCA/designee shall also ensure that an inmate receives his/her prescription medication.

Section 19 – Diagnosis and Treatment of Gender Dysphoria

This section establishes procedures to appropriately diagnose, treat, and manage inmates with Gender Dysphoria (GD) consistent with the core values and mission of the Pennsylvania Department of Corrections, and its commitment to provide adequate medical care and mental health services to all inmates in its custody.

A. Department Responsibilities

1. The Department Chief Psychiatrist shall have overall responsibility for the mental health diagnosis and treatment of inmates diagnosed with GD.[1]

2. The Department Chief of Clinical Services shall have overall responsibility for the medical treatment of inmates diagnosed with GD.[2]

3. The GD Treatment Review Committee, which shall include, at a minimum:

   a. Chief Psychiatrist;

   b. Chief of Clinical Services;

   c. Licensed Psychologist Director;

   d. contracted vendor State Chief Psychiatrist;

   e. contracted vendor State Medical Director; and

   f. external expert in transgender health care (provided by the Department).

4. The GD Treatment Review Committee shall:

   a. establish, periodically review, and revise Department policy, as necessary;

   b. review and approve each Individual Recovery Plan (IRP);

   c. assist the sites, if requested, with the diagnosis, treatment, and management of challenging cases;

   d. obtain consultation with subject matter experts outside the Department, as needed; and

   e. review all cases for gender confirmation surgery (GCS).

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[1] 4-4381
[2] 4-4381

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B. Diagnosis of GD

1. GD is a condition formally recognized and described by the American Psychiatric Association in the current version of the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition, (DSM-5), APA 2013.

2. The DSM-5 provides diagnostic criteria to consider when evaluating for the presence of this condition.

3. There are two required criteria that must be present for the diagnosis of GD:

   a. the finding of "a marked incongruence between one's experience/expressed gender and assigned gender, of at least six months duration…" (DSM-5, p. 452); and

   b. that "the condition is associated with clinically significant distress or impairment in social, school (for children)/occupational (for adults), or other important areas of functioning" (DSM-5, p. 452). It will be the primary responsibility of the Site Psychiatrist to establish this diagnosis.

C. Training

1. It shall be the responsibility of the contracted medical vendor to train its practitioners.

2. It shall be the responsibility of the contracted mental health vendor to train the mental health staff (psychiatrists, psychiatric certified registered nurse practitioners [PCRNPs], licensed psychologist managers [LPMs], licensed psychologists [LPs], psychological services specialists [PSSs], psychological services associates [PSAs], and social workers) who shall be involved in the diagnosis and treatment of transgender patients.

3. The training shall be specific to the evaluation, treatment, and management of patients with GD, and may involve professional meetings, group seminars, or individual presentations by experts in the field.

4. Refresher training shall be provided on a yearly basis.

5. The training must be pre-approved by the Department Chief Psychiatrist, or the Department Chief of Clinical Services, as appropriate.

6. The respective medical/mental health contracted vendors shall provide an annual training report to the Bureau of Health Care Services (BHCS).

D. Guidelines

1. The latest version of *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming people*, published by the World Professional Association for Transgender Health (WPATH), will serve as guidelines for the overall health care of identified inmates.

2. *UpToDate* will serve as guidelines for the specific medical treatment of inmates who require hormone therapy. *UpToDate* is a proprietary online software program that is nationally recognized for providing evidence-based and peer-reviewed medical information.

3. All practitioners shall have a current subscription to this online program (or a similar one approved by the BHCS), which is updated at least every six months.

E. Consulting Sub-Specialists

1. With prior approval by the BHCS, it shall be the responsibility of both the contracted medical vendor and mental health vendor, to identify a sub-specialist in their respective field who has current experience in the treatment of transgender patients.

2. These sub-specialists shall be available to consult regarding:

   a. writing and updating Department policy;

   b. the diagnosis, treatment, and ongoing management of challenging cases; and

   c. gender confirmation surgery.

F. Medical Intake

1. In accordance with Department policy, "**DC-ADM 008, Prison Rape Elimination Act (PREA),"** the **PREA Risk Assessment Tool (PRAT**) shall be administered to all inmates during intake and shall be the main initial identifier of transgender patients. **(28 C.F.R. §115.41)**

2. If an inmate identifies as "transgender," a **DC-97, Mental Health Referral Form,** shall be initiated and forwarded to the Psychology Department.

G. Department Mental Health Team

1. The Department Mental Health Team at the site level shall consist of:

   a. LPM;

b. LP;

c. PSS;

d. PSA; and

e. social worker.

2. A member of the Department mental health team shall review the **DC-97**, and complete a psychological evaluation for those inmates on their caseload in accordance with Department policy **13.8.1, "Access to Mental Health Care," Section 1**.

3. The psychology staff member completing this assessment shall attempt to retrieve any prior psychological and psychiatric treatment records utilizing the **DC-108, Authorization for Release of Information.**[3] These records should include treatment prior to incarceration (i.e. completed or currently prescribed hormone therapy, surgical interventions, and ongoing counseling).

4. The comprehensive evaluation shall be in accordance with Department policy **13.8.1, Section 1**. This comprehensive evaluation shall be completed within 30 days of receiving the **DC-97**.

5. If the evaluation was completed by a PSS, the report shall be reviewed and approved by the LPM/LP.

6. This initial psychological evaluation need only be completed once, unless new and relevant information is revealed to be included in an addendum or appropriate updated psychological evaluation.

7. If the inmate presents with any mental health symptoms related to being transgender or requests to see a psychiatrist, a **DC-97**, shall be completed and forwarded to the Site Psychiatrist for evaluation and diagnosis.

8. If the inmate has no apparent mental health symptoms related to being a transgender inmate, the inmate will be scheduled to be seen by the Psychiatric Review Team (PRT) to determine mental health roster placement, if appropriate, and the process of accessing mental health services in the future shall be explained. Areas to discuss within the PRT for transgender inmates will include, but not be limited to:

   a. helping the inmate live more comfortably within a gender identity and to deal effectively with non-gender issues;

[3] 4-4099

b. emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin;

c. seeking to define and address issues which may have undermined a stable lifestyle, such as substance abuse and/or criminality; and

d. addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may co-occur with GD and any effective treatment plan will fully address these symptoms, if present.

9. If the Site Psychiatrist determines the inmate is currently diagnosed with GD, the psychology team shall collaborate with the Site Psychiatrist to implement the IRP, as appropriate[4], and placement on the appropriate mental health roster.

10. The Department's mental health team is also available to provide supportive treatment services for inmates who are transgender or GD, if necessary.

11. Supportive individual psychotherapy goals for inmates with GD might include, but are not limited to:

    a. helping the individual live more comfortably within a gender identity and to deal effectively with non-gender issues;

    b. emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin;

    c. seeking to define and address issues which may have undermined a stable lifestyle, such as substance abuse and/or criminality; and

    d. addressing any co-occurring mental health issues. Mood disorders, anxiety disorders, substance use disorders, and personality disorders, etc., may co-occur with GD and any effective treatment plan will fully address these symptoms, if present.

12. If an institution has multiple individuals with GD, group psychotherapy facilitated by a Department mental health team member may also be a component of the treatment plan. Common concerns of individuals with GD, which may be addressed effectively in a group setting, include self-esteem issues and relationship issues.

13. Department mental health team members who provide mental health treatment for GD should maintain their professional set concerning suicide/crisis intervention skills and the ability to identify differential mental health diagnoses, and should

[4] 4-4350

further develop, if necessary, a capacity to promote awareness of GD needs and issues, and an overall understanding of basic gender and gender identity concerns.

H. Site Medical Director

1. The Site Medical Director/Acting Medical Director shall obtain a **DC-108, Authorization for Release of Information**,[5] from the inmate if he or she was receiving medical treatment prior to incarceration.

2. If there is documentation that the inmate was legally prescribed hormonal medications prior to incarceration, the Site Medical Director shall evaluate the inmate and the medications prescribed, in order to determine appropriateness to continue, based on established clinical guidelines. If there are no contraindications, the Site Medical Director shall re-order the medications. The evaluation shall be documented as a progress note.

3. If the inmate reports taking hormonal medications, but there is **NO** documentation that these were legally prescribed, the Site Medical Director shall evaluate the inmate and the medication(s) reported in order to determine appropriateness, based on established clinical guidelines. If there are no medical contraindications, the Site Medical Director shall re-order the medications for a maximum of 30 days while the diagnosis is being confirmed.

   If the Site Psychiatrist establishes the diagnosis of “Gender Dysphoria” and the IRP includes cross-gender hormone therapy, the inmate is to be referred back to the Site Medical Director for evaluation and treatment considerations.

4. If the diagnosis of GD is not confirmed, the inmate will be followed on site according to procedures outlined in **Subsection G.8. above**.

5. The Site Medical Director shall utilize *UpToDate* (or alternate source of medical information approved by the BHCS) for clinical guidance in selecting medications and dosages.

6. Prior to the ordering of any medications, the inmate will be required to sign either a **DC-572, Informed Consent for Feminizing Hormone Therapy (Attachment 19-A)** or a **DC-572A, Informed Consent for Masculinizing Hormone Therapy (Attachment 19-B).**[6]

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[5] 4-4099
[6] 4-4397

I. Site Psychiatrist

1. A psychiatric evaluation shall be completed by the Site Psychiatrist to determine if the inmate meets DSM-5 criteria for GD. The Site Psychiatrist has the option of providing a "Provisional" diagnosis of GD pending evaluation of outside medical records and scheduling follow-up evaluations.

2. The evaluation shall include an assessment of the inmate's ability to remain safe and function appropriately in the prison setting including any specific barriers related to the diagnosis of GD; recommendations shall be made for ongoing supportive psychotherapy. Recommendations shall be made regarding Hormone Therapy.

3. Once the diagnosis of GD is established, the Site Psychologist, in conjunction with the Site Psychiatrist, shall develop an IRP. If this plan includes hormone therapy, the inmate shall be referred to the Site Medical Director for evaluation and treatment.[7]

J. Corrections Health Care Administrator (CHCA)

The CHCA shall compile these three evaluations (Psychology, Psychiatry, and Medical) as a packet and send them to the following BHCS email resource account: CR, BHCS GEN DYS.

K. Gender Dysphoria Treatment Review Committee

1. A vote sheet, **DC-542, Gender Dysphoria Individual Recovery Plan Approval Form (Attachment 19-C)**, shall be circulated among staff members of the GD Treatment Review Committee for approval.

2. If there is not unanimous approval of the IRP, a teleconference meeting of the GD Treatment Review Committee shall be scheduled and the Department Chief Psychiatrist shall make the final determination whether or not to approve the IRP.

3. After review, the IRP shall be returned to the CHCA as either approved, or with recommendations.

L. Currently Incarcerated Inmates

1. At any time during incarceration, an inmate may reveal that he or she is transgender and exhibiting various mental health symptoms; this initial identification may include the **PRAT**, which shall be completed on all inmate transfers. **(28 C.F.R. §115.41[a])**

[7] 4-4350

2. Any staff member can refer this inmate to the Psychology Department by submitting a **DC-97**, for the initial evaluation and follow up; the internal procedures listed in **Subsection E. above,** shall then be followed.

3. The Site Psychiatrist shall use DSM-5 criteria in order to make the diagnosis of GD.

4. The Site Psychiatrist shall develop an IRP[8].

5. If the IRP includes hormone therapy, the inmate shall be referred to the Site Medical Director for evaluation and treatment.

6. Once completed, the CHCA shall forward the packet to the BHCS for review by members of the GD Treatment Review Committee.

M. Follow Up

1. If the diagnosis of GD is established, the inmate shall be placed on the C Roster, at a minimum, for mental health tracking.

2. On the C Roster, the inmate shall be scheduled to see the Site Psychiatrist every 90 days, and the LPM/LP/PSS every 30 days, or more frequently if clinically indicated.

3. If medications are prescribed, the inmate shall be followed up monthly by the Site Medical Director for three months, and then placed into a Chronic Care Clinic, and scheduled, at a minimum, every six months for an evaluation by the Medical Director/designee.[9]

N. Gender Confirmation Surgery (GCS)

1. Any case involving failure of hormone therapy to alleviate symptoms of dysphoria, or an inmate's requesting GCS shall immediately be referred to the GD Treatment Review Committee for review.

2. Decisions regarding GCS shall be made on a case-by-case basis, and a two-step process shall be utilized[10]:

   a. As detailed in **Subsection I. above**, the GD Treatment Review Committee shall evaluate clinical information provided by the site, circulate the **DC-542**, and render a decision:

[8] 4-4350
[9] 4-4359
[10] 4-4398

(1) if referral to an offsite specialist to evaluate the inmate is not recommended, the decision (with an alternate treatment plan) shall be returned to the site and discussed with the inmate; and

(2) if referral to an offsite specialist to evaluate the inmate is recommended, the Committee shall notify the contracted medical vendor to schedule the appointment.

b. The GD Treatment Review Committee shall review the consultant's recommendations:

(1) if GCS is not recommended by the specialist, the inmate shall be notified;

(2) if GCS is recommended by the specialist, the Committee shall refer the case to the larger Department Central Office Gender Review Committee (GRC), which has overall responsibility to consider on a case-by-case basis the needs of the transgender inmate population.[11] The GRC shall have final approval regarding GCS for any transgender inmates; and

(3) if the inmate disagrees with disapprovals by either the GD Treatment Review Committee, or the Central Office GRC, he or she may file a grievance in accordance with Department policy **DC-ADM 804, "Inmate Grievance System."**[12]

O. Resources

Please review **Diagnosis and Treatment of Gender Dysphoria Resources (Attachment 19-D),** for information contained in this procedures manual.

[11] 4-4381
[12] 4-4394

BULLETIN
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject: **Access to Health Care Procedures Manual Section 20 – Hepatitis C Protocol**		
Policy Number: **13.02.01, Section 20-01**		
Original Issue Date: **May 7, 2019**		
Date of Issue: **October 7, 2019**	**Authority:** **Signature on File** **John E. Wetzel**	**Effective Date:** **October 14, 2019**

The purpose of this bulletin is to update **Subsection E**. **Evaluation for Treatment with Anti-Viral Medication, 5.d.** with removal of the language for the inmate to "have been in the DOC at least six months and."

Subsection E.5.d. shall now read:

E. Evaluation for Treatment with Anti-Viral Medication

5. Other Criteria for Treatment: In addition to meeting the above criteria for Priority 1-3, inmates being considered for treatment of HCV infection should:

   d. ***have at least 20 weeks until expected release. Inmates with Priority Level 1 criteria who are outside these parameters may be considered on an individual basis;***

Section 20 – Hepatitis C Protocol

A. *Background*

1. This Hepatitis C Protocol for the Pennsylvania Department of Corrections (PA DOC) provides clinical guidelines for the diagnosis, management, and treatment of inmate patients with chronic Hepatitis C Virus (HCV).[1]

2. Introduction

   a. HCV is a slowly progressive disease, usually requiring decades to progress to cirrhosis; however, the natural history of HCV is variable and not all patients with chronic HCV will develop cirrhosis during their lifetime. Of every 100 persons infected with HCV, approximately: 15-25 will clear the virus from their body and be naturally cured with no risk of future liver disease; 75-85 will develop chronic infection; 60-70 with chronic infection will develop chronic liver disease; 5-20 with chronic infection will develop cirrhosis of the liver over a period of 20-30 years; and 1-5 will die from the consequences of chronic infection, such as end-stage cirrhosis or liver cancer (for content references, please see **Subsection *H*.1. below**).

   b. The goal of Hepatitis C anti-viral treatment is to achieve a sustained virological response (SVR), defined as undetectable HCV virus in the blood, 12 or more weeks after completing anti-viral treatment.

B. Screening

1. All new intakes will be screened at their home institutions utilizing the Hepatitis C Antibody test.[2] Anyone may refuse testing by signing a **DC-462, Release from Responsibility for Medical Treatment Form.**

2. The Infection Control Nurse (ICN) will review positive antibody results with all inmates, whether it be at intake or later during incarceration. The Medical Director/designee will order a confirmatory Hepatitis C Ribonucleic Acid (RNA) Quantitative Polymerase Chain Reaction (PCR) test (viral load).[3] Recommended immunizations ***(Hepatitis A and B)***, counseling/***education regarding this disease***, and literature ***explaining transmission of Hepatitis C*** will be provided during that encounter. ***The patient will be placed on the annual Influenza vaccination list maintained by the ICN.***

3. Inmate patients with documented (+) Hepatitis C Antibody test should not be retested, but entered into tracking.

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[1] 5-6A-4350, 5-6A-4356, 5-6A-4359
[2] 5-6A-4359
[3] 5-6A-4359

4. Inmate patients who have a documented undetectable Hepatitis C Quantitative PCR may become re-infected while out on parole. If they return to the PA DOC, the Medical Director/designee shall order a repeat viral load on intake.

C. Tracking

For all patients with a positive HCV antibody test, the ICN will maintain a current **Hepatitis C Tracking Spreadsheet (Attachment 20-A)** in Excel format. This spreadsheet will be forwarded to the Bureau of Health Care Services (BHCS) Infection Control Coordinator (ICC) on a monthly basis.

D. Chronic Care Clinic[4]

1. All patients who have chronic Hepatitis C (confirmed by a detectable viral load) will be entered into the Liver Disease Chronic Care Clinic. ***Initial screening will utilize the APRI (AST [Aspartate Aminotransferase] to Platelet Ratio Index)***. The ICN will confer with the Site Medical Director to determine if the patient's diagnosis is:

   a. F0-F2 (no fibrosis, mild fibrosis, or moderate fibrosis). ***APRI < 1.5 unless otherwise documented***;

   b. F3 (advanced fibrosis). ***APRI 1.5-2.0 unless otherwise documented***; ***and/or***

   c. F4 (cirrhosis). ***APRI > 2.0 unless otherwise documented***.

2. Patients who are antibody positive only (confirmed by an undetectable viral load) do not have chronic Hepatitis C and will be followed in Chronic Care Clinic at the discretion of the Site Medical Director, if the patient exhibits signs or symptoms of liver disease. Patients who have been treated with medication will continue to be followed in Chronic Care Clinic, whether or not they achieved an SVR.

3. At a minimum, the following will be documented in a Progress Note during the Chronic Care Clinic encounter:

   a. Subjective:

      (1) symptoms of cirrhosis or liver failure;

      (2) history of ascites, encephalopathy, or esophageal varices (bleeding or not);

      (3) estimated date of contracting the disease; and

      (4) any recent admissions to the Infirmary, emergency room (ER), or hospital.

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b. Objective:

(1) vital signs, weight, and Body Mass Index (BMI);

(2) examination of the sclera for jaundice;

(3) examination of the abdomen, including both ascites and the size and character of either hepatomegaly or splenomegaly;

(4) examination of the skin for changes suggestive of cirrhosis (jaundice, spider angiomata/telangiectasia, palmar erythema, and caput medusae);

(5) examination of the neurological system for the presence of asterixis ("liver flap");

(6) fibrosis stage, if known, and method used to determine the fibrosis stage (e.g. liver biopsy or elastography);

(7) calculation of the APRI, using the calculator located in the Resource Section of the electronic health record;

(8) calculation of the Model of End Stage Liver Disease (MELD) score and the (Child-Turcotte-Pugh) CTP score for patients with cirrhosis, using the calculator located in the Resource Section of the electronic health record;

(9) review of any results of the esophagogastroduodenoscopy (EGD), elastography, or abdominal ultrasound; and

(10) examination of pertinent laboratory results.

c. Assessment:

(1) F0-F2 (no fibrosis, mild fibrosis, or moderate fibrosis);

(2) F3 (advanced fibrosis); or

(3) F4 (cirrhosis).

d. Plan of Treatment:[5]

(1) schedule the follow-up Clinic appointment according to the assessment:

(a) F0-F2 (six months);

(b) F3 (three months); or

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(c) F4 (one month).

(2) diagnostics ordered will include the following:

(a) initial Chronic Care Clinic for all patients: Comprehensive Metabolic Profile (CMP), Complete Blood Count (CBC), Chronic Hepatitis Panel, and Prothrombin Time (PT)/International Normalized Ratio (INR);

(b) yearly labs for all patients: CMP, CBC, and PT/INR. Quantitative PCR (viral load) for those who have completed treatment;

(c) every six month labs for patients with cirrhosis (F4): CMP, CBC, PT/INR, and abdominal ultrasound to evaluate for Hepatocellular Carcinoma (HCC);

(d) every six month labs for patients without cirrhosis (F0-F3): Liver Function Tests (LFTs) and CBC; and

(e) monthly visits for patients with cirrhosis (F4): No labs required.

(3) ***education regarding the natural progression of this disease, transmission of Hepatitis C, and the importance of immunizations and annual Influenza vaccination.***

e. ***Additional Interventions for Inmates with Cirrhosis: (for content reference, please see Subsection H.2. below)***

(1) ***pneumococcal vaccine: Offer to all HCV-infected inmates with cirrhosis who are 19 through 64 years of age;***

(2) ***HCC screening: Liver ultrasound is recommended every six months for patients with cirrhosis (F4) or advanced fibrosis (F3);***

(3) ***esophageal varices screening: Screening for esophageal and gastric varices with EGD is recommended for patients diagnosed with cirrhosis;***

(4) ***other health care interventions recommended for patients with cirrhosis may include:***

(a) ***non-selective beta blockers for prevention of variceal bleeding in patients with esophageal varices;***

(b) ***antibiotic prophylaxis if risk factors are present for spontaneous bacterial peritonitis;***

(c) ***optimized diuretic therapy for ascites; and***

(d) ***lactulose and rifaximin therapy for encephalopathy.***

4. ***In general, Non-Steroidal Anti-Inflammatory Drugs (NSAID) should be avoided in advanced liver disease/cirrhosis, and metformin should be avoided in decompensated cirrhosis. The detailed management of cirrhosis is beyond the scope of these guidelines. Other resources should be consulted for more specific recommendations related to this condition.***

E. Evaluation for Treatment with Anti-Viral Medication[6]

1. The PA DOC will utilize the Federal Bureau of Prisons (FBOP) Priority Criteria as listed in the "Evaluation and Management of Chronic Hepatitis C Virus (HCV) Infection Clinical Practice Guidelines, ***January 2018***." (please refer to **Subsection *H*.2. below**)

2. Determining whether PA DOC priority criteria for treatment are met is an important part of the initial evaluation and ongoing management of inmates with chronic HCV infection. Although all patients with chronic HCV infection may benefit from treatment, certain cases are at higher risk for complications or disease progression and require more urgent consideration for treatment.

3. The PA DOC will use Fibrosure to determine fibrosis scoring for patients without a diagnosis of cirrhosis who have an APRI > ***0.7*** or select patients as clinically indicated.

4. The DOC has established priority criteria to ensure that those with the greatest need are identified and treated first (for content reference, please see **Subsection *H*.2. below**). The DOC Chief of Clinical Services will provide periodic guidance on specific strategies for implementing these priority levels:

   a. Priority Level 1 – High Priority for Treatment

      (1) Advanced hepatic fibrosis:

         (a) APRI > 2.0;

         (b) Metavir or Batts/Ludwig stage 3 or 4 on liver biopsy, Elastography, or Fibrosure; or

         (c) known or suspected cirrhosis.

      (2) Liver Transplant Recipients

      (3) HCC

      (4) Comorbid Medical Conditions Associated with HCV, including:

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(a) Cryoglobulinemia with renal disease or vasculitis;

(b) certain types of lymphomas or hematologic malignancies; and/or

(c) Porphyria cutanea tarda.

(5) Immunosuppressant Medication for a Comorbid Medical Condition

For example, certain chemotherapy agents and tumor necrosis factor inhibitors. Such cases will be considered for prioritized treatment on an individual basis.

(6) Continuity of Care for those already started on treatment, including inmates who are newly incarcerated in the PA DOC.

b. Priority Level 2 – Intermediate Priority for Treatment

(1) Evidence of progressive fibrosis.

(a) APRI > 0.7.

(b) Stage 2 fibrosis on liver biopsy, Elastography, or Fibrosure.

(2) Comorbid medical conditions associated with more rapid progression of fibrosis.

(a) Coinfection with Hepatitis B Virus (HBV) or Human Immunodeficiency Virus (HIV).

(b) Comorbid liver disease (e.g., autoimmune hepatitis, hemochromatosis, steatohepatitis).

(c) Diabetes Mellitus.

(3) Chronic Kidney Disease (CKD) with Glomerular Filtration Rate (GFR) < 59 mL/min per 1.73 m squared.

c. Priority Level 3 – Low Priority for Treatment

(1) Stage 0 to stage 1 fibrosis on liver biopsy, Elastography, or Fibrosure.

(2) APRI < 0.7.

(3) All other cases of HCV infection meeting criteria for treatment, as noted below under Other Criteria for Treatment.

5. Other Criteria for Treatment: In addition to meeting the above criteria for Priority 1–3, inmates being considered for treatment of HCV infection should:

a. have no significant or unstable medical conditions, to include, but not limited to, cardiopulmonary, cancer, and diabetes;

b. have no contraindications to, or significant drug interactions with, any component of the treatment regimen;

c. not be pregnant, especially for any regimen that would require ribavirin or interferon;

d. ~~have been in the DOC at least six months and~~ have at least ***20 weeks*** until expected release. Inmates with Priority Level 1 criteria who are outside these parameters may be considered on an individual basis;

e. have a life expectancy > ***12*** months;

f. demonstrate a willingness and an ability to adhere to a rigorous treatment regimen. Inmates with a history of non-compliance may be offered a one month trial of taking a multi-vitamin daily under direct observation. If successful, they may be considered for treatment on an individual basis; and

g. demonstrate a willingness and an ability to abstain from high-risk activities while incarcerated. Inmates with evidence for ongoing high-risk behavior, e.g. misconducts for illicit drug use or tattoos, will be considered for treatment on an individual basis. Referral for evaluation and treatment of substance abuse is required.

6. The first level of screening patients for treatment with anti-viral medications will occur at the patient's home site, ***during Chronic Care Clinics***. The review will be conducted utilizing the **Hepatitis C Treatment Referral Form** ***in the electronic health record*** and will be conducted by the Corrections Health Care Administrator (CHCA), ICN, and Site Medical Director, who will look for the presence of any exclusionary indications listed above.

7. If the CHCA determines that there are no exclusionary indications to anti-viral treatment ***(see Subsection E.4. above)***, ***and the APRI > 0.7***, a Fibrosure test needs to be ordered ***by on-site providers***. If the Fibrosure test indicates F-2, F-3, or F-4***,*** the **Hepatitis C Treatment Referral Form** shall be forwarded to the BHCS ICC for further evaluation, possible recommendations for further testing, and initial determination. ***All patients who are co-infected with HIV or Hepatitis B, or who have co-morbidities listed in Subsection E.4. above, or who have previously failed treatment for Hepatitis C, will also be forwarded to the BHCS ICC.***

8. ***If the APRI < 0.7 and the patients meet the criteria above for Priority Level 3, or if the Fibrosure indicates F0 or F1, the Hepatitis C Treatment Referral Form will be returned to the ICN for coordination of treatment on-site. This on-site treatment will be ordered by the medical vendor providers (physician, physician assistant, or***

nurse practitioner) trained in the prescribing of Direct Acting Antiviral medication for patients with minimal or no fibrosis. If a particular case is complicated, it can be forwarded to BHCS for appropriate referral.

F. Bureau of Health Care Services Review[7]

1. The BHCS will use the Fibrosure score ***if available*** as its main determinant of fibrosis to be used within the FBOP prioritization levels as outlined in **Subsection *E*.4. above**.

   a. Fibrosis Stage 0-1

      (1) ***If the patient meets all criteria for Priority Level 3, refer the case to the site ICN to coordinate on-site treatment.*** Repeat Fibrosure in one year ***if not yet treated***.

      (2) Follow in Chronic Care Clinic every six months.

   b. Fibrosis Stage 2

      (1) Refer to Temple University for final review and the ordering of Direct Acting Antivirals (DAA) medications unless there are contraindications.

      (2) Follow in Chronic Care Clinic every six months.

   c. Fibrosis Stage 3

      (1) Refer to Temple University for final review and the ordering of DAA medications unless there are contraindications.

      (2) Order full ultrasound screening for HCC every six months.

      (3) Follow in Chronic Care Clinic every three months.

   d. Fibrosis Stage 4

      (1) Order full ultrasound screening for HCC every six months.

      (2) Order baseline EGD for esophageal varices surveillance.

      (3) Refer to Temple University for final review and the ordering of DAA medications unless there are contraindications.

      (4) Follow in Chronic Care Clinic every month.

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2. The Chief of Clinical Services will render a decision and forward the determination, along with follow-up recommendations for those not meeting current priority criteria for greatest need of treatment with anti-viral medications, to the ICN and Site Medical Director, who will then discuss the results with the patient and document the encounter in the **DC-472, Progress Notes**.[8]

3. If the Chief of Clinical Services recommends treatment with anti-viral medication, the ***BHCS ICC*** will refer the patient to Temple University who will direct the anti-viral treatment. The referral will be made utilizing a **Hepatitis C Treatment Referral Form**, to include the following updated laboratory results:

   a. genotype, no time limit if completed during this incarceration; otherwise, one year;

   b. viral load (within ***six*** months);

   c. HIV (within one year);

   d. CMP (within one month);

   e. CBC (within one month);

   f. abdominal sonogram for patients with ***F3 or F4*** (within six months); and

   g. the treatment of HCV with anti-viral medications is rapidly evolving. New medications are being approved by the Federal Drug Administration (FDA) frequently. The regimens currently approved by PA DOC will be included in the Diamond Pharmacy Services Formulary for this contract. The Formulary will include all necessary prescribing information and will be updated quarterly via the PA DOC Pharmacy and Therapeutics Committee.

G. American Correctional Association (ACA) Accreditation

As part of the audit for ACA accreditation, each site is required to submit data representing Outcome Measures. This information is available on the **Hepatitis C Tracking Spreadsheet** and includes all inmates who are diagnosed with chronic Hepatitis C infection at a given point in time. ACA recommends selecting June as the midpoint of a calendar year.

1. Include all inmates within the facility with a current laboratory test indicative of Hepatitis C viral infection whether or not they have received antiviral treatment.

2. Exclude inmates diagnosed with chronic Hepatitis C infection, but housed in another correctional system, community-based facility, or home detention.

3. Exclude inmates with suspected acute Hepatitis C viral infection who are currently under evaluation for clearance of their infections (in other words, viremia).

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H. References

1. Centers for Disease Control and Prevention. "Hepatitis C FAQs for health professionals," accessed ***February 12, 2019***, at www.cdc.gov/hepatitis/hcv/hcvfaq.htm.

2. Federal Bureau of Prisons, January 2018, "Evaluation and Management of Chronic Hepatitis C Virus (HCV) Infection," accessed ***February 12, 2019***, at https://www.bop.gov/resources/pdfs/012018_hcv_infection.pdf.

3. AASLD and IDSA, "Recommendations for Testing, Managing, and Treating Hepatitis C," accessed ***February 12, 2019***, at http://www.hcvguidelines.org.

Abutment Tooth - A tooth that may be bordering a space where one or more teeth are missing and/or is supporting or is treatment planned to support a dental prosthesis.

Access to Dental Care - Access to emergency dental care is available 24 hours a day via a sick call system. All inmates, including those who are segregated for pre-disciplinary, disciplinary, or investigative reasons, have daily access to health care and record review.

Acquired Immunodeficiency Syndrome (AIDS) - A disease of a severely impaired immune system as a result of HIV infection. Because the body's ability to fight disease is decreased, unusual infections and forms of cancer occur. Theses are known as opportunistic infections.

ACT 84/Senate Bill 640 - An act passed by the state legislature that allows for a reciprocal exchange of medical and psychological information on inmates between the Department and county prisons.

Active List - A list of inmates currently on the institution roster who have been determined to be in need of treatment and have not signed a **DC-462** in which case the inmate would be considered inactive for the refused treatment only.

Active Tuberculosis - Used interchangeably with Tuberculosis Disease (See Below).

Adjustment - A procedure involving a dental prostheses in which small modifications are made to improve fit, comfort, retention, appearance, etc.

Administrative Custody (AC) - A status of confinement for non-disciplinary reasons, which provides closer supervision, control, and protection than is provided for in general population.

Advance Directive - A document in which a patient states choices for medical treatment and/or designates a surrogate to make treatment choices if the patient loses decision-making capacity.

Advanced Cardiac Life Support (ACLS) - Emergency lifesaving procedures to attempt to restore spontaneous circulation using basic CPR plus advanced airway management, endotracheal intubation, defibrillation, and intravenous medications.

Airborne Precautions - The use of a particulate mask (N-95 or HEPA) and negative air pressure rooms to reduce the risk of airborne transmission of infectious agents that are two to five microns in size (Measles; Varicella, or Tuberculosis).

Alveolus - One of the sockets in the alveolar process of the maxillary or mandibular bone in which the roots of the teeth are held (Alveoli is the plural form).

Amalgam Restoration - Commonly known as a silver filling.

American Association of Periodontology (AAP) Classification System - A system, adopted by the AAP, for categorizing the types of periodontal disease exhibited by patients. Through this classification system, a clear understanding of the severity of the disease and the number and types of appointments needed to treat the disease can be achieved.

American Dental Association (ADA) - A professional organization of dentists dedicated to serving both the public and the dental profession. The ADA promotes dentistry by enhancing the integrity and ethics of the profession.

American Society of Anesthesiologists (ASA) Classification System - A system of patient classification, adopted by the ASA, with the primary purpose of quickly and easily placing the patient into an appropriate risk category and providing guidelines for patient management. The classification must be made during the physical evaluation of the patient before any dental treatment is initiated.

Annual/Biennial Complete Dental Examinations - Complete dental examinations rendered yearly to inmates 50 or more years of age and once every two years to inmates less than 50 years of age.

Antibodies - Any of various substances existing in the blood or developed in immunization, which counteract toxins or bacterial poisons in the system.

Antigen - A substance that gives rise to an antibody when introduced into blood or tissue.

Aphakia - A condition of an eye in which the lens is absent. In rare cases, aphakia may occur as a congenital abnormality. More commonly, however, aphakia results from an eye injury or following a cataract operation.

Asymptomatic - Showing or causing no symptoms.

Authorized Temporary Absence (ATA) - Any authorized temporary absence from the facility as directed by the court.

Available Blood - Blood, obtained in a sterile manner, which is in the possession of the institutional health care provider or the source patient's physician pursuant to a valid authorization. Ref: 35 P.S. §7601 to §7612.

Basic Life Support (BLS) - Emergency lifesaving procedures including recognition of breathlessness and cardiac arrest, accessing the Emergency Medical Services System, and performing basic CPR.

Bicuspid Occlusion - A situation is which a dental patient has all of his/her eight bicuspids intact and occluding or meeting satisfactorily in order to permit chewing and closure of the bite.

Biennial - Every two years.

Biological Monitoring (spore test) - A test performed on the autoclave that directly measures sterilization. The spore used is Bacillus Stearothermophilus.

Bitewing Radiographs - Is a term for dental x-rays taken with the teeth nearly in occlusion. The purpose of exposing bitewings is to visualize anatomical tooth surfaces and bone located between the teeth, under the gums, and other areas not normally visible to the naked eye when

performing a dental examination. Bitewings enable the dentist to confirm the presence or absence of pathology in these areas. Bitewings do not allow visualization of the root tips.

Bridge - A fixed dental prosthesis that consists of a series of two or more crowns fabricated in a dental laboratory, soldered together, and cemented to prepared natural teeth.

Bureau of Health Care Services (BHCS) - This bureau is responsible for supervising and monitoring the delivery of all medical/mental health care services and food service operations throughout the state correctional system. These services are provided at a level consistent with community standards through continuous quality improvement processes, coordinating services with other Department bureaus and offices, and through networking with support services from applicable community and state agencies.

Calculus - Calcified dental plaque that forms as a hard tenacious mass on the teeth and root surface, above the below the gum line. Commonly referred to as tartar.

Cardiopulmonary Resuscitation (CPR) - Emergency lifesaving procedures combining rescue breathing and external chest compressions to artificially circulate oxygenated blood and attempt to restore spontaneous breathing and circulation.

Caregiver - The person designated by the inmate mother who shall be responsible for the care of the newborn child once the child is discharged from the hospital.

Caries - Commonly known as tooth decay or cavity.

Casting - A dental laboratory process whereby dental restorations and/or prostheses are fabricated. The process involves placing molten metals into a precise mould, then quenching, cooling, finishing, and polishing for placement into the mouth.

Centers for Disease Control (CDC) - The Federal Health Agency that is a branch of the U. S. Public Health Service under the U. S. Department of Health and Human Services. The CDC provides National Health and Safety guidelines and statistical data on AIDS and other diseases. **Management Directive 505.26** mandates that State agencies adhere to CDC guidelines on HIV/AIDS.

Certification of Significant Exposure to Blood/Body Fluids - The documentation by a physician regarding the significance of an occupational exposure, after the review of an incident/accident in which blood and/or body fluids contacted an employee/ health care worker, in accordance with the definition of significant exposure as found in PA Act 148 of 1990 or subsequent Centers for Disease Control and Prevention (CDC) definitions.

Charting - The process of recording the findings of a periodontal examination.

Chemically Dependent - Compulsive need for and use of a habit-forming substance characterized by tolerance and by well defined physiological symptoms upon withdrawal.

Chief of Dentistry - A licensed dentist appointed by the Secretary of the Department. The Chief of Dentistry reports to the Director of the BHCS and is responsible for the administration of the Department's dental program and for providing administrative and clinical supervision and support to dental staff.

Chronic Illness - A disease process that requires care and treatment over a long period and usually is not cured. Examples of chronic illness include asthma, heart disease, diabetes, hypertension, and some physical disabilities that limit a person's normal functions.

Colonization - Growth of organisms in a host that does not produce an inflammatory response.

Commitment - A term referring to the act of being remanded by the court to a State Correctional Facility. May also refer to an inmate so assigned or remanded (new commitment).

Communicable/Contagious Disease - An illness that is caused by a specific infectious agent (virus, bacteria, fungus) that can be transmitted by blood and body fluids via direct, indirect, or airborne contact from an infected person to susceptible person.

Community Corrections Center (CCC) - A residential facility operated directly by the Bureau of Community Corrections to provide residential and treatment services to certain inmates selected for placement into a community setting prior to or as part of parole.

Commutation - A plea to the Governor for a sentence change in accordance with the Pennsylvania Constitution.

Complete Dental Examination - A thorough examination and review of the medical history, examination of the head and neck (oral cancer exam, the extraoral and intraoral hard and soft tissues, periodontal exam, radio-graphs) and any other findings relative to the inmate's health and welfare.

Compliance Counseling - Direct, one-on-one counseling between the inmate and a licensed health care provider (physician, physician assistant, nurse, designee charged by the Corrections Health Care Administrator) to discuss the inmate's non-compliance with prescribed therapy, how to correct it, and the ramifications for continued non-compliance.

Compliance Counselor - A staff member that provides one-on-one counseling with the inmate, discussing the inmate's non-compliance with prescribed therapy, how to correct it, and the ramifications for continued non-compliance.

Composite Restoration - Fillings commonly know as tooth colored, white, or bonded.

Conditions Known to Increase an Infected Inmate's Risk of Developing Active TB Disease - HIV infection, diabetes mellitus, prolonged corticosteroid therapy, immunosuppressive therapy, some hematologic and reticuloendothelial diseases, injection drug use, end-stage renal disease, close contacts with persons with newly diagnosed infectious tuberculosis, and recent tuberculosis skin test converters and clinical conditions associated with rapid weight loss.

Contact Precautions - The use of barriers (gown and gloves) to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact (skin to skin contact).

Contact Staff - A Department employee who has direct inmate contact.

Contagious or Infectious Tuberculosis - Active TB - Confirmed or suspected TB of any anatomic site, or a clinical indication of tuberculosis disease AND evidence of tuberculosis infection (positive AFB, positive chest x-ray, positive PPD = Active TB).

Contagious or Infectious Tuberculosis - Confirmed or suspected TB of any anatomic site prior to meeting criteria for release from TB isolation (Section VI.E.5), or a clinical indication of tuberculosis disease and evidence of tuberculosis infection.

Corrections Health Care Administrator (CHCA) - The facility staff member responsible for overseeing the delivery of medical/mental health services to the inmate population via the medical vendor and Department staff.

Crash Cart - An emergency cart maintained in a health service area room. The cart is used to store emergency medications, equipment, and supplies expected to be used when providing medical care in life-threatening situations in the medical area.

Crown - Commonly known as a “cap,” a crown is a restoration, fabricated in a dental laboratory from precious or non-precious metal. The cast metal crown may also have a porcelain component for esthetic purposes. Some crowns are fabricated in a laboratory, entirely from porcelain or acrylic.

Cyanosis - Slightly bluish, grayish, slate-like or dark purple discoloration of the skin due to presence of abnormal amounts of reduced hemoglobin due to a deficiency of oxygen and excess of carbon dioxide caused by any condition interfering with the entrance of air into the respiratory tract.

Cytomegalovirus - One of a group of species - specific herpesviruses. The human cytomegalovirus inhabits the salivary glands and causes cytomegalic inclusion disease.

Cytomegalovirus Inclusion Disease - A disease, especially of the neonatal period, characterized by variable severity in which an asymptomatic infection may leave no sequelae to a disease with fever, hepatosplenomegaly, microcephaly, and, in neonates, mental or motor retardation and perhaps death. Due to infection with cytomegalovirus, which can occur congenitally, postnatally, or later in life. The virus can produce a latent infection that may be subsequently activated by pregnancy, multiple blood transfusions, or following immunosuppression therapy.

Decontamination - Cleaning an object to reduce the number of microorganisms and render the object safe for handling.

Dental Emergency - Any dental condition that can jeopardize the health, safety, and welfare of the inmate. The specific conditions constituting a dental emergency are outlined in the procedures manual.

Dental Orientation - A process that occurs upon reception or transfer to a new facility. A facility staff person will briefly describe the dental program and how to access dental services to these inmates.

Dental Screening - A visual inspection and assessment of the inmate's general dental condition upon entry or re-entry into the Department.

Dental Sick Call - A regularly scheduled process to respond to the urgent or emergency needs of the inmate population regardless of housing status.

Dentifrice - Toothpaste.

Dentition - The teeth in the dental arch; ordinarily used to designate the natural teeth in position in their alveoli.

Department - The Pennsylvania Department of Corrections.

Deputy Superintendent for Facilities Management (DSFM) - A management level employee directly responsible for the uniformed corrections officers, unit management (housing), counseling services, facility maintenance, facility safety ad the Facility Security Office.

Diabetes Mellitus - A chronic disease characterized by hyperglycemia and microvascular complications that lead, in some patients, to "end organ" disease, especially the eyes, kidneys, and nervous system.

Diagnostic and Classification Center (DCC) - A correctional facility, which assesses custody, security levels, programmatic and special needs of inmates who are newly received in to the Department, returned as parole violators, or temporarily transferred for pre-sentence assessment.

Diagnostic Study Stamp - The ink stamp used by the physician and/or physician's assistant to mark the results of a diagnostic report as being reviewed and whether the results are abnormal, normal, or not clinically significant.

Diagnostic Testing - Any test or procedure performed to assist in the diagnosis or determination of the health status of an inmate, to establish baseline data, to monitor a medical condition, or to monitor results of treatment.

Direct Observation - The observation of the inmate by a licensed health care provider as the inmate received every dose of the prescribed medication either orally, topically, injection, etc.

Direct Observation Therapy (DOT) - A comprehensive system ensuring compliance with prescribed medication therapy through education, direct observation, monitoring, and counseling.

Direct Observation Therapy Medications - Direct Observation Therapy medications include, but are not limited to, the following:

1. all tuberculosis medications (both prophylaxis and active);
2. all Hepatitis C medications;
3. all HIV medications;
4. all sexually transmitted disease medications;
5. all psychotropic medications;
6. insulin;
7. all controlled substances;
8. all non-steroidal medications;
9. all muscle relaxants;
10. all cold/flu protocols;
11. all decreasing dose steroids;
12. all anti-opportunistic medications associated with HIV;
13. all medications prescribed to an inmate who cannot or will not take the medication by himself/herself;
14. all refrigerated medications; and
15. all medications ordered to be dispensed by way of DOT.

Direct Observation Therapy Patients

1. any inmate who received at least one DOT medication;
2. any inmate assigned to the psychiatric review/mental health roster;
3. any inmate who, for whatever reasons, is incapable of self-administering medication; and
4. any inmate who refuses to participate in or comply with prescribed self-medication.

Direct Supervision - For this procedures manual, it is the supervision by a dentist who examines the patient, authorizes the procedure to be performed, is physically present in the dental facility and available during the performance of the procedure, and examines and takes full responsibility for the completed procedure. (From the 49 Pa. Code §33.)

Directly Observed Preventive Therapy (DOPT) - Directly Observed Preventive Therapy is the same as DOT, except that it is for prophylactic medication.

Directly Observed Therapy (DOT) - Is the assurance that the inmate takes each indicated dose of medication to treat tuberculosis disease; this includes assuring his/her presence, watching the inmate swallow each dose and documenting the encounter.

Disciplinary Custody (DC) - Disciplinary Custody, also known as DC time, is the maximum restrictive status of confinement to which inmates found guilty of Class I misconducts may be committed.

Disinfection - A process that kills or destroys nearly all disease-producing microorganisms (pathogens) with the exception of bacterial spores.

1. Disinfectant - a solution or chemical used to disinfect inanimate objects.

2. Antiseptic - a solution or chemical used only to destroy pathogens on living tissue.

Do Not Resuscitate (DNR) - Indicates resuscitation efforts should not be attempted regardless of the expected outcome of those efforts.

Droplet Precautions - The use of surgical type mask to reduce the risk of droplet transmission of infectious agents, which are larger than five microns in size (Haemophilus Influenzae Type B, Neisseria Meningitidis, Mumps, etc.).

Edentulous - Missing teeth. A patient may be partially edentulous, meaning some of the natural teeth are missing, or completely edentulous, meaning all of the natural teeth are missing.

Egg Crate Mattress - Equipment used to facilitate the even distribution of body weight in order to minimize pressure over bony prominences and minimize occurrence of decubitus ulcers (bed sores).

***Electronic* Medication Administration Record (*e*MAR)** - A comprehensive chronological history of all prescription medication administered to each inmate.

Endodontic Therapy - Commonly known as a root canal, the term refers to the complete removal of diseased or necrotic pulpal tissues, followed by complete obturation (filling and sealing) of the root canal with an ADA approved material (gutta percha).

Environmental Load - The amount of organisms that collect on a surface between cleaning.

Enzyme-Linked Immunosorbent Assay (ELISA) - A blood test, which indicates the presence of antibodies to HIV. The ELISA test for HIV does not detect the disease AIDS, but only indicates if viral infection has occurred. A person who has two positive ELISA tests and a positive Western Blot test is considered to be infected and can transmit the virus.

Epidemiological Significance - An organism, which can present a high risk of infection and disease to the population at hand (multiply resistant organisms).

Erythroblastosis Fetalis - A condition that develops in an unborn infant when antibodies, usually by RH incompatibility between the mother's blood type and the baby's, attack the red blood cells of the fetus. In some instances, this can lead to the death of the baby. It can be treated in utero (before birth) by medication or intrauterine transfusion. When the child is born, signs may include an enlarged liver and/or spleen, generalized edema (swelling, anasarca), jaundice, and anemia.

Eugenol - A dental medicament commonly known as oil of cloves used as an ingredient in temporary dental fillings and as a sedative dressing.

Explorer - Commonly known as "the pick," is the instrument used by the dentist during an examination to detect cavities, defects, and pathology of the teeth.

Facility - A State Correctional Facility, State Regional Correctional Facility, Motivational Boot Camp, Training Academy, and the Central Office complex as a group and/or individually.

Facility Dentist - Officially classified as a Dentist 1, is employed by a State Correctional Facility and is responsible for the provision of dental services at the facility. Is supervised directly by the CHCA and the Chief of Dentistry.

Facility Manager - The Superintendent of a State Correctional Facility, State Regional Correctional Facility, or Motivational Boot Camp, Director of a Community Corrections Center or Director of the Training Academy.

First Responder - Police, firefighter, rescue personnel or any other person who provides emergency response, first aid or other medically related assistance either in the course of their occupational duties or as a volunteer, which may expose them to contact with a person's bodily fluids. Ref: 35 P.S. §7601 to §7612.

Fixed Orthodontic Appliance - A device to correct a malocclusion that has been placed in the mouth in such a fashion as the patient cannot remove it under normal circumstances. A dentist removes the device as outlined in the procedures manual.

Fixed Prosthodontics - The replacement of missing teeth with crowns and bridges.

Flipper - A simple acrylic partial denture usually replacing one or more anterior teeth.

Fluorescent Treponemal Antibody Absorption Test (FTA/ABS) - A specific study that detects the presence of the antibodies to syphilis.

General Supervision - For this procedures manual, in a dental facility, supervision by a dentist who examines the patient, develops a treatment plan, authorizes the performance of the procedure and takes full responsibility for the provision of the services. A single authorization (standing order) may, when appropriate, apply to one or more classes or categories of patients. This definition is derived from the 49 Pa. Code §33.205(d)(2).

Gingival Margin - The line of gingival tissues representing the junction of the oral gingival and the sulcular epithelium; also referred as the Free Gingival Margin.

Gingivitis - A disease characterized by inflammation of the gums due to accumulation of plaque. As there is no destruction of the priodontium or loss of bone, the condition is reversible.

Glaucoma - A disease of the eye marked by high intraocular pressure, damaged optic disk, hardening of the eyeball, and partial or total loss of vision.

Health Appraisal - A physical examination for inmates over age 50.

Health Care Provider - An individual or institutional provider. Ref: 35 P. S. §7601 to §7612.

Health Care Worker (HCW) - An employee of the Department or contract staff who works in the Medical Department.

Health Screening - A physical examination for inmates under age 50.

Hemoccult Guaiac Slide Test - A method for testing feces for the presence of blood during a rectal examination.

Herpes Zoster (Shingles) - A local manifestation of recurrent or reactivation infection with the virus that causes chicken pox.

High Risk Behavior -

1. Sex with one or more men or women where there was exposure to semen, blood, or vaginal fluid, either anally, vaginally, or orally, when the sex was with:

    a. someone who has shared a needle;

    b. a man who has sex with another man;

    c. an organ/blood product (prior to 1985) recipient; and/or

    d. a partner whose drug or sexual history is unknown.

2. I.V. drug usage with shared needles/works.

3. History prior to date of receiving blood or blood products (hemophiliacs) and transfusion or organ transplant.

4. Birth to an infected mother, or if infection status is unknown, to a mother who has participated in the above “high-risk” activities.

High Risk Pregnancy - Pregnancy in which additional health concerns are capable of complicating the natural course of pregnancy. Medical conditions associated with high-risk pregnancy: Age - over 35, Diabetes, Hypertension, Recurrent miscarriages, Genetic problems, Previous ecclampsia, Thyroid disease, Autoimmune diseases (Lupus), Cardiac disease, Pulmonary disease (Asthma), Hemo/oncol disease or other chronic illnesses.

HIV/AIDS Education Coordinator - A staff member at the Department Training Academy who is the Department’s designated single point of contact for staff HIV/AIDS education issues. This staff person acts as a resource in an advisory capacity, and is responsible for functioning within the policy and procedures as defined by the Department.

HIV/AIDS Resource Coordinator for Inmates - A Department management level employee in the Medical Department at the facility who is designated by the Facility Manager. This staff member who is trained in HIV/AIDS issues, is designated to receive any confidential HIV/AIDS related information on an inmate, and is responsible for functioning within the policy and procedures as defined by the Department.

HIV/AIDS Workplace Coordinator - A staff member at a State Correctional Facility (SCI) or Community Corrections Center (CCC) who is trained in HIV/AIDS issues. This person acts as a single point of contact and is a resource in an advisory capacity. They are responsible for functioning within the rules/ responsibility guidelines as defined by the Department.

HIV and Asymptomatic - Those individuals without symptomatology who test positive by antibody serum screening and subsequent confirmation test.

HIV and Symptomatic - That part of the disease infection process in which the individual begins to develop symptoms such as swollen lymph nodes, weight loss, night sweats, etc.

Hold for Various Authority (HVA) - Inmates housed in a Department facility upon the request of another jurisdiction, but not necessarily under state sentence. A number of HVA’s are received for a 60-day court ordered evaluation.

Hospice Care - Hospice care is interdisciplinary comfort oriented care that allows terminally ill patients to die with dignity and humanity, with as little pain as possible, in an environment where they have mental and spiritual preparation for the natural process of dying.

Human Immunodeficiency Virus (HIV) - This is the name for the retrovirus that is the causative agent of AIDS.

Implant Prosthodontics - The replacement of missing teeth with osseous-integrated device capable of supporting restoration.

Infected - People are considered infected with tuberculosis if they are PPD positive. (American Thoracic Society Class 2). Also called “Latent”; this person is not contagious.

Infected - Latent TB - People are considered infected with tuberculosis if they are PPD positive, (American Thoracic Society Class 2), (positive PPD, negative chest x-ray = Latent TB). These people may work and are not infectious to other people.

Infection -Growth of organisms in a host causing an inflammatory response.

Infection Control Coordinator (ICC) - A Department management level employee at the Bureau of Health Care Services (BHCS) who is educated in infection control. This person acts as a resource in an advisory capacity to both the HIV/AIDS Education Coordinator and the facility HIV/AIDS Workplace Coordinator. The ICC shall function within the policy procedures as defined by the Department.

Infectious Tuberculosis - Persons with confirmed or suspected pulmonary or laryngeal TB capable of transmitting infection (positive AFB, positive chest x-ray, positive PPD = Active TB should be considered infectious if they are coughing and have sputum smears containing AFB, and are not receiving treatment, just starting treatment, or poor response to treatment.

Initial Oral Exam (IOE) - The first complete dental exam that a newly committed inmate receives.

Initial Reception Screening - Medical screening of inmates entering or re-entering the state correctional system. This screening shall include a physical examination, where applicable.

Inlay - A pre-fabricated filling that does not involve the replacement or support of any cusps and commonly involves laboratory processing.

Insertion - The process of delivering a finished pre-fabricated dental restoration or prosthesis to a patient. Involves placement and any required adjustments or cementation.

Instrument Milk - Substance for soaking instruments that acts as a lubricant. It is used on hemostats, scissors, etc.

Intra-Facility Transfer - The movement of an inmate from one Department Facility to another on either a temporary or permanent basis.

Intermediate - Refers to Level of Care #2 in the procedures manual. Is defined as a condition that does not rise to a level that would constitute an urgent or emergency condition. The type of dentistry referred to here is of a routine nature and the inmate is not in any difficulty.

Intraocular - Within the eye.

Junctional Epithelium - The epithelial collar that provides the epithelial attachment to the tooth surface; it is continuous with but structurally distinct from the sulcular epithelium.

Kaposi's Sarcoma (KS) - A cancer of the connective tissues in blood vessels. Pink or purple blotches on the skin are symptoms of Kaposi's Sarcoma.

Kennedy Classification System - A system used to classify the partially edentulous arch in a manner that will suggest certain principles of design for a given situation. The system has four main classes with several modifications possible to the first three classes.

Keratoconus - Cone-shaped protrusion of the cornea.

Laboratory Prescription Form - A "work order" that by law must be completed and signed by the dentist and forwarded to the dental lab along with the case. The form contains the dentist's order to the lab regarding the fabrication of the patient's restoration or prosthesis and it must be kept in the dental records.

Lesion - Refers to any pathological or traumatic discontinuity of tissue or loss of function of a part. There are many varieties of lesions that may occur in the mouth.

Level of Care - In this procedures manual, refers to a dental classification system for determining the serious-ness of the inmate's dental condition and serves as a guide for scheduling. There are four levels ranging from four being the most serious to one being the least serious.

Licensed Medical Practitioner - A physician, ***dentist,*** physician assistant, ***or certified registered nurse practitioner*** with a current license to practice in the Commonwealth of Pennsylvania.

Limited Examination - A focused evaluation performed during sick call or when an emergency condition is presented.

Long Term Care - A facility that provides skilled and/or personal care under a plan of care supervised by licensed/qualified personnel.

Management Directive 505.7 - This Management Directive explains the Personnel rules of the Commonwealth.

Management Directive 505.26 - This directive updates detailed policy and procedures on appropriate agency and Department employee responses relative to HIV infection and AIDS in Commonwealth workplaces.

Mandible - The lower jaw.

Mastication - The act of chewing.

Maxilla - The upper jaw.

Meaningful Abnormal Result - Any meaningful deviation from the expected value, that may indicate disease, or change in condition, or may lead to a beneficial alteration of therapy, as determined by the medical practitioner.

Medical/Psychiatric Hold - The process whereby an inmate cannot be transferred to another facility due to a significant or unstable medical or psychiatric condition.

Medically Necessary Care - Item(s) or medical orders, as determined by a physician/physician assistant, required by an inmate in order to maintain a healthy existence.

Medication Card – Pharmacy provided blister packaging.

Meningitis - An inflammation of the meninges (covering) of the brain. It is classified into two groups (aseptic and bacterial), each of which has several organisms, which can cause disease.

Mobile Equipment/Supplies - Emergency equipment/supplies that facility health care staff take with them when summoned to another area of the facility (block, yard, administrative area, etc.). Mobile equipment/supplies are used to provide immediate life support actions while transporting the patient to the health service area. It is portable, able to be carried up/down stairs, fits inside all doorways, and can be secured for transport within the medical transport vehicle.

Multi-Drug Resistant Tuberculosis (MDR-TB) - Mycobacterium tuberculosis strain resistant to more than one standard tuberculosis drug; in practice, often refers to organisms that are resistant to both Isoniazid and Rifampin with or without resistance to other drugs.

Narrative - Refers to a thorough description written in the dental record that details all materials used and all aspects of treatment(s) rendered to a patient during a dental appointment. The narrative shall include any unusual incidents or untoward events that occurred during treatment. The narrative may be written in the **"P"** section of the **SOAP** format or it may stand alone in certain situations as described in the procedures manual.

Natural Teeth - The teeth we are born with or that develops and erupts after birth. Any type of prosthesis is not considered natural.

Neutral Space - Refers to the space in the mouth that the tongue occupies and uses for movements required in speaking, eating, and other functions. Encroachment on this space by a dental prosthesis will nearly always lead to failure of the prosthesis.

Non-Contact Employee - A Department employee who does not have direct inmate contact.

Non-Surgical Therapy - The process of treating periodontal disease that does not involve a surgical procedure to gain access to the areas that normally lies below the gums.

Normal Result - Any result within the normal range.

Nosocomial Infection - Presence of an infection 72 hours after reception into the facility. “Noso” comes from the Greek word meaning hospital. Nosocomial means hospital acquired. For the purpose of this procedure manual, the term shall stand for acquired at the facility.

Not Clinically Significant - Any abnormal result that is not of clinical concern for that particular inmate, as determined by the practitioner.

Obstetrician/Gynecologist (OB/GYN) - A specialist in the field of obstetrics and gynecology.

Occupational Exposure - Eye, mucous membrane, or percutaneous contact with blood or other potentially infectious materials resulting from the performance of a HCW’s job related duties.

Onlay - A pre-fabricated restoration that replaces and/or supports one or more cusps. An onlay is normally fabricated in a dental laboratory.

Ophthalmology - A science dealing with the eye and its diseases.

Opportunistic Infections - Infections caused by organisms that do not normally cause disease in people with healthy immune systems.

Optometry - A profession consisting of examining the eyes, measuring vision, and treating certain defects by means of corrective lenses or other methods.

Oral Cancer Screening (OCS) - Is an evaluation of the head, neck, and oral tissues for detecting pre-cancerous lesions or neoplasms. A dentist shall screen a patient for oral cancer as part of the initial and each periodic oral examination; unless the screening has been performed and documented within the past six months.

Oral Hygiene Instruction (OHI) - Refers to a brief session in which one or more inmates are educated in proper care of the mouth. Proper brushing, flossing and dietary habits are normally discussed. Educational forms or pamphlets illustrating and describing these procedures are also distributed.

Orthodontics - A dental specialty dedicated to the correction of malocclusion and dentofacial abnormalities.

Osseous - Bony or referring to bone.

Palliative Care - The active total care of inmates whose disease is not responsive to curative treatment. Palliative care includes the control of symptomatic pain and psychological, social, and spiritual problems. The goal of palliative care is the achievement of the best possible quality of life for the inmate.

Panoramic Radiograph (Panorex) - A dental x-ray used to enable the visualization of the maxillary and mandibular dental arches and their associated structures.

Parenting Program - This program provides coordination and support for all aspects of an inmate's pregnancy (medical appointments, counseling sessions, education programming (prenatal-medical, and postpartum-parenting program), diet, exercise, work assignments, placement of newborn child, visitation, any other special needs of the inmate, etc.

Parole Violator (PV) - An individual who is being returned, or has been returned to the custody of the Department, due to a violation of their parole, in order to complete his/her sentence.

Pediculosis - The presence of head lice, scabies (body lice), or pubic lice.

PA Act 148 of 1990 - 35 P.S. §7601 to §7612 - Confidentiality of HIV-Related Information Act.

Per Dose Compliance - Monitoring each dose of mediation prescribed to ensure that the inmate is in compliance with the physician's orders.

Periapical - The area situated at or surrounding the root apex of a tooth. A Periapical Radiograph enables the dentist to visualize this area.

Periodic Oral Exam (POE) - Any routine complete exam following the initial exam.

Periodontal Screening and Recording (PSR) - An early detection system for periodontal disease introduced by the ADA, AAP, and Proctor and Gamble Corporation. PSR was created to give the dental profession an easy-to-use system to detect periodontal disease and streamline the record-keeping process.

Periodontics - A dental specialty dedicated to the study and treatment of diseases of the bone and tissues that support or help to support the teeth.

Periodontium - A term for the bone and tissues that support or help to support the teeth.

Permanent Assignment - Refers to a process in the Department whereby an inmate has completed the classification process at the Reception Center and is then assigned to one of the Pennsylvania State Correctional Facilities to serve the remainder of his/her sentence.

Permanent Restorations - Refers to the placement of a dental restoration, made from ADA approved materials for that purpose, and having a reasonable expectation of providing long-term service to the patient.

Personal Protective Equipment (PPE) - Includes gown, gloves, mask and goggles.

Physical Examination - A systematic inspection of the body and its systems to determine the presence or absence of disease.

Physical Impairment - Refers to mobility impairment (amputations, paraplegia), and the need for assistive devices, such as canes or crutches, visual, hearing and/or speech impairments.

Physician Assistant (PA) - An individual who practices medicine with the supervision of the licensed physician and is qualified to perform approximately 80 percent of the duties most commonly done by physicians. He/She is used to perform physical examinations, diagnose illnesses, determine treatment plans, order and interpret lab test tests, suture wounds, set fractures, and assist in surgical operations.

Plaque - A sticky, pasty material, formed from food debris, salivary components, bacteria and their by-products, that adheres to the teeth, gums and soft tissues in the mouth. Bacteria in plaque have been proven to cause tooth decay, gum disease and other oral pathology.

Polishing - A process whereby a dental hygienist applies a specialized dentifrice to the teeth in order to clean them and further remove materials such as plaque and stain. Polishing creates a smooth surface upon which it becomes more difficult for plaque and stain to adhere.

Porcelain Restoration - A dental restoration made through a specialized process in a dental laboratory, primarily to restore dental function and esthetics. Porcelain is commonly used for inlays, onlays, veneers, and crowns.

Precision Attachment - A fastening device for a dental prosthesis or a crown that is fabricated in a dental laboratory. A precision attachment is fabricated to increase the retention of a crown and/or a dental prosthesis.

Pregnancy Plan of Action - A document that outlines the plan of care for the pregnant inmate both prenatal and postpartum. The Medical Department staff and the Parenting Program staff shall coordinate this document.

Preventive Dentistry - The area of dentistry concerned with achieving and maintaining oral health in order to prevent the various dental disease processes**.**

Probe - A specialized instrument used during a periodontal exam.

Processed Acrylic Crown - A term that refers to a restoration that is fabricated in a dental laboratory in order to restore a tooth. Can function as a permanent or a temporary restoration.

Prophylaxis - A term in dentistry that refers to a preventive cleaning and polishing of the teeth.

Prosthesis - An artificial device, fabricated in a dental laboratory under the orders and direction of a dentist, to replace missing teeth and oral structures.

Prosthodontic Dentistry - The branch of dentistry concerned with the restoration and maintenance of oral function, comfort, appearance and health of the patient by the replacement of missing teeth and contiguous tissues with artificial substitutes.

Pulp - Refers to the “juicy” tissue comprised of blood vessels and nerves located inside the tooth.

Quehanna Motivational Boot Camp - A six-month voluntary program for eligible inmates, which is an alternative to standard incarceration. A regimented, disciplined environment involving, among other things, a strenuous, physical fitness program.

Recall - A term in dentistry that refers to the regular frequency of scheduling dental patients for a preventive exam and cleaning.

Reception Dental Facility - Refers to a facility to which a new commitment, returned escapee, CCC return, parole violator or ATA of more than six months is remanded. Any state correctional facility may function in this capacity in the event that one of the types of inmate mentioned above enters the facility. However, the facilities that will most commonly be referred to are SCI-Camp Hill for men and SCI-Muncy for women. Another common reference term for these facilities is the Diagnostic Classification Center (DCC).

Reline - A process whereby the tissue surface of a dental prosthesis is lined with an ADA approved material for improving fit, comfort, and retention.

Removable Orthodontic Appliances - Refers to orthodontic appliances that the patient may remove from the mouth, at will.

Removable Prosthesis - Refers to dental prosthetic devices, such as full and partial dentures, that the patient may remove from the mouth, at will.

Restorative Dentistry - The branch of dentistry concerned with the reforming, rebuilding, reconstructing, or re-contouring parts of teeth that have been broken down by lesions or injury, thereby restoring function and appearance.

Retention - A dental term for the ability of a dental restoration, prosthesis, or device through its physical properties to stay in place. Dental cements and other materials may enhance retention, but it is generally understood that a restoration, prosthesis or device must have significant retentive properties of its own in order to ensure success.

Returning Inmates - Individuals who were temporarily not in the custody of the Department of Corrections and have returned to the system.

Scaling - The process of using specialized instruments to remove plaque and calculus deposits that are adherent to the teeth and roots.

Sealant - A preventive procedure whereby composite material is bonded to the deep grooves of teeth to prevent the process of dental decay.

Self-Administered Medication - Any medication not listed as a Direct Observation Therapy medication and which the prescribing physician or physician assistant has made a determination is appropriate for self-administration with the patient.

Serologic Tests for Syphilis (STS) - The serologic blood test that is used to detect the presence of antibodies to syphilis.

Significant Exposure - Direct contact with blood or body fluids of an individual in a manner which, according to the most current guidelines of the Centers for Disease Control, is capable of transmitting Human Immunodeficiency Virus, including, but not limited to, a percutaneous injury (a needle stick or cut with a sharp object), contact of mucous membranes, or contact of skin, when the exposed skin is chapped, abraded or afflicted with dermatitis or if the contact is prolonged or involves an extensive area.

Percutaneous Exposure involves a break in the skin with a contaminated needle, instrument, or piece of broken glass.

Mucous Membrane Exposure involves splash to eye or mouth with blood/body fluids, (eye mucosa, mouth mucosa).

Signs of Death

1. pupils fixed and dilated;

2. no pulse/respiration;

3. *rigor mortis present;

4. *mottling present;

5. *incontinence of bowel/bladder present;

6. *cyanosis present; and/or

7. *may or may not be present at the time of assessment.

Site Administrator - On-site vendor employee who is responsible to assure that contracted medical services are provided to the inmate population.

Skilled Care Services - Professionally supervised nursing care and related medical and other health services provided for a period exceeding 24 hours to an individual not in need of hospitalization, but whose needs are such that they can only be met in a long term care facility on an inpatient basis, and who needs the care because of age, illness, disease, injury, convalescence or physical or mental infirmity. Skilled care includes the provision of daily inpatient services, which require the skills of professional and technical personnel, such as, but not limited to, registered nurses, licensed practical nurses, and certified nursing assistants. Such skills may include procedures, such as intravenous therapy, nasogastric tube insertion and feeding, oxygen therapy, stoma therapy, etc.

Snellen Chart - Chart imprinted with lines of black letters graduating in size from smallest on the bottom to largest on top. Used for testing visual acuity.

Snellen Visual Acuity Testing - Test for visual acuity where the patient reads a Snellen's chart at a certain distance with one eye, then with the other eye, and then with both eyes. The test consists of an eye chart, with rows of letters of decreasing sizes.

Source Patient - Any person whose body fluids have been the source of a significant exposure to an individual or a HCW.

Special Item(s) - Item(s) medically necessary such as medical supplies, electric razors, hearing aids, prosthetic devices, therabands, extra pillows, extra blankets, extra mattresses, support hose, orthopedic shoes, lower bunk, bottom tier cells, braces, canes, crutches, gloves, elastic bandages, wheelchairs, etc. This does not include eyeglasses.

Sterilization - Process by which microbes (including spores) are killed and are no longer detectable in standard culture media.

Stop/Review Date - The date on which the need for a prescribed special item(s) is reviewed by the staff member who prescribed the item(s) in order to determine if the inmate still requires the prescribed special item(s).

Sub-Acute Care - Daily inpatient services ordered by a physician, which require the skills of, and are provided directly by licensed health care staff. Such services are provided on a 24-hour basis to an individual who does not require hospitalization, but whose needs can be met in an inpatient unit. Examples of such services include, but are not limited to: pre and post surgical care as an adjunct to hospitalization, frequent dressing changes and/or treatment, contagious diseases requiring isolation, psychiatric observation, adjustment of medications, preparation for diagnostic testing, intravenous therapy, etc.

Subjective, Objective, Assessment, Plan (SOAP) - The elements of a progress note completed by a licensed health care provider within the inmate medical record.

a. **S**ubjective - The inmate’s self-proclaimed symptoms and own description of the problem, not perceptible to an observer.

b. **O**bjective - The provider's clinical findings, observations, and factual data.

c. **A**ssessment - The opinion of the cause or status of the health condition based on the subjective and objective data. Nursing diagnoses may be used in accordance with NANDA.

d. **P**lan - The series of actions or strategy for responding to the identified problem. This may be diagnostic, therapeutic, or educational.

Symptomatic - The exhibiting subjective evidence of a disease or condition.

Symptoms of Tuberculosis - Prolonged productive cough, hemoptysis, fever, chills, night sweats, and weight loss. Inmates with active, contagious disease may have only one of these symptoms.

Syphilis - Also known in the past as lues, is a contagious sexually transmitted disease that is caused by infection with spiral-shaped bacteria called Treponema pallidum. It can affect any tissue in the body, causing a wide variety of symptoms and complications.

Telebinocular Visual Acuity Test - A test used to measure distance, depth perception, and color vision.

Temporary Restorations - Dental restorations placed on an interim basis.

Temporomandibular Joint (TMJ) - The hinge-axis joint joining the mandible (jawbone) to the temporal bone.

Terminal Condition - An incurable and irreversible medical condition in an advanced state caused by injury, disease or physical illness which will, in the opinion of the attending physician and to a reasonable degree of medical certainty, result in death regardless of the continued application of life-sustaining treatment.

Tonometric Testing - A procedure used for testing for glaucoma. The tonometer measures Intraocular Pressure (IOP) using a pressure-sensitive tip placed gently near or against the eye (applanation or Schiotz tonometry), or by directing a brief puff of air gently onto the eye (air puff tonometry).

Topical Fluoride Application - A preventive dental treatment for the purpose of eliminating tooth sensitivity or decreasing the caries rate of a patient.

Transplant - An organ or tissue taken from the body and grafted into another area of the same individual or another individual, to transfer tissue form one part to another or form one individual to another.

Transplant Center - A facility capable of transplanting an organ or tissue taken from the body and grafted into another area of the same individual or another individual. These centers are located in university tertiary care hospitals.

Treatment Plan - A prioritized list of the treatment sequence required for a patient. The treatment plan is developed after all of the diagnostic findings of the dental examination are available.

Tuberculin Skin Test (TST) - A test to determine the presence of mycobacterium, infection based upon a positive reaction to tuberculin by the subject. The test to be used is the Mantoux test, or "PPD," consisting of an intradermal injection, which produces a wheal. It introduces 0.1 ml or five tuberculin units (TU) of purified protein derivative (PPD) injected intracutaneously (intradermal) into the skin of the ventral surface of the forearm.

Tuberculosis Disease (TB) - People are considered to have tuberculosis disease if they have clinically active TB in any location. The diagnosis is most convincingly made by isolation of Mycobacterium Tuberculosis on culture. A clinical diagnosis can be made on the basis of clinical or radiologic evidence and a response to anti-tuberculosis therapy.

Universal/Standard Precautions - Universal/Standard Precautions is an approach to infection control. According to the concept of Universal/Standard Precautions, all human blood and body fluids are treated as if know to be infectious for HIV, Hepatitis B, Hepatitis C, and other bloodborne pathogens. Universal/Standard Precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances where fluid is difficult or impossible to identify (mixture of oil and body fluids), this fluid shall be considered potentially infectious material.

Urgent Dental Condition - Conditions requiring prompt intervention to avoid progression to a more acute or emergency state. Urgent dental treatment is discussed fully in the procedures manual.

Varicella (Chicken Pox) - An acute viral disease characterized by sudden onset of fever and skin eruptions, which are maculopapular, vesicular, and leave a granular scab.

Western Blot - A blood test used to confirm the presence of antibodies to HIV. Compared to the ELISA test, the Western Blot is more specific.

340B Drug Discount Program – A U.S. government program created in 1992 that requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices. The intent of the program is to allow covered entities to stretch scare federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.