Wellpath
Mecklenburg County Sheriff's Office Policies & Procedures

Mecklenburg County Detention Centers

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To hope and healing.

Policy and Procedure Manual

MECKLENBURG COUNTY DETENTION CENTERS

These policies and procedures have been reviewed and approved by the following individuals for implementation within **MECKLENBURG COUNTY DETENTION CENTERS, June 1, 2019**.

Please note: For counties where services are provided by another entity, such policies will be deferred to the contract provider for that service. Any requirement by the medical staff will remain consistent with Wellpath policy.

Telisa White Facility Administrator	6-1-19 Date
Dr. Mary LeBliss MD Onsite Medical Director	6/1/19 Date
Molike M Green RN Health Services Administrator	6/1/19 Date
Tom Sybesma Regional Director of Operations	6/1/19 Date
Dr. Donald Rhodes MD Regional Director of Mental Health	6/1/19 Date
Dr. Carl Keldie Chief Clinical Officer	6/1/2019 Date
Cindy Watson President, Local Government Health Care	6/1/2019 Date
Joanna Garcia VP Accreditation and Quality	6/1/2019 Date

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1. PURPOSE

This policy is intended to ensure that patients have access to care to meet their serious medical, dental, and mental health needs. The Responsible Health Authority (RHA) / Health Services Administrator (HSA) is required to identify and eliminate any unreasonable barriers, intentional or unintentional, to patients receiving health care.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Patients are informed about how to access health care services and the grievance system during the admission/intake process, or as soon as possible. This information is communicated orally and in writing and is conveyed in a language that is easily understood by each patient. Arrangements to assist patients without English language skills are made in advance of need, when possible.

The RHA/HSA ensures that patients have access to medical, dental, and mental health care. Patients are seen in a timely manner by a health care professional and receive health care services for serious medical, dental, and mental health conditions.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Access to health care information is provided to English- and non-English-speaking patients at intake.

6.2. Access to health care signs are posted in all housing units.

6.3. Access to health care and grievance system information is available in the inmate handbook.

6.4. The RHA/HSA ensures there are no unreasonable barriers, intentional or unintentional, to patients receiving health care.

6.5. Patient Co-Payment for Health Services

6.5.1. If the institution maintains a patient co-payment program for health care services, patients will be required to pay for some health services that they initiate. At no time will any patient be denied health services of any kind because of his or her inability to pay for those services.

6.5.2. No fees are assessed for patient treatment arising from sexual abuse or when health care staff initiate the care.

6.5.3. Health care staff are responsible for completing a patient charge in accordance with facility policies.

- If a patient refuses to sign, health care staff will inform the patient that he or she will be charged regardless of whether the patient charge form is signed. Health care staff will write “refused to sign” on the form.

6.5.4. All patients receive care regardless of their ability to pay for chargeable services. Co-payment will be charged accordingly, and it will be the facility’s responsibility to pursue payment.

6.5.5. Chargeable Services are site specific:

- Sick Call Services:
  - ◊ Health Care Provider Services:
    a. Physician: $20.00
    b. Mid-Level Provider: $20.00
    c. Dentist: $20.00
  - ◊ Prescription Fee: No Fee Charged

6.5.6. Non-chargeable services are site specific:

- Health Assessments
- Chronic Care
- Mental Health Services
- Diagnostic testing and monitoring

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018
- Section: Governance and Administration: J-A-01 Access to Care (E)
- Section: Patient Care and Treatment: J-E-01 Information on Health Services (E)

NCCHC Standards for Health Services in Prisons 2018
- Section: Governance and Administration: P-A-01 Access to Care (E)
- Section: Patient Care and Treatment: P-E-01 Information on Health Services (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015
- Section: Governance and Administration: MH-A-01 Access to Care (E)
- Section: Patient Care and Treatment: MH-E-01 Information of Mental Health Services (E)

ACA Standards / 2016 Standards Supplement
- 4-ALDF-4C-01 Access to Care (M)
- 4-ALDF-4C-03 Clinical Services
- 4-ALDF-2A-27 Orientation
- 1-HC-1A-01 Access to Care (M)
- 1-HC-1A-02 Co-Payment

Forms

- Access to Healthcare
- Health Services Request

1. PURPOSE

This policy is intended to ensure that there is a designated Responsible Health Authority (RHA) / Health Services Administrator (HSA) and that he or she maintains a coordinated system for health care delivery.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The designated Responsible Health Authority (RHA) is the Health Services Administrator (HSA). The Site Medical Director is the designated Responsible Physician.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Designated Qualified Mental Health Clinician – A psychiatrist, psychologist, or psychiatric social worker who is responsible for clinical mental health issues when mental health services at the facility are under a different authority than the medical services

Health Care – The sum of all actions, preventive and therapeutic, taken for the physical and mental well-being of a population. Health care includes medical, dental, mental health, nutrition, and other ancillary services, as well as maintaining clean and safe environmental conditions

Health Services Administrator (HSA) / Site Supervisor – A person who by virtue of education, experience, or certification can assume responsibility for arranging all levels of health care and ensuring quality and accessible health services for patients

Qualified Health Care Professional – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients

Responsible Physician – A designated MD or DO who has the final authority at a given facility regarding clinical issues

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. The RHA/HSA is responsible for coordinating and arranging all levels of care provided at the facility and in community-based health care organizations.

6.2. The RHA/HSA will:

- Arrange for all levels of care
- Ensure quality, accessible, and timely health care services for patients
- Develop site-specific operational health care policies and procedures
- Establish systems for the coordination of care among multidisciplinary providers
- Develop a Quality Improvement Committee
- Have responsibility for making decisions regarding health care resources and the day-to-day operations of the health care program
- Establish a mission statement that defines the scope of health care services and developing mechanisms, including written agreements, when necessary, to ensure that the scope of services is provided and properly monitored

6.3. The RHA/HSA responsibilities are documented in a job description.

6.4. The RHA/HSA must be on-site at least weekly.

6.5. The Site Medical Director is the single designated licensed physician responsible for clinical judgment.

6.6. Physicians, dentists, and mental health clinicians are responsible for their respective health care services, are appropriately licensed, and are available to the facility frequently enough to fulfill the positions' clinical and administrative responsibilities.

6.6.1. The Site Responsible Physician / Medical Director, under the supervision of the Wellpath Chief Clinical Officer, is responsible for providing health care services to patients incarcerated within the facility. The Responsible Physician / Medical Director is responsible for reviewing policies, procedures, and protocols; supervising care provided by other medical practitioners; and participating in the Quality Improvement Committee.

6.6.2. Where there is a separate organizational structure for dental services, there is a designated dental clinician responsible for dental services provided to patients.

6.6.3. Where there is a separate organizational structure for mental health services, there is a designated Qualified Mental Health Clinician responsible for mental health services provided to patients. The designated Qualified Mental Health Clinician will take the lead role in mental health services management and clinical treatment, as well as communicating problems and resource needs to the RHA/HSA.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Governance and Administration: J-A-02 Responsible Health Authority (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Governance and Administration: P-A-02 Responsible Health Authority (E)

NCCH Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-02 Responsible Mental Health Authority (E)

ACA Standards / 2016 Standards Supplement

- 4-ADLF-4D-01 Health Authority (M)

- 1-HC-2A-01 Health Authority (M)

1. PURPOSE

This policy is intended to ensure that health care decisions are made by qualified health care professionals for clinical purposes.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Physicians, dentists, and mid-level providers have the freedom to practice their profession without interference from non-medical/dental personnel. Clinical decisions and actions regarding health care provided to patients are the sole responsibility of qualified health care professionals.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

Responsible Physician – A designated MD or DO who has the final authority at a given facility regarding clinical issues.

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Clinical decisions are determined by qualified health care professionals and implemented in an effective and safe manner. Custody staff support the implementation of clinical decisions.

6.2. Administrative decisions (such as utilization review) are coordinated, if necessary, with clinical needs so that patient care is not jeopardized.

6.3. Decisions on the type of treatment and need for transfer to outside health care agencies are the sole province of physicians, dentists, and mid-level providers. The RHA/HSA and Responsible Physician / Medical Director communicate and coordinate health care delivery needs to ensure health care is not compromised.

6.3.1. Health care staff will determine if the patient needs to be transported to the local emergency room for treatment. Custody staff will ensure requests for an ambulance have been accomplished.

6.4. Health care staff are subject to the same security regulations as other facility employees.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018
- Section: Governance and Administration: J-A-03 Medical Autonomy (E)

NCCHC Standards for Health Services in Prisons 2018
- Section: Governance and Administration: P-A-03 Medical Autonomy (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015
- Section: Governance and Administration: MH-A-03 Medical Autonomy (E)

ACA Standards / 2016 Standards Supplement
- 4-ALDF-4D-02 Provision of Treatment (M)
- 1-HC-2A-02 Provision of Treatment (M)

1. PURPOSE

This policy is intended to ensure that the facility's health and correctional administrators coordinate the health care delivery system through joint monitoring, planning, and problem resolution.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

At a minimum, a quarterly Medical Administrative Committee (MAC) meeting is conducted and attended by the Facility Administrator or designee and the Responsible Health Authority (RHA) / Health Services Administrator (HSA) or designee, as well as other necessary members of the medical, dental, mental health, and custody staffs, as appropriate. Minutes are documented, kept on file, distributed to attendees, and copies are available and reviewed by all appropriate personnel.

Health care staff meetings occur at least monthly to address pertinent health care issues. The RHA/HSA or designee is responsible for ensuring these meetings are conducted. Meeting minutes or summaries are made and retained for reference, and copies are available and reviewed by all health care staff.

Quality Improvement, emergency drills, and staff meetings are held, as appropriate. Mortality review findings are discussed with treating staff as appropriate.

Statistical reports of health care services are generated at least monthly. They are provided to the Facility Administrator and others as appropriate, and they are used to monitor trends in the delivery of health care.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

MAC – Medical Administrative Committee

6. PROCEDURE

6.1. Medical Administrative Committee (MAC) Meetings

6.1.1. The RHA/HSA or designee meets with facility administrators and other members of the medical, dental, mental health, and custody staffs, as appropriate, with the purpose of discussing issues related to health care services. These meetings are scheduled and discussions include, at a minimum, health care services, environmental inspection results, and a summary of quality improvement, infection control, and patient grievances. Other topics may also be included as they relate to the delivery of health care. A statistical report of health care services is also reviewed.

6.1.2. The RHA/HSA is responsible for arranging these meetings and ensuring that attendees are notified at least one (1) week in advance.

6.1.3. Meeting minutes and/or summaries include discussion about the effectiveness of health care services, any health environmental factors, security issues that may need improvement, changes that have occurred since the last meeting, and, when appropriate, recommended corrective action. The RHA/HSA ensures that minutes are documented, disseminated to attendees, and kept on file.

6.1.4. Any conditions identified that pose an immediate danger to staff or patient health and safety will be reported immediately.

6.2. Health Care Service Staff Meetings

6.2.1. The RHA/HSA or designee conducts regularly scheduled staff meetings on at least a monthly basis for the purpose of communicating current information on the health care delivery system.

6.2.2. Meeting minutes and/or summaries are documented to include when meetings are held, who attended, and topics discussed. These are retained for reference, and copies are distributed to attendees and other relevant health care staff.

6.2.3. The Mental Health Coordinator/Director may elect to hold department staff meetings. Minutes from these meetings are kept and copies provided to the RHA/HSA.

6.3. Statistical Reports

6.3.1. Monthly statistical reports will comply with the appropriate Wellpath Corporate Office requirements and are shared with the facility administrators during the MAC meeting and as necessary. These statistics are also forwarded to the Wellpath Corporate Office. The Monthly Statistics include, at a minimum, the following:

- Service volume (e.g., the number of patients receiving health care services by category of care: medical, dental, mental health, etc.)
- Referrals to specialists / off-site
- Deaths
- Incidences of certain illnesses
- Infectious disease monitoring (e.g., hepatitis, HIV, tuberculosis)
- Hospital admissions
- Pharmaceutical utilization
- Patients with chronic illnesses and special needs
- Communicable diseases

- Laboratory
- Emergency services
- Grievances

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Governance and Administration: J-A-04 Administrative Meetings and Reports (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Governance and Administration: P-A-04 Administrative Meetings and Reports (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-04 Administrative Meetings and Reports (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-7D-25 Quarterly Meetings
- 4-ALDF-7D-26 Statistical Reports
- 1-HC-7A-06 Communication

1. PURPOSE

This policy is intended to ensure that the Responsible Health Authority (RHA) / Health Services Administrator (HSA) ensures that health care policies and procedures are developed, documented, and readily available to health care staff. Policies and procedures address each applicable standard in the NCCHC *Standards for Health Services in Jails/Prisons*.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The RHA/HSA and Responsible Physician / Medical Director review and approve all policies and procedures on an annual basis.

Policy, procedure, and program manuals are readily available to health care staff at all times for reference. Newly employed health care staff are responsible for reviewing current policies and procedures and signing an acknowledgment that is placed into the employee's file.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Policy and Procedure manuals are site specific, prepared in a unified manner, and revised as needed.

6.2. Each policy and procedure is reviewed and approved by the RHA/HSA and Responsible Physician / Medical Director at the time of publishing and annually thereafter.

6.3. When a manual of policies and procedures is implemented, a front cover sheet with approval signatures for all policies and procedures will be prepared. The manual bears the date of the most recent review or revision and, at a minimum, the signatures of the facility's RHA/HSA and Responsible Physician / Medical Director.

6.4. Any employee may submit a request for consideration of a policy and procedure change. The parties authorized to approve policies and procedures will take the request into consideration.

6.5. The RHA/HSA is responsible for maintaining health care policies and procedures and for communicating to health care staff when changes are made, prior to implementation. Health care staff review policies and procedures any time they are revised or new policies are introduced.

6.6. Other policies, such as those for custody, kitchen, industries, and health care vendor or other contractors, do not conflict with health care policies.

6.7. The Policy and Procedure Manual is retained in a location that is accessible to health care staff members. To include online and hard copies (if necessary) in a common area within the facility.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Governance and Administration: J-A-05 Policies and Procedures (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Governance and Administration: P-A-05 Policies and Procedures (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-05 Policies and Procedures (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-7D-06 Policies and Procedures
- 4-ALDF-7D-07 Policies and Procedures

- 4-ALDF-7D-08 Policies and Procedures
- 4-ALDF-7D-09 Policies and Procedures
- 1-HC-7A-03 General Administration

1. PURPOSE

This policy is intended to establish a Continuous Quality Improvement (CQI) program that monitors and improves health care services delivered by Wellpath.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The Responsible Health Authority (RHA) / Health Services Administrator (HSA) will establish a CQI program to objectively monitor and evaluate the quality, effectiveness, consistency, and appropriateness of care delivered by health care staff. The CQI program will identify health care aspects to be monitored, implement and monitor improvement plans when necessary, and study the effectiveness of the improvement plans.

The RHA/HSA will establish a multidisciplinary CQI committee, with representatives from the major program areas. The Responsible Physician / Medical Director is involved in the CQI committee and participates beyond chart reviews.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

PHI – Protected Health Information as defined by HIPAA standards.

RHA/HSA – Responsible Health Authority / Health Services Administrator

IP – Improvement Plan

Thresholds – Expected level of performance (of aspects of health care) established by the quality improvement committee.

Quality Improvement Committee – Health staff from various disciplines (e.g., medicine, nursing, mental health, dentistry, health records, pharmacy, laboratory). The committee designs quality improvement monitoring activities, discusses the results, and implements corrective action. Committee membership should be fluid, depending on the issues being addressed.

6. PROCEDURE

6.1. The CQI committee will meet at least quarterly and can meet more often based upon need and contract requirements. Attendees will include facility representatives, Wellpath Regional Operations and/or Clinical leadership, RHA/HSA, Medical Director / Responsible Physician, and mental health representatives. The committee will:

6.1.1. Identify health care aspects to be monitored and establish thresholds

6.1.2. Design quality improvement monitoring activities

6.1.3. Analyze the results for factors that may have contributed to less than threshold performance

6.1.4. Design and implement improvement strategies to correct the identified health care concern

6.1.5. Monitor the performance after implementation of the improvement strategies

6.2. If the facility has less than 24/7 nursing, is not accredited, and is not required by contract to hold CQI Committee meetings, this can be accomplished via quarterly meetings with regional Operations and Clinical leadership.

6.3. CQI meeting minutes or summaries are made and retained for reference, and copies are available and reviewed by all appropriate staff.

6.3.1. CQI studies, committee meeting minutes, and related documents will be retained for at least three (3) years in accordance with accreditation cycles. If the facility is not accredited, the retention policy will remain for three (3) years.

CQI documents that are older than three (3) years will be destroyed in a secure manner and treated as PHI when destroyed, in accordance with policy *HCD-100_G-08 Patient Safety Organization (PSO)*.

6.4. Health record reviews are done under the guidance of the Responsible Physician / Medical Director or designee to ensure that appropriate care is ordered and implemented and that care is coordinated by all health care staff, including medical, dental, mental health, and nursing.

6.5. When the CQI committee identifies a health care problem or concern, a Process and/or Outcome Quality Improvement study is initiated and documented. At least one (1) Process and/or Outcome Quality Improvement study is completed per year.

6.5.1. Process Quality Improvement studies examine the effectiveness of the health care delivery process by:

- Identifying a facility problem
- Conducting a baseline study
- Developing and implementing an improvement plan
- Restudying the problem to assess the effectiveness of the improvement plan

6.5.2. Outcome Quality Improvement studies examine whether expected outcomes of patient care were achieved by:

- Identifying a patient clinical care problem
- Conducting a baseline study
- Developing and implementing a clinical improvement plan
- Restudying the problem to assess the effectiveness of the improvement plan

6.6. An annual calendar of studies is distributed to facilities to ensure that all required areas are being monitored, as determined by NCCHC and ACA standards as well as areas

recommended by the Wellpath Chief Clinical Officer, Patient Safety Officer, and/or the Corporate Office CQI Committee.

6.7. The CQI Committee will establish acceptable minimum thresholds for site-specific issues or problems which are studied. If a study or an indicator in a study scores below the acceptable minimum threshold, an improvement plan will be developed to address the issue. The indicators which required improvement will be restudied once the improvement plan has been implemented, until threshold is reached.

The CQI Committee will use the established internal method of random sampling when performing audits and will use the reference sample size charts provided in the studies to pick the appropriate sample size for the study.

6.8. The CQI Committee completes an annual review of the effectiveness of the CQI program by reviewing CQI studies and minutes of CQI, administrative and/or staff meetings, or other pertinent written materials.

6.9. The CQI Committee operates under the direction and as a subcommittee of the Wellpath Corporate Office CQI Committee. All analyses developed for the purpose of patient safety and quality improvement are considered confidential and privileged as Patient Safety Work Product pursuant to policy *HCD-100_G-08 Patient Safety Organization (PSO)*.

7. REFERENCES

HCD-100_G-08 Patient Safety Organization (PSO)

NCCHC Standards for Health Services in Jails 2018

- Section: Governance and Administration: J-A-06 Continuous Quality Improvement Program (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Governance and Administration: P-A-06 Continuous Quality Improvement Program (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-06 Continuous Quality Improvement Program (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-24 Health Care Internal Review and Quality Assurance (M)

- 1-HC-4A-03 Internal Review and Quality Assurance (M)

1. PURPOSE

This policy is intended to ensure that health care encounters and exchanges of information remain private.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

All health care staff make every reasonable effort to ensure patient encounters are conducted in private, in accordance with community standards and professional ethical codes, and are carried out in a manner designed to encourage the patient's subsequent use of health care services.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing, and medical assistants, and clerical workers)

PHI – Protected Health Information as defined by HIPAA standards

6. PROCEDURE

6.1. Discussions of protected patient health information occur in private, without being overheard by patients and non-health care staff.

6.2. Health care is provided with consideration of the patient's dignity and feelings.

6.3. Every reasonable effort is made to ensure clinical encounters are conducted in private and not observed or overheard by custody staff unless the patient poses a probable risk to the safety of health care staff. When custody staff is present, either auditory or visual privacy is provided. Custody staff observing clinical encounters are instructed to keep confidential any health care information obtained.

6.4. Privacy is afforded during physician exams, with special considerations for pelvic, rectal, breast, or other genital exams. Chaperones are utilized, as indicated. Female patients are provided a female escort for encounters with a male health care provider.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Governance and Administration: J-A-07 Privacy of Care (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Governance and Administration: P-A-07 Privacy of Care (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-07 Privacy of Care (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-19 Privacy
- 1-HC-3A-10 Privacy

1. PURPOSE

This policy is intended to ensure that a confidential health record is created and maintained using a standardized format.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The Responsible Health Authority (RHA) / Health Services Administrator (HSA) or designee approves the method of recording entries in the health record and the content and format of the record. Entries in the health record have the place, date, time, signature, and credentials on each document. All health record notations are to be legible.

Documentation, at a minimum, shall be documented using SOAPE format or the appropriate form/template.

Active and inactive health records are kept confidential and separate from confinement records. Further, health records are to be secured at all times and accessible only to authorized health care staff. Access to the health records is controlled by the RHA/HSA or designee.

The RHA/HSA or designee will share pertinent medical information with custody staff about those patients whose physical/mental conditions may affect the safety and security of the facility, in accordance with state and federal laws. The circumstances are specified when correctional staff are advised of a patient's health status. Only the information necessary to preserve the health and safety of a patient, other patients, volunteers, visitors, or the correctional staff is provided. Information provided to correctional, classification staff, volunteers and visitors addresses only the medical needs of the patient as it relates to housing, program placement, security, and transport.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

SOAPE – Documentation which indicates the sequence of how items should appear when charting: subjective, objective, assessment, plan, and evaluation

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients

EHR – Electronic Health Record

MAR – Medication Administration Record

6. PROCEDURE

6.1. A health record is created at the time of the patient's first encounter with health care staff, and all health encounters are documented.

6.2. Health care staff that have a valid need are to have access to health records.

6.3. The patient's identification appears on each page of the health record.

6.4. The order of the health record is standardized at the site and consistent in all health records, whether the health record is a paper chart or Electronic Health Record (EHR).

6.5. Contents of the health record include the following, at a minimum:

- Patient name, plus at least one (1) other identifier (e.g., identification number, DOB, etc.)

- Master Problem List
- *Receiving Screening* and *Initial Health History and Physical Assessment* forms
- Progress notes of all significant findings, diagnoses, treatments, and dispositions
- Provider orders
- Medication Administration Records (MARs)
- Laboratory and X-ray reports
- Reports of diagnostic studies
- Flowsheets
- Consent and Refusal forms
- Release of Information forms
- Results of specialty consultations and off-site referrals
- Discharge summaries
- Special Needs Treatment Plans, if applicable
- Immunization records, if applicable
- Place, date, and time of each clinical encounter
- Credentials of each documenter
- All other relevant materials

6.6. Paper records include a legible signature and title of the provider.

6.7. If electronic records are used, procedures address integration of health information in electronic and paper forms.

6.7.1. Signatures for health care staff are completed electronically.

6.8. Electronic health records are password protected to protect access and provide security of the record.

6.9. Where mental health and dental records are separate from medical records, a process ensures that pertinent information is shared. At a minimum, a listing of current problems and medications is common to all mental health, medical, and dental records of a patient.

6.10. Health records stored in the facility are maintained under secure conditions and separate from correctional records (e.g., discipline reports, grievances, property, etc.).

6.10.1. The RHA/HSA is responsible for establishing and monitoring systems that ensure the security of health records.

6.10.2. At no time are health records to be incorporated into the confinement record.

6.10.3. Paper health records are returned in a timely manner after use.

6.10.4. Records requiring physician review/signature for paper charts are kept in a designated area in an organized manner that affords their availability to all health care staff should they be needed.

6.10.5. Inactive records are stored securely, kept for a specific duration, and released in accordance to the jurisdiction’s legal requirements.

6.11. Health care staff receive instruction on confidentiality of health information during initial orientation.

6.12. In order to maintain health record confidentiality, no unauthorized entry into the health record is permitted.

6.13. Health record information is transmitted to specified and designated community health care providers and agencies upon written request or authorization of the patient, when required by law.

6.14. Mental health, alcohol, and drug abuse information is confidential under federal regulations and can be disclosed only by specific written consent of the patient, in accordance with state and federal law.

6.14.1. Release of Information (ROI) forms shall be processed by the RHA/HSA or designee.

6.15. If records are transported by non-health care staff, the records are sealed.

6.15.1. Instructions for transport personnel regarding medication or other special treatment will be located on the outside of the transfer envelope in lay terminology, including any specific precautions such as mask or glove requirements.

6.16. When a patient is transferred to another correctional facility:

6.16.1. A copy of the current health record or a comprehensive health summary accompanies the patient. Health conditions, treatments, and allergies are included in the record.

6.16.2. The transfer and sharing of health records complies with state and federal law.

6.16.3. Written authorization by the patient is required to transfer health records and information to facilities outside the correctional system's jurisdiction unless otherwise provided by law or administrative regulation.

6.16.4. Storage of health records of patients who are released from the facility are organized in a manner that facilitates retrieval of the patient's inactive health record should the patient return to the facility.

6.17. There is a system for the timely reactivation of records when requested by a treating health professional.

6.18. If a patient has been admitted previously, the prior health record (if available) is reactivated and reviewed.

6.19. Qualified health care professionals have access to information in the patient's custody record when the health authority determines that such information may be relevant to the patient's health and course of treatment.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Governance and Administration: J-A-08 Health Records (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Governance and Administration: P-A-08 Health Records (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Clinical Records: MH-H-01 Clinical Record Format and Contents (E)
- Section: Clinical Records: MH-H-02 Confidentiality of Clinical Records and Information (E)
- Section: Clinical Records: MH-H-03 Management of Mental Health Information (I)
- Section: Clinical Records: MH-H-04 Access to Custody Information (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-13 Confidentiality (M)
- 4-ALDF-4D-14 Sharing of Information (M)
- 4-ALDF-4D-26 Health Records
- 4-ALDF-4D-27 Transfers
- 4-ALDF-4D-28 Inactive Records
- 1-HC-3A-03 Confidentiality (M)
- 1-HC-4A-06 Health Records
- 1-HC-4A-07 Transfers
- 1-HC-4A-08 Inactive Records

Forms

- Release of Information (ROI)
- Receiving Screening
- Initial Health History and Physical Assessment
- Provider’s Orders
- Informed Consent
- Refusal of Clinical Services

1. PURPOSE

This policy is intended to ensure that prescriptive treatment is performed pursuant to written or verbal orders which are signed by health care staff who are authorized by state laws to practice within the state where the facility is located.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Physicians, physician assistants, nurse practitioners, psychiatrists, and dentists are generally the individuals who are authorized to write or provide verbal medical orders. Applicable DEA certificates and/or registrations are kept on file in each practitioner's credentialing file.

Verbal orders are signed in accordance with state law.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

V.O. – Verbal Order

T.O. – Telephone Order

NKA – No known allergies

6. PROCEDURE

6.1. Orders for medical treatment are written on the Provider's Orders sheet.

6.2. Health care orders include the date, time, patient's name, identification number, and known allergies. If the patient has no allergies, "NKA" is to be written on the order sheet.

6.3. Medication orders require, in addition to the above requirements, the name of the medication, the dosage, the route, the frequency, and the duration.

6.4. Written health care orders may be transcribed by non-licensed staff when permitted by law; however, licensed health care staff must countersign these orders. The sign-off includes the date, time, and initials of the transcriber.

6.5. When the licensed provider is not physically on site, the health care orders can be provided verbally via the following steps:

6.5.1. The licensed nurse reads back the order obtained verbally for accuracy.

6.5.2. The health care order is transcribed by a licensed nurse with the initials "V.O." or "T.O.", nurse's signature, and the licensed provider's name.

7. REFERENCES

NONE

Forms

- Provider's Orders

1. PURPOSE

This policy is intended to establish a procedure to conduct a thorough review of all deaths in custody to verify best practices; to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; to identify issues that require further study; and to prevent future deaths.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

In-custody deaths will have a clinical and administrative mortality review within 30 days of death. Deaths occurring after release from custody and proximate to care (which may have a relationship to continuity of care) may have a mortality review performed, on a case-by-case basis. A psychological autopsy is performed on all deaths by suicide within 30 days.

Clinical mortality reviews, as a part of the CQI Program, are Patient Safety Work Product (PSWP) and part of the Patient Safety Evaluation System (PSES). Information developed through the internal mortality review process may not be released outside of Wellpath.

Mortality reviews incorporate CQI principles of analysis, action planning, and audit that action plans were implemented.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Mortality Review – A mortality review consists of both an administrative and clinical mortality review, as well as a psychological autopsy, if death is by suicide.

Clinical Mortality Review – The clinical mortality review is an assessment of the clinical care provided and the circumstances leading up to a death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved.

Administrative Mortality Review – The administrative mortality review is an assessment of correctional and emergency response actions surrounding a patient's death, regardless of the availability of autopsy results, and is conducted in conjunction with custody staff.

Psychological Autopsy – The psychological autopsy is a written reconstruction of an individual's life. It is usually conducted by a psychologist or another qualified mental health professional.

RHA/HSA – Responsible Health Authority / Health Services Administrator

MAR – Medication Administration Record

EMR – Electronic Medical Record

CCE – Critical Clinical Event

RDMH – Regional Director of Mental Health

PSES – Patient Safety Evaluation System

PSWP – Patient Safety Work Product

6. PROCEDURE

6.1. Death Notification Process:

Responsible	Actions to be taken
Wellpath employee who learns of the death	Notifies supervisor.

Responsible	Actions to be taken
Supervisor or designee	Notifies RHA/HSA.
	Requests involved Wellpath staff to complete documentation in the health record.
RHA/HSA	Ensures the health record is complete, including loose filings, MARs, and scanning loose papers into EMRs.
	Secures the original health record and releases medical records to the county coroner, if deemed necessary. Electronic health records are locked to prevent edits or additions.
	Ensures the event is entered into the risk management information system (RMIS) (DataTrkWeb) for CCE notification purposes, as soon as possible, but no later than 24 hours after the event. This process electronically notifies Director of Operations, Chief Operating Officer, Chief Medical Officer, Legal staff, Regional Director of Mental Health, Regional Medical Director, Regional Director of Operations, and Responsible Physician / Medical Director.

6.1.1. Individuals designated by the patient are notified in case of a serious illness, injury, or death, unless security reasons dictate otherwise.

6.1.2. Authorities having jurisdiction are immediately notified of a patient's death.

6.2. Clinical Mortality Review

Responsible	Actions to be taken
Corporate CQI Coordinator	Sends a notification email with timeline of required items and recommended participants for the Clinical Mortality Review.

Responsible	Actions to be taken
	Schedules Wellpath internal preliminary call and mortality review meetings and invites relevant parties, subject to confidentiality considerations.
	Tracks completion of the mortality review process.
RHA/HSA or Designee	Requests autopsy results.
	Completes *Form 01a Patient Informational Report* and submits to the Corporate Office for review by the Legal and Clinical Divisions at least seven (7) days prior to the scheduled Clinical Mortality Review and prior to the Administrative Mortality Review.
	After the Wellpath internal preliminary call, RHA/HSA completes a draft of *Form 01c Report and Recommendations* and submits to the Corporate Office for review by Legal and Clinical Divisions no less than three (3) business days prior to the Administrative Mortality Review Meeting.
Wellpath Mental Health Director	If death was a suicide, Mental Health Director will draft the Psychological Autopsy and submit to the RDMH at least seven (7) days prior to the Administrative Mortality Review. **If Wellpath is not responsible for the mental health portion of the contract, a psychological autopsy will be at the discretion of the entity responsible for mental health care.
Regional Director of Mental Health	If death was a suicide, RDMH reviews the draft Psychological Autopsy and recommends edits, if appropriate. Submits Psychological Autopsy to VP Behavioral Health or designee for review and finalization. **If Wellpath is not responsible for the mental health portion of the contract, a psychological autopsy will be at the discretion of the entity responsible for mental health care.

6.3. Clinical Mortality Review Invited Participants: (*denotes a required participant)

- Health Authority
- Other health care and supervision staff relevant to the incident
- Staff involved in the event (participate when possible)
- Regional or Corporate Office CQI representative*
- Patient Safety Officer*
- Director of Operations* and/or RVP* (one of whom must attend)
- Regional Medical Director*
- Appropriate in-house counsel*
- Clinical Risk Manager
- If event was a suicide:
  - Regional or Corporate Office Mental Health representative*
  - Chief of Psychiatry and Chief of Psychiatry for Corrections

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6.4. **Administrative Mortality Review:**

Responsible	Actions to be taken
RHA/HSA or designee	Schedules Wellpath Administrative Mortality Review meetings and invites relevant parties, subject to confidentiality considerations.
	Holds Administrative Mortality Review meeting, reviewing the areas on *Form 01c Reports and Recommendations* and any other relevant factors to the specific event.
	Submits all Mortality Review report forms to the Corporate Office CQI Coordinator.
	Assembles any recommendations regarding future improvements and submits them to the next CQI committee meeting for review.
	If improvements were recommended as part of the Mortality Review meeting, the RHA/HSA or designee will develop an improvement plan and enter it into the RMIS (DataTrkWeb system) within seven (7) days of the Mortality Review meeting.
	Informs staff of the findings of the Mortality Review meeting.
RHA/HSA or designee	Documents implementation of the Improvement Plan and submits to the Wellpath Corporate Office upon completion of action steps.
	Obtains autopsy results, if performed and available.
	Shares autopsy results with site Responsible Physician / Medical Director.

Responsible	Actions to be taken
RHA/HSA or designee	Forwards autopsy results to regional or Corporate Office personnel.
Corporate CQI Coordinator	Compiles Mortality Review materials, creates files, and submits to Patient Safety Officer and CQI Director for review.
Corporate CQI Director	Requests Risk Management review, if applicable.
Site CQI Committee	Reviews the results of the Mortality Review.
	At final conclusion of the review process, destroys copies of Part III (*Form 01c Report and Recommendations*) on the local level, and the original will be maintained at the Corporate Office. Copies of mortality review *Form 01a Patient Informational Report* and *Form 01b Mortality Review Meeting Signature Sheet* may remain at the facility.
	Affirms recommendations for improvement and may make other recommendations.
	Writes minutes that reflect recommendations but that do not include identifying details from the Mortality Review.
	Determines how improvements should be implemented.
Regional Medical Director, Associate Chief Clinical Officer, Patient Safety Officer	Reviews autopsy results and determines whether the Mortality Review needs to be reopened. Advises Site Responsibly Physician / Medical Director if the Mortality Review Committee needs to be reconvened.

Responsible	Actions to be taken
Regional Director of Operations, Regional Vice President, Regional Medical Director	Works with appropriate personnel to implement changes.
CQI Program Manager	Requests and tracks supporting documentation for improvement plans.

6.5. Administrative Mortality Review Invited Participants: (* Denotes Required Participant)

- Patient Safety Officer
- Director of Operations* and/or RVP (one of whom must attend)
- Regional Medical Director*
- Appropriate in-house counsel
- Clinical Risk Manager
- Facility Administrator, Custody/client representative
- If event was a suicide, invites:
  - Regional or Home Office Mental Health representative*
  - Chief of Psychiatry and Chief of Psychiatry for Corrections

6.6. Treating staff are informed of pertinent findings of all reviews.

6.7. A log is maintained that includes:

- Patient name or identification number
- Age at time of death
- Date of death
- Date of clinical mortality review
- Date of administrative review
- Cause of death (e.g., hanging, respiratory failure)
- Manner of death (e.g., natural, suicide, homicide, accident)
- Date that pertinent findings of reviews shared with treating staff
- Date of psychological autopsy, if applicable

7. REFERENCES

HCD-100_A-09A Morbidity
HCD-100_A-09B Critical Clinical Events

NCCHC Standards for Health Services in Jails 2018

- Section: Governance and Administration: J-A-09 Procedure in the Event of an Inmate Death (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Governance and Administration: P-A-09 Procedure in the Event of an Inmate Death (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-10 Procedure in the Event of an Inmate Death (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-12 Notification
- 4-ALDF-4D-23 Inmate Death
- 1-HC-3A-02 Notification
- 1-HC-7A-05 Offender's Death

Forms

- Form 1a Patient Information Report
- Form 1b Mortality Review Meeting
- Form 1c Mortality and Morbidity Review Report and Recommendations
- Form 2 Psychological Autopsy

1. PURPOSE

This policy is intended to ensure morbidity reviews are conducted to verify best practices; to determine the appropriateness of clinical care; to ascertain whether certain changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Critical Clinical Events (CCEs) in which there are concerns of multi-system issues, multidisciplinary hand-off issues, clinical care concerns, or other complicated process or system issues may be deemed by the CQI work group to require a morbidity review within 30 days of the event.

Morbidity reviews are performed by a multidisciplinary team that includes site, regional, and Corporate Office staffs to determine contributing and root causes, verify best practices, and identify opportunities for improvement, if applicable.

Morbidity reviews, as part of the CQI Program, are Patient Safety Work Product (PSWP) and part of the Patient Safety Evaluation System (PSES). Information developed through the morbidity review process may not be released outside of Wellpath.

This is a companion policy to *HCD-100_A-09B Critical Clinical Events*.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

CCE – Critical Clinical Event

PSES – Patient Safety Evaluation System

PSWP – Patient Safety Work Product

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. The CQI Work Group, a sub-committee of the Corporate Office CQI Committee, meets weekly to review each CCE reported.

6.1.1. A morbidity review will be endorsed and requested by a member of the Patient Safety Committee (a subcommittee of the Corporate Office CQI Committee) in order to be scheduled and performed. The Patient Safety Committee is composed of the Patient Safety Officer, the CQI Director, and in-house attorney.

6.2. The morbidity review is performed within 30 days of the event.

Responsible	Actions to be taken
CQI Work Group	On a weekly basis, the CQI Work Group reviews each CCE as a multidisciplinary team.
Patient Safety Committee	If concerns of multi-system issues, multidisciplinary hand-off issues, clinical care concerns, or other complicated process or system issues exist, a morbidity review may be considered. In order to be scheduled, a member of the Patient Safety Committee will request the morbidity review.
Corporate CQI Coordinator	Notifies RHA/HSA, Regional Director of Operations, Regional Vice President, Regional Medical Director, VP Behavioral Health, Chief of Psychiatry, Chief of Psychiatry for Corrections, and Regional Director of Mental Health (if applicable) of the determination of need for the morbidity review and sends an email with timeline of required items for the morbidity review.

Responsible	Actions to be taken
	Schedules morbidity review meeting and invites relevant parties, subject to confidentiality considerations.
	Tracks completion of the morbidity review.
RHA/HSA or designee	Ensures the event is entered into the risk management information system (RMIS) (DataTrkWeb) for CCE notification purposes, as soon as possible, but no later than 24 hours after the event.
	Completes Part I (*Form 01a Patient Informational Report*) and submits to Corporate CQI Coordinator at least one (1) day prior to the scheduled morbidity review meeting.
	After the morbidity review call, drafts *Form 01c Report and Recommendations* and submits to the Corporate Office for review by Risk Strategies and Clinical Divisions.
	If improvements were recommended as part of the morbidity review meeting, the RHA/HSA will develop an improvement plan and enter it into the RMIS (DataTrkWeb system) within seven (7) days of the morbidity review meeting.
	Generates an improvement plan in the RMIS (DataTrkWeb), if applicable.
	Informs treating staff of the findings of the morbidity review meeting.
Site CQI Committee	Reviews the results of the morbidity review.
	At final conclusion of review process, destroys local copies of morbidity review.

Responsible	Actions to be taken
	Writes minutes of the site CQI Committee that reflect recommendations but that do not include details from the morbidity review.
Regional and Corporate Office Personnel	Works with appropriate personnel to implement changes, as applicable.
	Tracks the implementation and monitoring of the improvements implemented.

7. REFERENCES

HCD-100_A-09 Procedure in the Event of Patient Death
HCD-100_A-09B Critical Clinical Events

Forms

- Form 01a Patient Informational Report
- Form 01b Mortality Review Meeting
- Form 01c Mortality and Morbidity Review Report and Recommendations
- Form 2 Psychological Autopsy

1. PURPOSE

This policy is intended to ensure that Wellpath has a process to identify and track events that may affect patient safety.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Critical Clinical Events (CCEs) are events that may affect patient safety. Wellpath defines CCEs and the potential review processes in order to increase patient safety, to increase the quality of care provided to its patients, and to improve future performance.

A CCE is (1) an occurrence involving death or serious physical or psychological injury, or risk thereof, traditionally known as a SENTINEL EVENT; (2) a clinical event with significant implications for Wellpath clients; and/or (3) a clinical event that Wellpath has deemed high risk and monitors for purposes of verifying best practices.

The CCE process, as a part of the CQI Program, is confidential Patient Safety Work Product (PSWP) and is part of the Patient Safety Evaluation System (PSES). Information developed through the CCE process may not be released outside of Wellpath.

A list of events designated as CCEs is developed annually and distributed as the *Critical Clinical Events Quick Guide*.

Each CCE is reviewed by the Corporate Office CQI Work Group, who recommends one of the follow levels of review:

- CQI Work Group Review (occurs during the weekly multidisciplinary CQI Work Group meeting)

- Root Cause Analysis
- Morbidity Review – see corresponding policy *HCD-100_A-09A Morbidity*
- Mortality Review – see corresponding policy *HCD-100_A-09 Procedure in the Event of Patient Death*

Each level of review is completed by a multidisciplinary team and utilizes the root cause analysis problem solving methodology. CCE reviews are carried out by the site CQI committee or subcommittee for this purpose. Membership includes those who contribute to the care process, including custody staff as appropriate.

Depending on the findings of the review performed, an improvement plan may be developed to address deficiencies. The site CQI committee or its representative is responsible for the development of the improvement plan.

At the conclusion of the CCE review process, the following material is retained on-site:

- Improvement Plan (IP) contained in the Risk Management Information System (RMIS)
- Generalized documentation that the CCE review was discussed in the CQI committee meeting, omitting specific findings

The following material is retained in the Wellpath Corporate Office under the control of the CQI department:

- Full record of CCE review and recommendations
- Supporting documentation necessary as determined by the CCE Corporate Office CQI Committee

The CCE process, as part of the CQI program, is a confidential peer review process and will not be released to auditors, outside attorneys, media representatives, or others without court order.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

CCE – Critical Clinical Event

IP – Improvement Plan

PSES – Patient Safety Evaluation System

PSWP – Patient Safety Work Product

RDO – Regional Director of Operations

RHA/HSA – Responsible Health Authority / Health Services Administrator

RMHD – Regional Mental Health Director

RMD – Regional Medical Director

6. PROCEDURE

6.1. The following procedure will be followed upon the occurrence of an event that meets the definition of a CCE. Mortalities are included in steps 1 through 3, then follow the procedure outlined in the Mortality Review policy, *HCD-100_A-09 Procedure in the Event of a Patient Death*. At any point, non-fatal events can be designated as requiring a Morbidity Review. When a determination is made by a member of the Patient Safety Committee that a Morbidity Review is required, the CCE process below will end and the procedure outlined in the Morbidity Review policy (*HCD-100_A-09A Morbidity*) will commence.

6.2. Treating staff are informed of the CCE review findings.

Step	Who	When	Does What
1	RHA/HSA, RDO, or designee	ASAP	Enters the event into the RMIS (DataTrkWeb). Those sites that do not have access to the RMIS will send an email using the CCE email distribution list, copying the RDO
2	CQI Work Group	Weekly, and as needed	Convenes as a multidisciplinary group and reviews all CCEs received since the last meeting of the group

Step	Who	When	Does What
3	In-House Counsel	As events are received and during CQI Work Group weekly meeting	Evaluates current information regarding the event to determine if further legal investigation or action is warranted If invoking attorney client privilege, directs the investigation in anticipation of litigation
4	CQI Program Manager	Within one (1) business day	Determines level of review and assigns lead investigator and notifies Clinical and Operational leadership for the site
5	RMD and/or RDO/RVP	Within two (2) business days	Notifies CQI department of any information that may result in the need to adjust the level of the review or the investigator
6	CQI Program Manager	Within one (1) business day	Notifies site RHA/HSA of lead investigator appointed, and provides deadlines to RHA/HSA for review completion
7	Designated lead investigator (with RHA/HSA assistance)	Within 10 business days from notification by CQI Program rep	With appropriate on-site and regional staff involvement, investigates and assembles material as appropriate. Completes Root Cause Analysis forms and initial proposed IP in the RMIS (or the paper forms if the RMIS is unavailable)
8	CQI Program Manager	Within three (3) days of receipt	Documents review in RMIS and communicates any risk concerns to Legal Requests Senior Clinician Review from the Patient Safety Officer, Associate Chief Clinical Officers, VP Behavioral Health, Chief of Psychiatry/Chief of Psychiatry for Corrections, or the Regional Directors of Mental Health
9	Patient Safety Officer, Regional Director of Mental Health, or VP Behavioral Health	Within five (5) days of receipt	Reviews materials and plans for improvement
			Recommends that: (1) No IP is warranted (2) Proposed IP is appropriate with no changes (3) Minor revisions to IP are warranted, or (4) Higher-level investigation is warranted (see shaded section below)
			Presents findings and recommendations to the Corporate Office CQI committee as appropriate
If no additional analysis/investigation is necessary, skip to section below shaded rows.			

Step	Who	When	Does What
9a	RHA/HSA or designated staff member	Within 10 business days	Organizes follow-up root cause analysis AND/OR revised IP to be completed within 10 business days. Completes report in RMIS (uses paper forms if RMIS is unavailable)
9b	CQI Program Manager	Within three (3) business days	Coordinates follow-up review to appropriate Corporate Office staff (RMD, RVP, RMHDs, VP Behavioral Health, and/or Chiefs of Psychiatry, Chief Clinical Officer, Associate Chief Clinical Officer, Patient Safety Officer, CQI Director, and others as appropriate)
9c	Patient Safety Officer, Associate Chief Clinical Officers, Chiefs of Psychiatry, or VP Behavioral Health, RMHDs	Within five (5) business days of receipt	Reviews follow-up report and/or revised IP and provides additional feedback as warranted
10	RHA/HSA, in consultation with RMD and/or RDO/RVP as appropriate	Within five (5) business days	Modifies IP if required. Implements IP Tracks completion of IP in site CQI minutes
11	CQI Program rep or designee	Within five (5) days of the target date on the IP	Tracks IPs to confirm that IP has been implemented, and requires submission of supporting documentation

7. REFERENCES

HCD-100_A-09 Procedure in the Event of Patient Death
HCD-100_A-09A Morbidity

Critical Clinical Events Quick Guide

1. PURPOSE

This policy is intended to ensure the facility protects a patient's right to disagree with or question the health care system.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath maintains a grievance process to address patients' concerns about health care services. Patients have the right to communicate concerns regarding health treatment and services and to receive a response. Responses to the patients' concerns are completed by health care staff in accordance with the facility's policies and procedures. Grievances will be reviewed on a routine basis by the site CQI Committee.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Patients are informed of the grievance procedure at the time of intake.

6.2. The Responsible Health Authority (RHA) / Health Services Administrator (HSA) will respond in writing to the patient within the specified timeframe, per contract, but no later than seven (7) days after receipt. Written responses are based on principles of adequate medical care.

6.3. Patient grievances will be investigated and the patient provided with a written response, which is documented.

6.3.1. Grievances or complaint responses may include a face-to-face component for clinical issues but may involve written correspondence for simple questions and answers.

6.4. Copies of grievances and Wellpath's response are sent to the Facility Administrator or designee for review. Grievances and responses will not be placed into the patient's medical record.

6.5. If a patient is not satisfied with the response, the patient may utilize the facility's grievance appeal process.

6.6. Grievance trends will be discussed at health care staff meetings, Continuous Quality Improvement meetings, and Medical Administrative Committee meetings.

6.7. Monthly statistics will include whether grievances were founded or unfounded as well as the type by category (e.g., medication error, missed appointment, health staff complaint, etc.).

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Governance and Administration: J-A-10 Grievance Process for Health Care Complaints (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Governance and Administration: P-A-10 Grievance Process for Health Care Complaints (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-11 Grievance Mechanism for Mental Health Complaints (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-2A-27 Orientation
- 4-ALDF-6B-01 Grievance Procedure
- 1-HC-1A-01 Access to Care (M)
- 1-HC-3A-01 Grievances

1. PURPOSE

This policy is intended to establish standards for communication between health care staff and the medical on-call provider when a provider is not on-site.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

During the time that the provider is not on-site, the on-call provider shall provide coverage for medical consultation with health care staff. Health care staff contacting the on-call provider for consultation will communicate information related to patient status in an organized manner. As a reminder for the importance of structured communication with the provider, each facility will place an SBAR telephone placard near each telephone used by health care staff. In addition, all health care staff will complete “SBAR for Clinical Communication” training.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

SBAR – Situation, Background, Applicable Nursing Data, Recommendation/Request - Provides a framework for communication between members of the health care team

On-Call Provider – The responsible provider for a facility when an on-site provider is not physically present or available on-site

MAR – Medication Administration Record

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

6. PROCEDURE

6.1. If a health care staff member determines it is necessary to contact an on-call provider, the health care staff member shall be prepared to provide an organized and complete verbal report so that the provider can make a decision about the plan of care.

6.1.1. Health care staff should be prepared *prior* to making the call to the provider with information about the patient's current status, history, and significant changes in condition.

6.1.2. The health care staff member is to have the health record and MAR readily available.

6.1.3. Health care staff should obtain current vital signs to include temperature, blood pressure, pulse, respirations, and pulse oximetry.

6.1.4. The health care staff's observations of the patient's current status/complaint will be documented following Wellpath guidelines for documentation in the health record and for reference when discussing the situation with the provider.

6.2. It is recommended that health care staff communicate information to the provider in SBAR format, including Situation, Background, Applicable Nursing Data, Recommendation/ Request. When situations are not emergent or urgent, health care staff are to group issues together and make a call to the provider to consult on multiple patients at once.

6.3. The health record will be documented with the details of the call to the provider including, but not limited to, health care staff evaluation of the patient; date and time of call to provider; name of the provider called; details of call; any orders received; read back of verbal and/or telephone orders; implementation of orders received; and any follow-up care provided to the patient.

6.4. It is expected the on-call provider will answer any call from a facility for which he or she is scheduled for on-call. It is further expected that the provider make a return call within one (1) hour from the time of initial contact.

6.4.1. If there is no response from the primary on-call provider, efforts will be made by health care staff to contact the provider taking second call (ex: a doctor as backup for a mid-level), up to notification of the Regional Medical Director or Regional Director of Mental Health for urgent/emergent patient care issues.

6.4.2. In emergency situations, patient transfer to an acute care hospital should not be delayed due to lack of provider response or order.

6.4.3. For routine, non-emergency situations, health care staff will continue to attempt to reach the on-call provider or back up provider, as indicated, and should not rise such calls to the level of Regional Medical Director or Regional Director of Mental Health.

7. REFERENCES

NONE

1. PURPOSE

This policy is intended to ensure that health care policies, procedures, and practices emphasize health promotion, wellness, and recovery.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath is committed to instructing patients in methods of promoting their own health and preventing disease. Health care staff instruct patients at the time service is rendered on how to avoid preventable diseases. Such instruction is documented in the health record. Informative brochures from various health organizations are also made available to patients in the clinic area.

At no time under any circumstances will smoking or the use of any tobacco product, including electronic devices, be permitted inside any facility.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

PREA – Prison Rape Elimination Act

RDN – Registered Dietitian Nutritionist

6. PROCEDURE

6.1. One-on-one patient teaching on health education and instruction in self-care are provided to patients at the time of the encounter and on a regular, ongoing basis. Patients are encouraged to take an active partnership role in the treatment process.

6.1.1. Education may include, but is not limited to:

- Personal hygiene and nutrition
- Dental hygiene
- Prevention
  - ◊ STD
  - ◊ HIV
  - ◊ TB/Airborne Transmissible Disease (ATD)
  - ◊ Hepatitis
- Self-examination of breast, testicular, and skin cancers
- Drug abuse and dangers of self-medication
- Family planning, including both services and referrals, as appropriate
- Chronic diseases and/or disabilities
- Stress management

- Skills to help pursue personal recovery

6.1.2. All patient education is documented in the patient's health record. Documentation includes, but is not limited to:

- Topics discussed
- Patient understanding
- Written information provided to the patient

6.2. Written information provided to the patient will be in a language and skill level appropriate for the patient.

6.3. During the intake screening, verbal and written information on access to health care and PREA (Sexual Assault Awareness) is given.

6.4. Whenever possible, written, audio, and/or video materials will be made available to patients for educational purposes.

6.4.1. General health educational information is accessible to all patients (i.e., library, housing areas).

6.4.2. Information on the health hazards of tobacco is available. Pamphlets, education, self-help classes, and informational digital media from the American Cancer Society, the American Lung Association, and the American Heart Association are utilized.

6.5. Health care staff promote and provide education on exercise and physical activity options in the facility.

6.6. Smoking is prohibited in all inside areas. If the facility allows smoking outside, specific areas are designated.

6.7. The facility provides a nutritionally adequate diet to the general population.

6.7.1. A registered dietitian nutritionist (RDN), or other licensed nutrition professional, as authorized by state scope of practice law, documents a review of the regular diets for nutritional adequacy at least annually.

6.7.2. The facility has a procedure in place to notify the RDN whenever the regular diet menu is changed.

6.8. Health promotion and disease prevention include medical services such as periodic complete physical exams, routine health screenings, and immunizations.

6.8.1. Prophylactic immunizations and gamma globulin treatment is provided in cooperation and in accordance with local Public Health guidelines.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Health Promotion, Safety, and Disease Prevention: J-B-01 Healthy Lifestyle Promotion (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Health Promotion, Safety, and Disease Prevention: P-B-01 Healthy Lifestyle Promotion (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Mental Health Promotion: MH-F-01 Mental Health Education and Self-Care (I)
- Section: Mental Health Promotion: MH-F-02 Healthy Lifestyle Education and Promotion (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-1A-21 Smoking
- 4-ALDF-4C-21 Health Education
- 1-HC-1A-18 Health Education

Forms

- Patient Education Forms (English & Spanish)

1. PURPOSE

This policy is intended to ensure that there is a comprehensive institutional program that includes surveillance, prevention, and control of communicable disease.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath will maintain an effective Infection Control program that focuses on the prevention, diagnosis, and treatment of infectious and communicable diseases. The Infection Control Committee is a subcommittee of the CQI committee. Infection control issues, including recommendations to control and prevent the spread of infectious diseases, are addressed at the scheduled CQI Committee and Medical Audit Committee meetings. A multidisciplinary team that includes clinical, security, and administrative representatives meets at least quarterly to review and discuss communicable disease and infection control activities and about confidentiality and special supervision.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

PPE – Personal Protective Equipment

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Surveillance

6.1.1. The RHA/HSA ensures surveillance to detect patients with serious infections and communicable diseases is effective.

6.1.2. Patients are screened for communicable diseases during any or all of the following:

- Initial booking process / receiving screening
- Health Assessment / communicable disease screening
- Sick Call

6.1.3. All patients will receive a skin test for tuberculosis during the initial intake or within seven (7) days of admission to the facility.

6.1.4. Tuberculosis testing will be repeated annually, at a minimum, for patients remaining in custody.

6.2. Control

6.2.1. There is a written Exposure Control Plan approved by the Responsible Physician / Medical Director. The plan addresses the management of, at a minimum, tuberculosis; HIV; and Hepatitis A, B, and C. The plan is reviewed and updated at least annually and is consistent with the current requirements and published guidelines of the Centers for Disease Control and Prevention (CDC), the National Institute of Occupational Safety and Health (NIOSH), and the Occupational Safety and Health Administration (OSHA).

6.2.2. Patients found to have an infectious disease which has not been treated will either be seen and treated immediately by qualified health care staff or be referred to the hospital emergency department.

6.2.3. If appropriate, patients with contagious diseases are segregated until a medical evaluation can be completed.

6.2.4. Patients requiring respiratory isolation are housed in a functional negative pressure room.

- If the facility is equipped with negative air pressure rooms used to house patients requiring respiratory isolation, a procedure is followed to ensure daily checks of rooms are conducted.

- For facilities not equipped with negative pressure rooms, the procedure requires transport to a community hospital where the patient can be appropriately isolated.

6.2.5. Effective ectoparasite control procedures are used to treat infected patients and disinfect bedding and clothing. The patient's bedding and clothing infected with ectoparasites are disinfected. Prescribed treatment is given to the infected patient and is ordered only by providers taking into account all conditions including pregnancy, open sores, and rashes. If the facility routinely delouses patients, only over-the-counter medications, such as those containing pyrethrins, are used.

6.3. Prevention

6.3.1. Patients are encouraged to utilize the daily sick call for any medical conditions which might appear contagious.

6.3.2. Immunizations are provided to prevent diseases when appropriate.

6.3.3. Standard Precautions, including but not limited to Personal Protective Equipment (PPE), are always used by health care staff to minimize the risk of exposure to blood and bodily fluids of potentially infected patients. Health care staff utilize needle safety devices during the course of their duties.

6.3.4. Training is provided annually on Bloodborne Pathogens and Standard Precautions.

6.3.5. The RHA/HSA or designee is the Infection Control Nurse who is responsible for maintaining proper record keeping and serving as an advisor in the area of infection control.

6.3.6. Appropriate medical, dental, and laboratory equipment/instruments are appropriately cleaned, decontaminated, and sterilized per applicable recommendations and/or regulations.

6.3.7. Sharps and bio-hazardous wastes are disposed of properly on a routine basis. All Biohazard waste is properly stored and appropriately labeled per OSHA requirements. Functional, accessible, and visible sharps disposal containers are available.

6.3.8. All custodial, sanitation, and inmate workers are trained in appropriate methods for handling and disposing of biohazardous materials and spills.

6.4. Reporting

6.4.1. Health care staff shall report all appropriate communicable diseases to the County Health Department in accordance with federal, state, and local laws and regulations.

6.4.2. The RHA/HSA or designee ensures there is analysis and trending of data specific to infection control issues and/or focus studies.

6.5. Discharge

6.5.1. Health care staff work to ensure that patients who are released with communicable or infectious diseases are given community referrals.

6.6. Environmental Inspection

6.6.1. A monthly environmental inspection is conducted of areas where health services are provided to verify that:

- Equipment is inspected and maintained

- The unit is clean and sanitary
- Measures are taken to ensure the unit is occupationally and environmentally safe

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Health Promotion, Safety, and Disease Prevention: J-B-02 Infectious Disease Prevention and Control (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Health Promotion, Safety, and Disease Prevention: P-B-02 Infectious Disease Prevention and Control (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Safety: MH-B-01 Infection Prevention and Control Program (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-14 Communicable Disease and Infection Control Program (M)
- 4-ALDF-4C-15 Communicable Disease and Infection Control Program - Tuberculosis
- 4-ALDF-4C-16 Communicable Disease and Infection Control Program (M) - Hepatitis
- 4-ALDF-4C-17 Communicable Disease and Infection Control Program (M) - HIV
- 4-ALDF-4C-18 Communicable Disease and Infection Control Program (M) - Waste
- 1-HC-1A-11 Communicable Disease and Infection Control Program (M)
- 1-HC-1A-12 Communicable Disease and Infection Control Program - Tuberculosis
- 1-HC-1A-13 Communicable Disease and Infection Control Program (M) - Hepatitis
- 1-HC-1A-14 Communicable Disease and Infection Control Program (M) - HIV
- 1-HC-1A-15 Communicable Disease and Infection Control Program (M) - Waste

Wellpath Infection Control Manual

1. PURPOSE

This policy is intended to ensure that patients are provided with clinical preventive services as medically indicated.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The Responsible Physician / Medical Director or designee determines the medical necessity and/or timing of screenings and other preventive services (e.g., mammograms, colorectal screening, prostrate screening, pap smears).

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

NONE

6. PROCEDURE

6.1. The Responsible Physician / Medical Director determines the frequency and content of periodic health assessments.

6.2. The Dentist determines the frequency and content of periodic dental evaluations.

6.3. The Responsible Physician / Medical Director determines the medical necessity and/or timing of screening for communicable diseases (e.g., HIV, syphilis, gonorrhea, chlamydia) to include laboratory confirmation, treatment, and follow-up as clinically indicated.

6.4. Immunizations are administered to patients as clinically indicated.

6.5. Patients who have had a positive TB skin test shall undergo a symptom screen annually. Any of these patients who have an abnormal symptom screen will be masked and placed in isolation, and the provider will be contacted to order a chest X-ray.

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An example of a current Periodic Health Assessment Plan

Ages 11-20:

Blood pressure
Height and Weight
PPD screening

Ages 21-64:

Blood pressure
Height and weight
PAP test every three years in those with normal previous screenings
Colorectal cancer screening with FOBT at age 50 or older
Mammogram (women 50-69)
PPD screening

Ages 65 and older:

Blood pressure
Height and weight
FOBT
Colorectal cancer screening with FOBT at age 50 or older
Mammogram (women 50-69)
Vision and hearing screening
PAP test only in women not previously screened or with previous abnormal screenings
PPD screening

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Health Promotion, Safety, and Disease Prevention: J-B-03 Clinical Preventive Services (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Health Promotion, Safety, and Disease Prevention: P-B-03 Clinical Preventive Services (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-25 Health Appraisal Data Collection
- 4-ALDF-4C-26 Periodic Examinations

1. PURPOSE

This policy is intended to ensure that the health and safety of the inmate worker population are protected.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

There is an institutional committee or equivalent body that identifies and oversees inmate occupational-associated risks through a medical surveillance program.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

6. PROCEDURE

6.1. An initial medical screening of an inmate for contraindications to a work program, based on job risk factors and patient condition, is conducted prior to enrollment in the program.

6.2. Ongoing medical screening of inmates in work programs is conducted in the same way as medical screening of employee workers in equivalent jobs.

6.3. The Responsible Physician / Medical Director reviews and approves the health aspects of the medical surveillance program.

6.4. Inmate illness or injury potentially related to occupational exposure or with occupational implications is identified and the information provided to the CQI Committee for review.

6.5. Health care and custody staffs shall work collaboratively to ensure that inmates assigned to housekeeping duties in the health care delivery areas shall be instructed in Universal Precautions for Bloodborne Pathogen Exposure Control and Aerosol Transmissible Diseases (ATD) and issued personal protective gear and instructions appropriate to the situation.

6.6. Custody staff will provide health care staff with a list, as needed, of patients who have not yet been cleared for work requiring kitchen clearances.

6.7. The food service director shall be responsible for monitoring the health and cleanliness of all patient food service workers daily. Individuals deemed by the food service director and/or supervisors to require further medical evaluation relative to continued appropriateness for kitchen duty shall be referred to health care staff.

6.8. All patients working in the food service area are instructed to wash their hands upon reporting to duty and after using toilet facilities.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Health Promotion, Safety, and Disease Prevention: J-B-04 Medical Surveillance of Inmate Workers (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Health Promotion, Safety, and Disease Prevention: P-B-04 Medical Surveillance of Inmate Workers (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4A-13 Health Protection (M)
- 4-ALDF-4D-11 Inmate Assistants

- 1-HC-2A-18 Offender Assistants
- 1-HC-6A-13 Food Service Employees (M)

1. PURPOSE

This policy is intended to ensure that contraception is made available as clinically indicated.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Patients, both male and female, are screened for high-risk sexual behavior as part of the intake screening process. For women who are on a method of contraception at intake, continuation of contraception is considered and made available as clinically indicated. Sterilization of patients is prohibited, except in medically necessary and life-threatening situations. Emergency contraception is available at intake for women who report the need for emergency contraception.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

NONE

6. PROCEDURE

6.1. All patients are screened for high risk for sexually transmitted diseases as a component of the 14-day health assessment and communicable disease screening.

6.2. Patients are queried regarding the use of contraception and provided individual counseling and verbal/written educational information regarding sexually transmitted disease transmission and prevention, safe sex, and parenting skills. Written health education materials are available in English and Spanish.

6.3. At intake, any woman who requests emergency contraception due to the risk of pregnancy from unprotected sexual intercourse within the prior five (5) days will be further assessed for emergency contraception.

6.4. Continuing contraception is available after receiving screening, after a recent sexual assault that carries the risk of unwanted pregnancy, and when medically necessary.

6.5. For planned releases to the community, arrangements are made to initiate contraception for females, upon request. Females desiring to initiate contraception will be scheduled with a provider, at their request, 60 days prior to a scheduled release from custody. Information about contraception methods and community resources is also available upon request.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Health Promotion, Safety, and Disease Prevention: J-B-06 Contraception (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Health Promotion, Safety, and Disease Prevention: P-B-06 Contraception (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-13 Pregnancy Management (M)
- 1-HC-1A-10 Pregnancy Management (M)

1. PURPOSE

This policy is intended to ensure health care staff communicate with the facility administration and treating health care professionals regarding patients' significant health needs that must be considered in classification decisions in order to preserve the health and safety of the patient, other patients, and staff.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Health care staff notify custody staff whenever there is a significant health need that must be considered in classification decisions in order to preserve the health and safety of the patient, other patients, or staff. Such information is documented. Only that information necessary to preserve the health and safety of the patient, other inmates, volunteers, visitors, and staff is provided.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions.

6. PROCEDURE

6.1. Custody staff are advised of patients' special health needs that may affect housing, work and program assignments, disciplinary measures, transport to and from outside appointments, clothing or appearance, activities of daily living, and admissions to and transfers from institutions. Such communication is documented.

6.2. Health care and custody staffs communicate about patients with special needs conditions that may include, but are not limited to, the following:

- Chronically ill
- On dialysis
- Adolescents in adult facilities
- Have communicable diseases
- Physically disabled
- Pregnant
- Frail or elderly patients
- Terminally ill
- Mentally ill or suicidal
- Developmentally disabled
- Suspected victims of physical or sexual abuse
- Gender dysphoria
- Transgender

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Health Promotion, Safety, and Disease Prevention: J-B-07 Communication on Patients' Health Needs (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Health Promotion, Safety, and Disease Prevention: P-B-07 Communication on Patients' Health Needs (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-08 Communication on Patients' Mental Health Needs (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-12 Notifications
- 4-ALDF-4D-14 Information Sharing
- 1-HC-3A-06 Special Needs
- 1-HC-7A-06 Communication

Forms

- Special Needs Communication Form

1. PURPOSE

This policy is intended to ensure that the Responsible Health Authority (RHA) / Health Services Administrator (HSA) and custody staff implement systems to reduce risk and prevent harm to patients.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The RHA/HSA promotes patient safety by instituting systems to prevent adverse and near-miss clinical events. This is done through the Continuous Quality Improvement (CQI) program and the Wellpath Safety Program.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Adverse Clinical Event – An injury or death caused by medical management rather than by the patient's condition. Adverse clinical events may be caused by system errors that result in human error, whether the error occurs by omission (failing to do something that is supposed to be done) or commission (doing something that is not supposed to be done).

CCE – Critical Clinical Event

Near-Miss Clinical Event – An error in clinical activity without a consequential adverse patient outcome.

Patient Safety Systems – Practice interventions designed to prevent adverse and near-miss clinical events.

RHA/HSA – Responsible Health Authority / Health Services Administrator

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. The RHA/HSA, in coordination with the CQI program, has established an error reporting system for health care staff to voluntarily report, in a non-punitive environment, adverse and near-miss events that affect patient safety. In addition, the RHA/HSA, Medical Director, or a corporate representative can recommend a review of an adverse or near-miss clinical event. A Critical Clinic Event (CCE) is defined as an occurrence involving death or serious physical or psychological injury, or risk thereof. The following are examples of events that may be reviewed:

6.1.1. Medication errors

6.1.2. Near suicides

6.1.3. Hospitalizations resulting from delayed care or inappropriate treatment

6.1.4. Potential serious occurrences that were identified prior to an adverse patient outcome

6.2. CCE reviews are conducted on clinical occurrences that are considered a patient safety issue, such as those listed above.

6.3. At the conclusion of the CCE review process, the following material is retained on-site:

6.3.1. Record of plan of correction/improvement

6.3.2. Record that the CCE review was discussed in the CQI committee meeting (without findings)

6.4. At the conclusion of the CCE review process, the following material is retained in the Wellpath Corporate Office under the control of the Patient Safety Officer:

6.4.1. Full record of CCE review and recommendations

6.4.2. Full record of Root Cause Analysis (if one was performed)

6.4.3. Supporting documentation necessary as determined by the Risk Manager

6.5. The Wellpath Safety Program is followed at all times.

6.6. Wellpath has an established Medication Error Program that is based on the program established by the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP). Wellpath's Program is in compliance with all aspects of the NCC MERP program. The Wellpath Program requires the reporting and tracking of all medication errors, not just those that result in harm to the patient. NCC MERP continues to emphasize the importance of monitoring all medication errors to identify underlying or root causes of error. The Wellpath CQI Committee is responsible for reviewing medication errors and establishing action plans as appropriate.

7. REFERENCES

HCD-100_A-09B Critical Clinical Events
HCD-100_G-08 Patient Safety Organization (PSO)

NCCHC Standards for Health Services in Jails 2018
- Section: Health Promotion, Safety, and Disease Prevention: J-B-08 Patient Safety (I)

NCCHC Standards for Health Services in Prisons 2018
- Section: Health Promotion, Safety, and Disease Prevention: P-B-08 Patient Safety (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015
- Section: Safety: MH-B-02 Patient Safety (I)

ACA Standards / 2016 Standards Supplement
- 4-ALDF-1A-08 Injury Prevention
- 1-HC-6A-01 Injury Prevention

Wellpath Safety Program

1. PURPOSE

This policy is intended to document the clinical workflow process for the clinical decision support provided by the HCV Committee.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The HCV Committee will provide decision support for practitioners who are evaluating and treating patients with HCV. HVC patients who have been risk stratified and identified as possible candidates for Direct Acting Antivirals (DAA) therapy for their HCV will be presented to the HCV Committee.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

HCV Committee – Hepatitis C Virus Committee

RMD – Regional Medical Director

6. PROCEDURE

6.1. The HCV Committee is a subcommittee of the Wellpath Continuous Quality Improvement Committee.

6.2. The HCV Committee is composed of Standing Members and Ad Hoc Members. There must be at least three (3) Standing Members to convene a meeting.

6.2.1. Standing Members include the Chief Clinical Officer, Patient Safety Officer, Associate Chief Clinical Officer, designated Regional Medical Directors (RMDs), Vice President of Pharmacy, Pharmacy Director, and Regional Clinical Provider.

6.2.2. Ad Hoc Members include RMDs, Infectious Disease Nurses, Site Medical Directors, Regional Pharmacists, and Site Health Care Practitioners.

6.3. The RMD or designee will present patients in his or her region to the HCV Committee as candidates for DAA therapy. Prior to presenting the patients, the RMD or designee will perform the following steps:

6.3.1. Meet with the patient to complete a pertinent history and to ascertain the patient's ability and desire to be medicated with a DAA for their HCV.

6.3.2. The Hepatitis C Committee Worksheet will be completed (obtain from RMD).

6.4. The HCV Committee will evaluate presented data and recommend:

6.4.1. Request Addition Information: The HCV Committee may request the RMD to gather and provide additional information before recommendations can be provided.

6.4.2. Diagnostic and Therapeutic Interventions: The patient may be requested to be brought back to the HCV Committee after treatment of other more critical or timely issues, such as organ transplant, cancer, or other clinical or psychiatric issues.

6.4.3. Continue to Be Monitored: The patient can be monitored in Chronic Care Clinic at the site. The patient may be resubmitted to the HCV Committee if the parameters set for resubmission are reached or the practitioner or RMD feels it is clinically indicated.

6.4.4. DAA Medication(s) are Indicated: If this is recommended:

- Written consent will be obtained from the patient.

- Medications will be recommended, and the practitioner at the site will consider the recommendations and write orders.
- The lab schedule will be sent to the practitioner at the site with any additional instructions, if indicated.

7. REFERENCES

HCV Lab Schedule

1. PURPOSE

This policy is intended to ensure that systems are in place to identify and report potential cases of elder abuse and that appropriate and standardized action is taken in those cases.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath will address suspected cases of elder abuse in accordance with state and local guidelines.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Elder – A person 60 years of age or older, unless otherwise defined by the local jurisdiction

Abuse – To treat a person with cruelty or violence

PREA – Prison Rape Elimination Act

ER – Emergency Room

Physical Abuse – The use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include, but is not limited to, such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, choking, pulling hair, and burning. In addition, inappropriate use of drugs and physical restraints,

force-feeding, reckless driving, and physical punishment of any kind also are examples of physical abuse.

Sexual Abuse – Non-consensual sexual contact of any kind, which includes any unwanted touching, forced sexual activity, be it oral, anal, or vaginal, forcing the victim to perform sexual acts, painful or degrading acts during intercourse (e.g., urinating on victim), and exploitation through photography or prostitution.

Emotional Abuse – Subtle and quite often unseen, it is the infliction of anguish, pain, or distress through verbal assaults; insults; threats; intimidation; humiliation; harassment; isolating a person from his/her family, friends, or regular activities; or enforced social isolation.

Financial Abuse – Includes threatening, coercing, putting undue pressure or forcing an elder person into selling or handing over an asset or property, stealing goods from an elder person, using an elder person's banking and financial documents without authorization, managing the finances of a competent elder person without permission or misuse of an elder person's money or possessions.

Elder Abuse – A single or repetitive act, or lack of an appropriate action, occurring within a relationship where there is an implication of trust that results in harm to an elder person. This abuse can be an act of commission or of omission (usually described as ''neglect''), and it may be either intentional or unintentional. Elder abuse can be physical, psychological/emotional, financial, or sexual.

6. PROCEDURE

6.1. Wellpath staff should report **any suspicion of abuse**, regardless of whether it occurred prior to or during incarceration, to their supervisor as soon as it is suspected. In the event that the supervisor is the suspected abuser, the Regional Director of Operations should be contacted. In the event that the suspected abuser is an employee of an agency other than Wellpath, a family member or friend of the patient, or another patient/resident, the Wellpath supervisor or Regional Director of Operations will contact facility administration.

6.2. The patient should be placed in as safe of an environment as possible as soon as the abuse is suspected. The alleged abuser should be removed from all aspects of the patient's care and should have no contact with the patient until the review has been completed.

6.3. In the event of suspected **physical abuse**, the patient should be evaluated by a Wellpath practitioner as soon as possible unless the patient's condition is emergent or the practitioner is not on site, at which time the patient should be referred to the local Emergency Room (ER). The practitioner's role is that of triage and stabilization and not evidence collection. In the event of on-site treatment, the supervisor should work closely with facility administration to alert local authorities who will collect and document evidence.

6.4. In the event of suspected **sexual abuse**, local Prison Rape Elimination Act (PREA) policy should be followed.

6.5. In the event of suspected **emotional abuse**, the patient should be evaluated by a Wellpath qualified mental health professional as soon as possible unless the patient's condition is emergent or the practitioner is not on site, at which time the patient should be referred to the local ER.

6.6. In the event of suspected **financial abuse**, Wellpath Human Resources should be contacted if the alleged abuser is an employee of Wellpath. If this is not the case, the employing agency of the alleged abuser should be notified. If the alleged abuser in not employed at all, contact Wellpath Legal Department for guidance as to reporting.

6.7. The supervisor or the Regional Director of Operations will assist the person reporting the alleged abuse with any mandatory reporting requirements as required by state and local guidelines and will work with local authorities to assist in their investigation. In every case of suspected abuse of any kind, facility administration and Wellpath Legal Department should be notified within 24 hours of the initial report of the suspected abuse.

6.8. After initial evaluation of the patient's health and safety needs, the responsible practitioner will determine if ongoing clinical services are indicated, and a treatment plan will be developed. The patient will be added to the medical chronic care and/or mental health special needs rosters if the patient meets criteria for these programs.

7. REFERENCES

World Health Organization Monograph on Elder Abuse

TITLE: HCD-100_B-09 Staff Safety --Mecklenburg NC	REFERENCE: 59932 PAGE: 1 OF 3 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that health care staff work in a safe environment.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The Responsible Health Authority (RHA) / Health Services Administrator (HSA) and facility administration work together to implement measures to ensure a safe environment.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions

MAC – Medical Administrative Committee

6. PROCEDURE

6.1. Wellpath has an Employee Safety Program.

6.2. Appropriate measures are taken to ensure the safety of all health care staff in the facility. Staff will report all issues to the RHA/HSA within 24 hours.

6.3. When a safety concern arises, custody staff are requested and readily available to health care staff. Methods of communication between health care staff and custody staff are available.

6.4. If there is a safety concern regarding the health care staff, it is reported to facility administration and documented in MAC meeting notes.

6.5. On each shift where health care staff are present, inventories are maintained on items subject to abuse (e.g., needles, scissors, and other sharp instruments) and discrepancies are immediately reported to custody staff.

6.6. There is a designated Safety Officer for the health care staff who provides monthly in-services on safety issues during the staff meetings.

6.7. As in the community, health care staff identify and use contemporary equipment during the course of their duties (e.g., personal protective equipment, needle safety devices such as self-sheathing needles or needless systems).

6.8. Weekly sanitation inspections are conducted of all facility areas by a qualified department staff member.

6.9. Disposal of liquid, solid, and hazardous material complies with applicable government regulations.

6.10. All new direct care staff receive a test for tuberculosis prior to job assignment and periodic testing thereafter. (See HR policy *Tuberculosis Skin Testing* for more information.)

6.11. All direct care staff are offered the hepatitis B vaccine series. (See HR policy *Hepatitis B Vaccinations* for more information.)

7. REFERENCES

Wellpath Safety Program
Wellpath Infection Control Manual

Wellpath Employee Handbook

NCCHC Standards for Health Services in Jails 2018

- Section: Health Promotion, Safety, and Disease Prevention: J-B-09 Staff Safety (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Health Promotion, Safety, and Disease Prevention: P-B-09 Staff Safety (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Safety: MH-B-03 Staff Safety (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-1A-01 Sanitation (M)
- 4-ALDF-1A-02 Sanitation (M)
- 4-ALDF-4A-13 Health Protection (M)
- 4-ALDF-4D-06 Employee Health
- 4-ALDF-4D-07 Employee Health
- 1-HC-6A-01 Injury Prevention
- 1-HC-6A-02 Injury Prevention (M)
- 1-HC-6A-12 Facility Sanitation (M)

Forms

- Sharp and Instrument Count Sheet

1. PURPOSE

This policy is intended to ensure that there is an effective program for evaluating and managing patients who have experienced potential exposures to human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV), through various means.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath will maintain an effective blood-borne pathogen exposure protocol that focuses on the evaluation and management of potential exposures to HIV, HBV, and HCV.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

NONE

6. PROCEDURE

6.1. Health care staff will follow the 11-Step Program for evaluating and managing potential blood-borne pathogen exposures.

Step 1: Evaluate the Exposure

Step 2: Evaluate the Source Case

Step 3: Evaluate the Health Status of the Exposed Person

Step 4: Determine Need for HIV Post-Exposure Prophylaxis (PEP)

Step 5: Determine Need for HBV Post-Exposure Management

Step 6: Determine Need for HCV Post-Exposure Follow-Up.

Step 7: Determine Need for Tetanus Vaccine

Step 8: (Human Bites Only) Determine Need for Antibiotic Prophylaxis

Step 9: (Sexual Exposures Only) Conduct Screening for Sexually Transmitted Diseases

Step 10: Provide Counseling, Education, and Referral

Step 11: Complete Reporting and Documentation

6.2. The facility complies with all state and federal mandatory reporting laws.

7. REFERENCES

CDC. Antiretroviral post-exposure prophylaxis after sexual, injection-drug use, or other non-occupational exposure to HIV in the United States: recommendations for the U.S. Department of Health and Human Services. *MMWR;*54(No. RR-2):1-19. Available at *http://www.cdc.gov/mmwr/PDF/rr/rr5402.pdf*

CDC. Guidance for evaluating health-care personnel for hepatitis B virus protection and for administering post-exposure management. MMWR. 2014;62(10):1-24.

CDC. Updated information regarding antiretroviral agents used as HIV post-exposure prophylaxis for occupational HIV exposures. MMWR. 2007;56(No. 49):1291-1292. Available at: http:///www.cdc.gov/mmwr/pdf/wk/mm5649.pdf.

CDC. Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for post-exposure prophylaxis.

MMWR. 2001;50(No.RR-11) Available at: http://www.cdc.gov/MMWR/preview/MMWRhtml/rr5011a1.htm.

USPHS. Updated U.S. Public Health Service guidelines for the management of occupational exposures to human immunodeficiency virus and recommendations for post-exposure prophylaxis. Infect Control Hops Epidemiol. 2013;34(9:875-892. Available at: http://www.jstor.org/stable/10.1086/672271.

CDC. Diphtheria, tetanus, and pertussis: recommendations for vaccine use and other preventive measures: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR. 1991;40(No.RR-10):1-28. Available at: http://www.cdc.gov/MMWR/preview/MMWRhtml/00041645.htm

Gilbert DN, Moellering RC, Eliopoulos GM, Sande MA, eds. The Sanford Guide to Antimicrobial Therapy 2006. Sperryville, VA: Antimicrobial Therapy, Inc.; 2006.

Rittner AV, Fitzpatrick K, Corfield A. Best evidence topic report. Are antibiotics indicated following human bites? Emerg Med J. 2005;22:654.

CDC. Sexually transmitted diseases treatment guidelines, 2015. MMWR. 2015;59(No. RR-12):1-119. Available at: https://www.cdc.gov/std/tg2015/default.htm.

1. PURPOSE

This policy is intended to ensure that qualified health care professionals are legally eligible to perform their clinical duties.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

All qualified health care professionals have credentials and provide services consistent with the licensure, certifications, and registration requirements of the jurisdiction.

Wellpath is responsible for verifying the credentials of each health care staff member hired or contracted on a full-time, part-time, or PRN basis.

A complete file of current licenses, certifications, reference checks, and applications is maintained at the Wellpath Corporate Office. Copies of current licenses, certifications, CPR training, job descriptions, and completed applications are also maintained at the facility by the Responsible Health Authority (RHA) / Health Services Administrator (HSA) or designee in a readily accessible location.

Wellpath employees will also undergo the security clearance required by the facility.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. The RHA/HSA or designee will ensure that new hires undergo a credential verification process that confirms the current licensure, certification, and/or registration prior to making an offer of employment.

6.2. Each employee will be held responsible for providing renewal verification of his or her license prior to expiration date.

6.3. Providers must complete the credentialing process that is conducted by the Wellpath Corporate Office and must provide the facility a copy of current licensure and, when appropriate, DEA registration.

6.4. Inquiries into any sanctions or disciplinary actions of State Boards, employers, and the National Practitioner Data Bank (NPDB) are conducted.

6.5. A license that limits practice to only correctional health care will not be acceptable for suitable employment.

6.6. Qualified health care professionals do not perform tasks beyond those permitted by their credentials.

6.7. Employment references may be obtained via mail or over the phone with documentation. Each applicant is required to provide a minimum of two (2) references.

6.8. Health care staff who interact with patients must maintain current CPR certification and provide documentation of this certification to the RHA/HSA.

6.9. Specialists providing on-site or telehealth care services have appropriate licenses and certifications on file.

6.10. Students or interns will work only under staff supervision and will deliver care commensurate with their level of training.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Personnel and Training: J-C-01 Credentials (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Personnel and Training: P-C-01 Credentials (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Personnel and Training: MH-C-01 Credentials (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-03 Personnel Qualifications (M)
- 4-ALDF-4D-05 Credentials (M)
- 1-HC-2A-03 Personnel Qualifications (M)
- 1-HC-2A-05 Credentials (M)

1. PURPOSE

This policy is intended to ensure individuals delivering patient care are reviewed through a clinical performance enhancement process that evaluates the clinical performance of the clinician to identify areas of best practice and where improvement is possible or required.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Site CQI committees, along with the Responsible Health Authority (RHA) / Health Services Administrator (HSA), are responsible for ensuring that required peer reviews are completed in accordance with accrediting agencies' requirements. The review creates a confidential opportunity for the clinician to receive feedback regarding performance from another clinician with an understanding of the clinical practice being reviewed. It is not a Human Resource function and must not have any direct adverse consequences. Wellpath also requires peer reviews of registered nurses and licensed practical/vocational nurses at NCCHC-accredited facilities.

Certification that the peer reviews have been completed can be shared without violating confidentiality. Documents containing the actual substance of the review are considered Patient Safety Work Product (PSWP) and thus are protected from discovery at the federal level through the Patient Safety Organization (PSO) and may not be shared outside of Wellpath.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Clinical Performance Enhancement (Peer Review) – The process of having a health professional's work reviewed by another professional of at least equal training in the same general discipline, such as the review of the facility's physicians by the Responsible Physician / Medical Director

Direct Patient Care Clinicians – All licensed practitioners providing the facility's medical, dental, and mental health care. This includes physicians, dentists, mid-level practitioners, and qualified mental health professionals.

Independent Review – The assessment of a health care professional's compliance with discipline-specific and community standards. The review includes an analysis of trends in a practitioner's clinical practice. This review may be conducted by someone who may or may not be directly employed by the institution, if the reviewing practitioner has not been previously involved in the care of the patient(s) involved.

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Peer reviews will be completed in accordance with the accreditation requirements that pertain to the individual site:

6.1.1. Sites with NCCHC accreditation will coordinate and conduct ANNUAL reviews of the appropriate clinicians.

6.1.2. Sites with ACA accreditation will coordinate and conduct BIENNIAL reviews of the appropriate clinicians by a peer EXTERNAL to the facility.

6.1.3. Sites with Joint Commission accreditation will coordinate and conduct BIENNIAL reviews of the appropriate clinicians.

6.1.4. Sites with no accreditation will coordinate and conduct BIENNIAL reviews of the appropriate clinicians.

6.2. The clinician performing a peer review is expected to review aspects of care provided and work performed appropriate for the clinician being reviewed. The reviewer will randomly select charts for the review. Focused review topics and objective criteria may be collaboratively identified and developed by the Medical Director, the RHA/HSA, and

the reviewer. The reviewer will discuss his or her findings with the clinician being reviewed.

6.3. Improvement plans will be created when areas of improvement are required. The reviewer will work with the clinician and the RHA/HSA to establish an improvement plan.

6.4. Peer reviews are kept confidential and incorporate at least the following elements: the name and credentials of the individual being reviewed; the date of the review; the name and credentials of the reviewer; a summary of the findings and corrective action, if any; and confirmation that the review was shared with the individual being reviewed.

6.4.1. Wellpath provides worksheets specific to peer review. Once the findings of the review are communicated to the clinician reviewed, any and all worksheets shall be forwarded to the CQI department of the Wellpath Corporate Office for submission to the PSO. Only the certification that the review was completed will be maintained by the RHA/HSA.

6.5. The site maintains a log or written report outlining each clinician being reviewed and date of previous and next peer review for accreditation purposes.

6.6. The RHA/HSA implements an independent review when there is concern about any individual's competence or when such action is necessary.

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6.7. The following table identifies clinicians who may perform specific peer reviews:

Reviewer	Can review the following clinician
Chief Clinical Officer Associate Chief Clinical Officer Patient Safety Officer Regional Medical Director	Regional Medical Director Site Medical Director Staff Physician Somatic Advanced Practice Nurse Physician Assistant
Site Medical Director	Staff Physician Somatic Advanced Practice Nurse Physician Assistant
Staff Physician	Staff Physician Somatic Advanced Practice Nurse Physician Assistant
Dentist	Dentist
Somatic Advanced Practice Nurse	Somatic Advanced Practice Nurse
Physician Assistant	Physician Assistant
Chief Psychiatric Officer Chief Psychiatric Officer of Corrections Regional Psychiatric Director Consulting Psychiatrist	Director of Psychiatry Psychiatrist Psychiatric APN
Site Director of Psychiatry Site Psychiatrist	Psychiatrist Psychiatric APN
Psychiatric APN	Psychiatric APN
VP Behavioral Health	Psychologist Master Level Mental Health Professional
Master Level Mental Health Professional Regional Director of Mental Health	Master Level Mental Health Professional
Registered Nurse	Registered Nurse Licensed practical/vocational nurse
Licensed practical/vocational nurse	Licensed practical/vocational nurse

6.8. The findings of the peer review may not be released to surveyors, accrediting agencies, or other parties except at the approval of Wellpath attorneys.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Personnel and Training: J-C-02 Clinical Performance Enhancement (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Personnel and Training: P-C-02 Clinical Performance Enhancement (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Personnel and Training: MH-C-02 Clinical Performance Enhancement (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-25 Peer Review (M)
- 1-HC-4A-04 Peer Review (M)

TITLE: HCD-100_C-03 Professional Development -- Mecklenburg NC	REFERENCE: 59936
	PAGE: 1 OF 3 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that all qualified health care professionals maintain current clinical knowledge and skills.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

All qualified health care professionals receive at least 12 hours per year of continuing education or staff development appropriate to their position and local accreditation requirements. Additionally, health care staff who interact with patients will maintain CPR certification.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. The Continuing Education Program may include in-house education in the form of classes, self-study programs, outside seminars, conferences, or videotaped educational programs.

6.2. The in-service program includes, at a minimum, regularly scheduled in-service programs for one (1) hour of training, on average, for a total of 12 hours per year.

6.3. The RHA/HSA maintains a list of the state's continuing education requirements for each category of licensure of all qualified health care professionals.

6.4. It is the responsibility of the individual employee to ensure that continuing education requirements for re-licensure are met.

6.5. Documentation of in-services and continuing education are maintained in the employee's training file.

6.5.1. When the health care professional is a Certified Correctional Health Professional, a valid certification suffices.

6.5.2. In states where at least 12 hours of continuing education is required annually to maintain a clinical license to practice, a current license suffices.

6.5.3. A list of completed courses, dates, and number of hours per course is on file.

6.6. CPR Certification:

- Is required for all health care staff who interact with patients
- Must be current
- Is obtained from a recognized certification program instructor, i.e. American Heart Association or American Red Cross (see policy *CR-110-07 CPR Certification*)

6.7. Reference Material:

6.7.1. A basic reference library will be maintained on-site and is available to the health care staff.

6.7.2. At a minimum, the reference materials include current medical, pharmacological and nursing textbooks, and a medical dictionary.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Personnel and Training: J-C-03 Professional Development (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Personnel and Training: P-C-03 Professional Development (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Personnel and Training: MH-C-03 Training for Mental Health Staff (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-7B-08 Training and Staff Development
- 4-ALDF-7B-13 Training and Staff Development
- 1-HC-2A-08 Employee Orientation

1. PURPOSE

This policy is intended to ensure that correctional officers are trained to recognize the need to refer a patient to a qualified health care professional.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Educational programs are established and approved by the Responsible Health Authority (RHA) / Health Services Administrator (HSA) in cooperation with facility administration. Established Wellpath-approved materials guide the health-related training of correctional officers who work with patients. Each officer receives training at least every two (2) years. Training is in accordance with NCCHC and ACA guidelines.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Wellpath is responsible for approving all health-related training for custody staff who work with patients.

6.2. Custody staff who work with patients receive health-related training at least every two (2) years. Training includes, but is not limited to:

- Administration of first aid
- Recognizing the need for emergency care and intervention in life-threatening situations
- Recognizing acute manifestations of chronic illnesses (e.g. asthma, seizures), intoxication, withdrawal, and adverse reactions to medications
- Recognizing signs and symptoms of mental illness
- Recognizing dental emergencies
- Procedures for appropriate referral of patients with medical, dental, and mental health complaints to health care staff
- Precautions and procedures with respect to infections and communicable diseases
- Response to emergency or disaster conditions
- Maintaining patient confidentiality
- Alcohol and other drugs
- Procedures for suicide prevention
- Cardiopulmonary resuscitation (CPR) including the use of an automated external defibrillator

6.3. An outline of the training, including course content and length, is kept on file for custody staff.

6.4. A certificate or other evidence of attendance is kept on-site, by custody staff, for each employee.

6.5. The RHA/HSA or designee, in conjunction with the Facility Administrator or designee, will ensure that at least 75% of all custody staff on each shift are current in their health-related training.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Personnel and Training: J-C-04 Health Training for Correctional Officers (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Personnel and Training: P-C-04 Health Training for Correctional Officers (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Personnel and Training: MH-C-04 Mental Health Training for Correctional Officers (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-7B-10 Training and Staff Development
- 1-HC-2A-04 Personnel Qualifications

1. PURPOSE

This policy is intended to ensure that staff who administer or deliver prescription medication are appropriately trained.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Custody or health care staff who administer or deliver prescription medication to patients must be permitted by state law to do so. Medication administration training is approved by the Responsible Physician / Medical Director and Facility Administrator or designee.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

MAR – Medication Administration Record

6. PROCEDURE

6.1. Medication administration training will include, but not be limited to:

6.1.1. Medications used within the facility, including their action and possible side effects

6.1.2. Security matters inherent in the administration or delivery of medications in a detention environment

6.1.3. Administration or delivery of medication to ensure patients take medication as prescribed and do not hoard medication

6.1.4. The “Five Rights” of medication administration or delivery:

- Right patient
- Right medication
- Right dose
- Right route
- Right time

6.1.5. Accountability for administering or delivering medications in a timely manner according to practitioner orders

6.1.6. Accountability for proper inventory of medications and proper disposal of syringes and needles

6.1.7. Medications approved for “keep on person”

- Date and time patient received medication
- Signature of patient receiving medication

6.2. Health care staff will be oriented to the medication administration process during new employee orientation, as appropriate. The program will include:

6.2.1. Review of pharmacy policy and procedure

6.2.2. Observation of the medication administration process

6.2.3. Conducting medication administration under direct supervision

6.2.4. Documenting on the Medication Administration Record (MAR)

6.2.5. Completing the proper inventory of:

- New medications arriving from the pharmacy
- Use and accounting of stock supply
- Controlled substances and sharps counts

6.3. A current Drug References Manual is available for review of the actions and possible side effects of medications. The Wellpath formulary is also available as a resource.

6.4. Documentation of completed training and testing is kept on file for staff who administer or deliver medications.

6.5. Training curriculum will be reviewed annually and updated as needed.

7. REFERENCES

Controlled Substance Book
Wellpath Formulary
Pharmacy Policy and Procedure
Drug References Manual

NCCHC Standards for Health Services in Jails 2018
- Section: Personnel and Training: J-C-05 Medication Administration Training (E)

NCCHC Standards for Health Services in Prisons 2018
- Section: Personnel and Training: P-C-05 Medication Administration Training (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015
- Section: Personnel and Training: MH-C-05 Medication Administration Training (E)

ACA Standards / 2016 Standards Supplement
- 4-ALDF-4C-38 Pharmaceuticals (M)
- 1-HC-1A-35 Pharmaceuticals (M)

Forms

- Sharp and Inventory Count Sheet
- Keep on Person Agreement Form

1. PURPOSE

This policy is intended to ensure that health care services are provided by health care staff and not inmate workers.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Inmates are prohibited from being used as health care workers. Inmates are not substitutes for health care staff, but they may be involved in appropriate peer-health related programs or re-entry health care training programs.

Inmates under close, direct supervision may be used to work in the health care unit to provide housekeeping and janitorial assignments by the facility.

Inmates who are assigned to work in the health care unit and/or in food service areas will receive an initial medical screening and are approved by the Responsible Health Authority (RHA) / Health Services Administrator (HSA) or designee. Inmate workers must be trained before starting to work.

Inmates are expected to perform the duties they are assigned in a satisfactory and acceptable manner and to submit to the order and discipline of the medical unit.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

NONE

6. PROCEDURE

6.1. Other than those in a re-entry health care training program, inmates assigned to work in the health care unit **will not** be permitted to perform any of the following duties:

- Making treatment decisions or performing direct patient care
- Determining in anyway access to health care for other inmates
- Distributing or collecting sick-call slips
- Scheduling health care appointments
- Handling, administering, or having access to surgical instruments, syringes, needles, or medications
- Operating diagnostic, therapeutic, or any other type of medical equipment
- Transporting or viewing health records

6.2. Inmates in peer-health related programs are permitted to:

- Assist patients in activities of daily living (except for infirmary-level care patients)
- Participate in a buddy system for non-acutely suicidal inmates, after documented training
- Participate in hospice programs, after documented training

6.3. Patients have the right to refuse care delivered by inmates who are in a re-entry health care training program (e.g., dental assistant, nursing assistant).

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Personnel and Training: J-C-06 Inmate Workers (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Personnel and Training: P-C-06 Inmate Workers (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Personnel and Training: MH-C-06 Inmate Workers (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4A-13 Health Protection (M)
- 4-ALDF-4D-11 Inmate Assistants
- 1-HC-2A-18 Offender Assistants
- 1-HC-6A-13 Food Service Employees (M)

1. PURPOSE

This policy is intended to ensure that the Responsible Health Authority (RHA) / Health Services Administrator (HSA) ensures sufficient numbers and types of health care staff are available to care for the patient population.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Health care services are organized and staffed to meet the health care needs of the facility.

Health care services are provided by qualified health care personnel. Wellpath establishes job descriptions that detail the requirements and duties of each position. The job descriptions are designed to ensure that employees function within their scope of practice.

Wellpath does not utilize students or interns to meet staffing levels. Students or interns working in the system will work under direct staff supervision, commensurate with their level of training.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions.

Qualified Mental Health Professional (QMHP) – Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

6. PROCEDURE

6.1. The health services program is operated on a contractual agreement between Wellpath and.

6.2. The staffing plan was developed and implemented based on the physical layout of the facility, the average daily population, and the scope and degree of medical, mental health, and dental services to be provided.

6.2.1. The RHA/HSA approves the staffing plan.

6.2.2. The Wellpath staffing plan is reviewed annually to assess the adequacy and effectiveness of the ability to meet the health needs of the patient population and address when deficiencies are noted in the provision of services.

6.3. Clinical provider and nursing time is sufficient to fulfill clinical responsibilities and ensure that there is no unreasonable delay in patients receiving necessary care.

6.4. Responsible Physician / Medical Director must have sufficient time to fulfill administrative responsibilities.

6.5. A documented plan is in place for custody staff to follow when a health situation arises and health care staff are not present.

6.6. Position Descriptions

6.6.1. The RHA/HSA is responsible for ensuring that there is a job description available for each member of the health care staff and that it includes qualifications, duties, and responsibilities.

6.6.2. At the time of employment, each employee will be given a copy of his or her job description to review and sign as acknowledgement that he or she understands the duties and responsibilities.

6.6.3. A signed copy of the job description is maintained in each employee file.

6.6.4. The job description is used for performance evaluations.

6.7. Students and Interns

6.7.1. Students and interns receive appropriate orientation to include education of health care and security policies and confidentiality of information. Wellpath will maintain written agreements with the training and education facility that cover the scope of work, length of agreement, and any legal or liability issues. Students and/or interns agree in writing and abide by facility policies including those related to security and confidentiality of information.

6.7.2. Students and/or interns will be supervised as follows:

- Medical Students, Physician's Assistant candidates, and Nurse Practitioner students will work under the direct supervision of the Medical Director or other staff physician.
- Nursing students will work under the direct supervision of a nurse licensed in the state.
- Psychology, social work, and counseling students will work under the direct supervision of a Qualified Mental Health Professional.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Personnel and Training: J-C-07 Staffing (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Personnel and Training: P-C-07 Staffing (I)

NCCHC Standards for Health Mental Health Services in Correctional Facilities 2015

- Section: Personnel and Training: MH-C-07 Mental Health Staffing (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-2A-15 Staffing

- 4-ALDF-4D-03 Personnel Qualifications (M)
- 4-ALDF-4D-10 Students and/or Interns
- 1-HC-2A-05 Credentials (M)
- 1-HC-2A-17 Students and/or Interns
- 1-HC-4A-05 Staffing

1. PURPOSE

This policy is intended to ensure that health care services continue to be coordinated via a designated, trained health care liaison when qualified health care professionals are not available for an extended period of time.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

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

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Health Care Liaison – May be a correctional officer or other person without a health care license who is instructed by the Responsible Physician / Medical Director or designee in limited aspects of health care coordination.

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

6. PROCEDURE

6.1. When qualified health care professionals are not on site, a designated health care liaison shall be present on each shift.

6.2. The health care liaison is instructed in the role and responsibilities by the Responsible Physician / Medical Director or designee. The health care liaison may be a custody officer or other person without a health care license.

6.3. The health care liaison has a plan that includes contact information for the on-call health care staff, ambulance, and other emergency community contacts.

6.4. The health care liaison receives instruction in reviewing patient information and maintains confidentiality of patient information.

6.5. Duties assigned to the health care liaison post are appropriately carried out.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Personnel and Training: J-C-08 Health Care Liaison (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Personnel and Training: P-C-08 Health Care Liaison (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Personnel and Training: MH-C-08 Mental Health Liaison (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-04 Health Trained Staff Member
- 1-HC-2A-04 Health Trained Staff Member

1. PURPOSE

This policy is intended to ensure all health care staff are properly acclimated to work in the correctional environment and understand their roles and responsibilities.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath requires newly employed health care staff, at the time of employment, to participate in a formal on-boarding process addressing the company, the facility, and their job responsibilities.

The orientation program is approved by the Responsible Health Authority (RHA) / Health Services Administrator (HSA) and Facility Administrator and is reviewed annually or more frequently, as needed.

Each employee will be given an Orientation Check List to be completed as soon as possible, but no later than 90 days from his or her employment date. The RHA/HSA is responsible to ensure copies are placed in the complete employee file upon completion.

Part-time and contract staff receive formal orientation appropriate to their assignments, and additional training is provided as needed.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. All health care staff receive a basic orientation on or before the first day of on-site service. At a minimum, this addresses the following:

- Relevant security and health care policies
- Procedures and response to facility emergency situations
- Overview of correctional rules and regulations
- Staff member's position description
- Inmate/Staff relationships

6.2. Within 90 days of employment, all health care staff complete the on-boarding process. Completion of the program is documented and maintained on file. In-depth orientation for newly hired health care staff will include, but not be limited to the following:

- Tour of the facility
- Emergency and disaster procedures
- Security and contraband regulation
- Infection Control, including Standard Precautions, and OSHA guidelines
- Procedure for patient transfers
- Suicide prevention and intervention
- Medication administration training
- Inmate social system

- Organization of the facility
- Patient request for health care system
- Sick call/access to care process
- Nursing Assessment Protocols and Procedures
- Chronic illness care
- Confidentiality of the health records and health information
- Review of all policies and procedures, including all reference materials
- How to access test results
- Jail/Prison Management System
- Appropriate conduct with patients
- Occupational exposure
- Personal protective equipment
- Biohazardous waste disposal
- Relevant information on correctional field practices

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018
- Section: Personnel and Training: J-C-09 Orientation for Health Staff (I)

NCCHC Standards for Health Services in Prisons 2018
- Section: Personnel and Training: P-C-09 Orientation for Health Staff (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015
- Section: Personnel and Training: MH-C-03 Training for Mental Health Staff (E)

ACA Standards / 2016 Standards Supplement
- 4-ALDF-7B-05 Training and Staff Development

- 4-ALDF-7B-09 Training and Staff Development – Health Care Employees
- 4-ALDF-7B-13 Training and Staff Development – Contract Personnel
- 1-HC-2A-06 Employee Orientation
- 1-HC-2A-07 Employee Orientation – Contract Personnel
- 1-HC-2A-08 Employee Orientation – Health Care Staff

Forms

- Orientation Checklist

1. PURPOSE

This policy is intended to ensure that pharmaceutical operations are sufficient to meet the needs of the facility and conform to legal requirements.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Pharmaceutical services are provided in accordance with all local, state, and federal laws regarding prescribing, dispensing, administering, storage, accountability, and procuring pharmaceuticals.

The site will maintain a current and active Drug Enforcement (DEA) registration, either facility-specific or provider-specific, in accordance with state law, if CII-CV controlled substances are maintained at the facility.

The contracted pharmacy service provides a consulting pharmacist to perform on-site inspections, including satellites, at least quarterly. Copies of inspections, to include off-site locations, shall be kept on file in the Responsible Health Authority's (RHA) / Health Service Administrator's (HSA) office.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

MAR – Medication Administration Record

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Wellpath maintains a formulary that is developed by the Pharmacy and Therapeutics Subcommittee of the Medical Executive Committee with input from the Wellpath Site Medical Director and the pharmacy representative. The formulary is reviewed and updated annually and as needed.

6.2. The prescribing provider will re-evaluate prescriptions prior to renewal. In cases where the provider is not on site, a verbal order may be requested and renewal accomplished per verbal order/protocol.

6.2.1. Verbal orders must be co-signed by the provider no later than 48-72 hours or as required by state regulations.

6.3. Medications are inventoried by appropriate health care staff when they are received. A Medication Administration Record (MAR) is kept to record each dose as it is administered. MARs will be filed into the patient's health record at the end of each month, when the patient is released from the facility, and/or when the patient's full course of treatment is completed.

6.4. Medications are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Antiseptics, other medications for external use, and disinfectants are stored separately from internal and injectable medications.

6.5. Medications requiring special storage for stability, such as refrigeration, are so stored separately. Daily temperature logs are kept on each refrigerator.

6.6. The facility maintains records as necessary to ensure adequate control of and accountability for all medications, except those that may be purchased over the counter.

6.7. Controlled medications are kept in a double locked cabinet, separate from non-controlled medications. Records are maintained to ensure adequate control.

6.8. Ointments, creams, lotions, shampoos, inhalers, and suppositories ordered by a qualified health care provider are given to the patient in a sufficient quantity to last the

duration of the prescribed medication or for one (1) month, whichever is less, and will be kept at the patient's bedside unless contraindicated or prohibited by the facility.

6.9. Patients do not prepare, dispense, or administer medication except for those approved to be on a Keep on Person program that is approved by the Facility Administrator and the Responsible Physician / Medical Director. Patients are permitted to carry medications for the emergency management of a condition when ordered by a clinician and approved by the facility.

6.10. Other medications ordered will be kept on the medication cart. Injectable or refrigerated medications are stored in the medication room until they are to be administered.

6.11. Patients receiving injectable medications are brought to the medical unit, if possible, to receive the injection.

6.11.1. Patients receiving insulin will be allowed to draw up and administer their own insulin in the medical unit under nursing supervision as part of patient teaching, when appropriate.

6.12. In the case of medication refusals, documentation on the MAR will indicate the patient refused the medication.

6.12.1. Scheduled Routine Medications

If a patient misses four (4) doses in a seven (7) day period, or establishes a pattern of refusal, the patient is referred to the prescribing provider. The referral is submitted after the fourth missed dose.

6.12.2. **High-Priority Medications** (see attached High Priority List)

Health care staff shall make contact (must be documented) with a patient on a High-Priority Medication who does not show to medication pass in order to check patient status and obtain a refusal. Patient will be educated on the dangers of missed medication. If a patient refuses or misses a High-Priority Medication, the patient is referred to the prescribing provider for chart review and the determination of the need for a face to face encounter.

6.13. An adequate and proper supply of antidotes and emergency medications (e.g., naloxone, epinephrine) and related information is available.

6.14. The poison control telephone number is posted in areas where overdoses or toxicology emergencies are likely.

6.15. Medications are administered in accordance with local and state law. Nursing personnel are trained in the appropriate method of medication administration and possess a current license to practice in the state.

6.16. The physician, psychiatrist, physician assistant, or nurse practitioner writes an order for a medication clearly and precisely on the Provider's Order Sheet. Each medication order must include the information below. If any of this information is missing or unclear, clarification is sought from the prescriber.

- Name of the patient
- Diagnosis, if known
- Allergies
- Date of order
- Name of the medication, dosage, route of administration, and duration, including stop date, that medication is to be given
- If medication is to be given as needed (PRN), the circumstances under which the medication should be administered must also be included.

6.17. The physician will limit his or her choice of medications to those on the formulary, except when no suitable alternative exists.

6.18. The responsibilities of a pharmacist employed by a Wellpath contracted pharmacy include:

6.18.1. A licensed pharmacist employed by a Wellpath contracted pharmacy is responsible for the dispensing of prescriptions.

6.18.2. Medications ordered by the physician are transmitted to the pharmacy daily.

6.18.3. The pharmacist shall use the transmitted order as authorization to dispense the medication.

6.18.4. The pharmacist will dispense and label all medications according to state and federal laws.

6.18.5. Each patient will have a patient profile that is initiated and kept current by the pharmacist.

6.18.6. The prescription filling service will be open at least six (6) days a week.

6.18.7. Delivery service is available six (6) days a week.

6.18.8. There is a provision for obtaining needed medications from a local pharmacy when the urgency of the patient's condition makes it unacceptable to wait for the medication to be available through the contract pharmacy. The Responsible Physician / Medical Director must make this judgement.

6.19. The consulting pharmacist is responsible for:

- Coordinating pharmacy services with other services
- Serving on the Pharmacy and Therapeutics Committee
- Ensuring that an account of all controlled substances is maintained and accurately reconciled
- Verifying appropriate storage, security, and record keeping
- Facility pharmacy operation

6.20. General Information

6.20.1. All medications must be administered as ordered and on time. Medication will be considered on time if it is given within one (1) hour before or one (1) hour after the scheduled time. For time-critical scheduled medications, administer at the exact time indicated, when necessary, or within 30 minutes before or 30 minutes after the scheduled time (or more exact timing when indicated, as with rapid-, short-, and ultra-short-acting insulins).

6.20.2. A licensed nurse will transcribe medications ordered by a qualified health care provider to the individual patient's MAR.

6.20.3. No expired medications will be knowingly administered.

6.20.4. Medication storage areas are devoid of outdated, discontinued, or recalled medications, except in a designated area for disposal.

6.20.5. Each patient must show facility-approved proof of identification in order to receive prescribed medication.

6.20.6. For patients found to be diverting medications (cheeking or palming), the prescribing provider will be contacted regarding alternative methods of administration.

6.20.7. Additional information regarding pharmaceuticals can be found in the Pharmacy Manual.

6.21. Security of Medication

6.21.1. The medication room and all cabinets/med carts will be locked at all times when health care staff are not within line of sight.

6.21.2. Nurses are responsible for ensuring that all medications are kept secure.

6.21.3. No patient will have access to any prescription medication other than those administered or provided by a qualified health care staff member.

6.21.4. Once multi-dose vials are opened, they must be dated and initialed, and they must be used or discarded as specified by the manufacturer, not to exceed 30 days.

6.21.5. No patient is to receive medication prescribed, or labeled, for another patient.

6.22. Controlled Substances

6.22.1. A limited supply of controlled medications will be kept in the facility. These medications are under the control of the Responsible Physician / Medical Director, and they are monitored and accounted for by the RHA/HSA or designee.

6.22.2. Class II, III, IV, and V medications will be counted at the end of every shift by the nurse going off duty and the nurse coming on duty. Any discrepancies in the count must be reported immediately to the on-duty medical-unit supervisor and resolved prior to the present nursing staff going off duty.

6.22.3. All controlled substances must be signed out to the patient receiving them at the time they are administered.

6.23. Non-Prescription Medication

6.23.1. The Site Medical Director and RHA/HSA along with custody administration determine which medications and medical supplies will be sold over-the-counter through commissary.

6.23.2. There may be a limit on the amount of medications that can be purchased and held by patients. That limit may be determined by medical staff and/or custody administration.

6.23.3. Indigent patients and those who are not eligible for medications from the commissary are provided medications as prescribed on regularly scheduled medication pass after being seen on sick call.

6.24. Backup Pharmacy

6.24.1. A local pharmacy will be contacted to obtain medications that are not readily available for those patients with urgent needs that do not allow time for delivery from the contracted pharmacy.

Diamond Pharmacy
866-307-9742 Ext. 2100

7. REFERENCES

Wellpath Pharmacy Manual
Wellpath Medication Formulary

NCCHC Standards for Health Services in Jails 2018

- Section: Ancillary Health Care Services: J-D-01 Pharmaceutical Operations (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Ancillary Health Care Services: P-D-01 Pharmaceutical Operations (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Mental Health Care Services and Support: MH-D-01 Mental Health Pharmaceutical Operations (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-38 Pharmaceuticals (M)
- 4-ALDF-4C-39 Non-Prescription Medication
- 1-HC-1A-35 Pharmaceuticals (M)
- 1-HC-1A-36 Nonprescription Medication

Forms

- Provider's Orders
- Keep on Person Agreement Form
- Daily Temperature Logs

1. PURPOSE

This policy is intended to ensure that medication services are clinically appropriate and provided in a timely, safe, and sufficient manner.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath will provide patients with adequate and appropriate medications when clinically indicated. Medications are administered or delivered to the patient in a timely and safe manner. No partial doses of medication will be administered without a new order from the prescribing clinician.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

KOP – Keep on Person medication

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health

professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients

RHA/HSA – Responsible Health Authority / Health Services Administrator

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

6. PROCEDURE

6.1. Prescription medications are administered or delivered to the patient only upon the order of a physician, dentist, or other legally authorized individual. The Responsible Physician / Medical Director determines prescribing practices in the facility.

6.2. Medications are delivered in a timely manner, 24 to 48 hours unless specified by a practitioner. The Responsible Health Authority (RHA) / Health Services Administrator (HSA) is responsible for ensuring a policy addresses the expected time frames from ordering to delivery and an alternative pharmacy plan if the time frames cannot be met then the backup pharmacy Diamond Pharmacy will be notified. The backup pharmacy will deliver within 24 hours.

6.2.1. An appropriately licensed nurse will contact the prescriber for additional instructions should there be no viable option to obtain medication within specified time frames.

6.3. Medications will be administered to patients at the prescribed dosage.

6.3.1. If the patient refuses to take the full dose as prescribed, then the QHP will not administer the medication at all.

6.3.2. The QHP will note that the medication was refused.

6.3.3. If the medication is a High-Priority Medication, then the QHP will notify the prescriber immediately after med pass is complete.

6.4. Wellpath maintains a medication formulary and an established non-formulary medication ordering and approval process that ensures non-formulary medications are obtained in a timely manner.

6.5. Medications are prescribed only when clinically indicated, and the orders include start and stop dates.

6.6. Medications are kept under the control of appropriate health care staff members, except for self-medication programs which are approved by the Facility Administrator and Responsible Physician / Medical Director.

6.6.1. Patients are permitted to carry medications necessary for the emergency management of a condition when ordered by a provider.

6.7. Patients entering the facility on verifiable prescription medication continue to receive the medication in a timely fashion as prescribed, or acceptable alternate medications are provided as clinically indicated. Justification for an alternate treatment plan is documented. (See policy *HCD-100_E-09A Medication Verification*)

6.7.1. Patients entering the facility on court-ordered medications for the restoration/maintenance of competency will continue to receive such medications as required by the court order, unless medically contraindicated.

6.7.2. All court orders will be forwarded to Wellpath Legal Department for review and guidance.

6.8. The ordering clinician is notified of the impending expiration of an order so that the clinician can determine whether the medication administration is to be continued or altered.

6.9. QHPs administering the medication will verify the 5 Rights of drug administration and delivery before administering the medication.

- Right patient
- Right medication
- Right dose
- Right route
- Right time

6.10. The QHP is responsible for taking every reasonable precaution to ensure that:

6.10.1. The patient takes the medication in the presence of the QHP.

6.10.2. There has been a check for “cheeking” or “palming” to ensure that medication has been ingested.

6.10.3. The patient speaks after taking the medication and/or drinks water.

6.11. The QHP will keep the medication out of reach of patients at all times.

- Medications are administered at set times according coordination of medical and security, or they are administered as ordered per the provider.
- Daily – 1000
- BID – 1000 & 2200
- TID – 0600; 1200; &1800
- QHS – 2200

6.12. As needed (PRN) prescription medications are administered or delivered to the patient only upon the order of a physician, dentist, or other legally authorized individual.

6.12.1. PRN over-the-counter (OTC) medications are administered or delivered to the patient as part of a QHP intervention when allowable by state and federal regulations.

6.12.2. PRN prescription medications and PRN OTC medications are delivered in a timely manner.

- Twice a day PRN medications will have a minimum of 12 hours between administered doses
- Three times a day PRN medications will have a minimum of eight (8) hours between administered doses

- Four times a day PRN medications will have a minimum of six (6) hours between administered doses

6.12.3. PRN prescription medication is not delivered or administered if the maximum number of recommended doses for the specific medication has been reached.

- A current drug guide or the online *Up-to-Date* webpage will be utilized as reference for maximum recommended daily dosage.

6.13. QHPs are not authorized to repackage or relabel medications. This function is performed only by a licensed pharmacist, physician, or other persons as authorized by law.

7. REFERENCES

HCD-100_E-09A Medication Verification

NCCHC Standards for Health Services in Jails 2018
- Section: Ancillary Health Care Services: J-D-02 Medication Services (E)

NCCHC Standards for Health Services in Prisons 2018
- Section: Ancillary Health Care Services: P-D-02 Medication Services (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015
- Section: Mental Health Care Services and Support: MH-D-02 Medication Services (E)

ACA Standards / 2016 Standards Supplement
- 4-ALDF-4C-38 Pharmaceuticals (M)
- 4-ALDF-4C-39 Non-Prescription Medication
- 1-HC-1A-35 Pharmaceuticals (M)
- 1-HC-1A-36 Non-prescription Medication

1. PURPOSE

This policy is intended to ensure that sufficient and suitable space, supplies, and equipment are available for the facility's medical, dental, and mental health services.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Sufficient space, equipment, and supplies are available for the delivery of health care services in the facility.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. The Responsible Health Authority (RHA) / Health Services Administrator (HSA) will ensure that examination and treatment rooms for medical, dental, and mental health care are large enough to accommodate the necessary equipment, supplies, and fixtures

to meet the needs of the patient population, and to permit privacy during clinical encounters when these services are provided on-site.

6.2. Pharmaceuticals, medical supplies, and mobile equipment are available and checked regularly.

6.3. The facility has a system in place to regularly check the health unit's inventory of equipment, supplies, and medications, and to reorder as appropriate. Inventories are maintained and checked at least daily for items subject to abuse (e.g. syringes, needles, scissors, and other sharp instruments).

6.3.1. All syringes and needles will be signed for when taken out of stock, listing:

- Date
- Patient Name
- Health care staff's initials

6.3.2. Health care staff will count syringes daily and make a notation as to:

- Date
- Correct or Incorrect count
- Health care staff's initials

6.3.3. All syringes and needles will be kept out of reach of patients at all times.

6.3.4. All syringes and needles will be secured in a locked cabinet.

6.4. There is adequate office space designated as administrative space for administrative files, secure storage of health records and personnel files, and writing desks.

6.5. Private interviewing space, desks, chairs, and lockable file space are available for provision of mental health services.

6.6. There is a waiting area for patients with access to seats, drinking water, and toilets during clinical encounters.

6.7. When laboratory, radiological, or other ancillary services are provided on site, the designated area is adequate to hold equipment and records.

6.8. The facility will, at a minimum, have the following equipment, supplies, and materials for the examination and treatment of patients.

Examination Rooms:

- Hand-washing facilities or appropriate alternate means of hand sanitization
- Examination table
- A light capable of providing direct illumination
- Scale
- Thermometers
- Blood pressure monitoring equipment
- Stethoscope
- Ophthalmoscope
- Otoscope
- Transportation equipment (e.g., wheelchair, stretcher)
- Trash containers for biohazardous materials and sharps – per OSHA standards, needle boxes must be secured to avoid tipping and spillage
- Sterilizer for non-disposable medical equipment
- Equipment, space, and supplies for pelvic examinations if the facility houses female patients
- Oxygen
- Automated External Defibrillator

- Pulse Oximeter
- Personal protective equipment (PPE)

6.9. Basic equipment required for on-site dental examination includes, at a minimum:

Dental Room / Dental Operatory:

- Hand-washing facilities or appropriate alternate means of hand sanitization
- Dental examination chair
- Examination light
- Sterilizer / Autoclave
- Dental instruments
- Trash containers for biohazardous materials and sharps – per OSHA standards, needle boxes must be secured to avoid tipping and spillage
- Dentist stool
- X-ray unit with developing capability
- Blood pressure monitoring equipment
- Oxygen
- Personal protective equipment (PPE)

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Ancillary Health Care Services: J-D-03 Clinic Space, Equipment, and Supplies (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Ancillary Health Care Services: P-D-03 Clinic Space, Equipment, and Supplies (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Mental Health Care Services and Support: MH-D-03 Clinic Space, Equipment, and Supplies (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-2D-03 Medical and Dental Instruments, Equipment, and Supplies (M)
- 1-HC-7A-09 Physical Plant – Health Services

Forms

- Sharp and Instrument Count Sheet

TITLE: HCD-100_D-04 On-Site Diagnostic Services -- Mecklenburg NC	REFERENCE: 59946
	PAGE: 1 OF 3 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that necessary on-site diagnostic services are provided for patient care and are registered or accredited, or otherwise meet applicable state and federal laws.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath will provide timely access to necessary diagnostic services to meet the needs of the patient population.

Each facility is responsible to define the specific waived testing that will be provided on-site and to maintain a list of these waived tests. The list of waived tests is referred to as the Waived Testing Index, is available at all times, and must meet FDA and CLIA requirements. A current Clinical Laboratory Improvement Amendments (CLIA) Waiver will be on record at the facility.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

CLIA – Clinical Laboratory Improvement Amendments Waiver

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

6. PROCEDURE

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

6.2. There is a procedure manual for each service completed on-site, including protocols for the calibration of testing devices to ensure accuracy.

6.3. The manufacturer's instructions and recommendations inserts from the waived testing packages will be readily available to all staff.

6.4. Any diagnostic procedure ordered by qualified health care staff will be arranged through contracted or fee-for-service providers.

6.5. On-site diagnostic testing that is available will include, at a minimum, the following:

- Multiple test dipstick urinalysis
- Finger stick blood glucose test
- Peak flow meters (handheld or other)
- Stool blood-testing material
- Pregnancy test kits
- Urine drug screen

6.6. All diagnostic services will be performed by licensed/certified health care staff within their scope of practice in accordance with state/federal laws.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Ancillary Health Care Services: J-D-04 On-Site Diagnostic Testing (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Ancillary Health Care Services: P-D-04 On-Site Diagnostic Testing (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Mental Health Care Services and Support: MH-D-04 Diagnostic Services (I)

1. PURPOSE

This policy is intended to ensure that medical diets that enhance patients' health are provided.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

In general, sufficient variety is offered so that patients with specific dietary restrictions can meet their needs in an appropriate fashion. Medical diets are provided that enhance patients' health and are modified when necessary. Wellpath health care staff are not responsible for ordering religious or preferential diets (e.g., vegetarian, vegan, etc.).

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Medical Diets – Modified diets ordered for temporary or permanent health conditions. This includes modifying the types, preparation, and/or amounts of food. Examples include, but are not limited to, diabetic/consistent carbohydrate, low sodium, low fat, celiac, renal, soft, liquid, pregnancy, and nutritional supplementation.

Heart-Healthy Diet – Refers to foods that are low in saturated fat, cholesterol, and sodium and are high in fiber, as promoted by the American Heart Association.

RDN – Registered Dietitian Nutritionist

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

6. PROCEDURE

6.1. Medical diets are provided per provider order and documented in the health record.

6.2. The following special diets are available at the facility:

- Renal
- Cardiac
- Religious
- Vegetarian
- Diabetic
- Soft
- Bland
- Pregnancy
- Liquid
- High Protein

6.3. Orders for medical diets are communicated in writing and include the type of diet, the duration for which it is to be provided, and special instructions, if any. They are renewed annually by the provider.

6.4. When patients refuse prescribed diets, follow-up nutritional counseling is provided. A therapeutic decision is made to stop or alter the diet accordingly.

6.5. Diets related to a self-reported food allergy are determined by Qualified Health Care Professional.

6.6. Workers who prepare medical diets are supervised in diet preparation.

6.7. A Registered Dietitian Nutritionist (RDN), or other licensed qualified nutrition professional, as authorized by state scope of practice laws, documents a review of the regular diets for nutritional adequacy at least annually.

6.7.1. The facility has a procedure in place to notify the RDN whenever the regular diet menu is changed.

6.7.2. Written documentation of menu reviews includes the date, signature, and title of dietitian.

6.8. Special attention is paid to the nutritional needs of juveniles, who generally require more calories and micronutrients than adults and may require more frequent meals or snacks.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Ancillary Health Care Services: J-D-05 Medical Diets (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Ancillary Health Care Services: P-D-05 Medical Diets (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4A-07 Dietary Allowances (M)
- 4-ALDF-4A-09 Therapeutic Diets
- 1-HC-1A-37 Dietary Allowances (M)
- 1-HC-1A-38 Therapeutic Diets

Forms

- Provider's Orders

1. PURPOSE

This policy is intended to ensure that a program exists to address the needs of patients who engage in self-deprivation of nourishment and/or fluids and that such patients are precluded from self-harm through monitoring and reporting, and, if necessary, legal action.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Most hunger strikes that occur within correctional settings are short lived and do not present a serious threat to the well-being of the patient. The facility's response to hunger strike should be in proportion to the problem presented and should respect an individual's rights to manage his or her own body.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Hunger Strike – Failure to accept solid nutritional support (food with caloric value) for a minimum of 72 hours (typically nine [9] consecutive meals) or any refusal of liquids in excess of 24 hours in duration regardless of if the failure is volitional or the result of mental illness

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

RHA/HSA – Responsible Health Authority / Health Services Administrator

RDO – Regional Director of Operations

RMD – Regional Medical Director

CCE – Critical Clinical Event

Qualified Mental Health Professional (QMHP) - Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

6. PROCEDURE

Patient Care

6.1. A hunger strike may come to the attention of custody staff through a patient declaring himself/herself to be refusing food and/or drink, through staff noting such a refusal, or through a third party bringing the matter to staff's attention. In general, a "Hunger Strike" exists when the refusal to accept solid nutritional support exceeds 72 hours in duration. However, it is Wellpath policy that if the facility establishes an alternative definition, the facility definition shall apply. Because hunger strikes can become life threatening, certain steps must be followed in managing the patient on hunger strike.

6.2. Ascertain whether a hunger strike is occurring and determine the nature of the strike (food, drink, both, etc.). Again, Wellpath defines a hunger strike as failure to accept solid nutritional support (food with caloric value) for a minimum of 72 hours (typically nine [9] consecutive meals) or any refusal of liquids in excess of 24 hours in duration, regardless of it the failure is volitional or the result of mental illness.

6.2.1. Complete refusal of both food and drink may be fatal in just a few days. Refusal to accept food while continuing to accept liquid nourishment is less dangerous; if calorie-containing liquids are accepted, the circumstance should not be considered a hunger strike unless continuing weight loss is documented. If few or no calories are accepted in liquids, physical health will generally not be threatened for several weeks or even months.

6.2.2. The presence or allegation of a hunger strike shall be documented both in the health and facility records. Custody staff should document intake of food and/or drink when the patient is living in general population or segregation. Patients who are living in inpatient units may have their food and drink intake documented by health care staff. However, no patient should be admitted to medical housing/infirmary solely because he or she is on a hunger strike; only health care needs should result in such placement. Similarly, the patient should be moved into a segregation setting only if the patient's behavior warrants such a segregation placement.

6.2.3. After it is confirmed that a patient is on a hunger strike and appropriate documentation has begun, the assessment continues. Minimum health care documentation for monitoring a hunger strike includes periodic vital signs including orthostatics, weight, urine for specific gravity and ketones, and if in an inpatient unit, intake of food and drink. A Wellpath Hunger Strike Monitoring Form (Attachment 1) is available to document these parameters.

6.2.4. If a hunger strike is occurring, the Responsible Health Authority (RHA) / Health Services Administrator (HSA) must keep the facility administration fully informed.

6.3. Assess the patient for the presence of serious mental or physical illness.

Mental Illness

6.3.1. The patient on a hunger strike is to be assessed urgently for the presence of serious mental illness by a QMHP. Serious mental illness may be the sole cause of the hunger strike or may contribute to the problem. In the presence of serious mental illness, hunger striking moves from the realm of a voluntary, competent decision to that of an activity taken by a potentially mentally incompetent individual.

- If there is any concern about reaching a determination regarding the possible role of mental health symptoms in the patient's hunger strike decision, the evaluator is encouraged to seek consultation with his or her clinical supervisor.

6.3.2. If serious mental illness is present and the hunger strike is dangerous to the physical health of the individual, unless the examiner can be certain that the patient has the capacity to make the decision to refuse food and/or drink, the circumstances should be considered emergent, and forcible psychiatric treatment should be sought. Depending upon the physical status of the patient, forcible nutrition (or at least liquids) should be provided only after consulting the facility's legal counsel and pending decisions regarding forcible treatment.

6.3.3. Simultaneously, assistance from the facility's legal counsel should be sought in obtaining a court order for forcible treatment and forcible nutrition. (In general, patients who are on a hunger strike who are not eating because of serious mental illness respond rapidly to firm, consistent treatment that includes neuroleptic medication.)

- In such cases, mental health staff should notify their Regional Director of Mental Health about the status of the case.

6.3.4. If there is no serious mental illness present, mental health staff should not attempt to force treatment on the individual, but should frequently reassess the patient to ensure that no serious mental illness develops or becomes noticeable. The frequency of reassessment should be planned by the mental health professional based on the individual needs of the patient. If serious mental illness is not present at the time of the initial evaluation but is subsequently present, the patient is to be managed as described in the previous paragraphs.

Physical Illness

6.3.5. If there is a serious underlying physical illness present that will rapidly be affected negatively by the hunger strike or

6.3.6. If debilitation secondary to the lack of nutrition is noted (e.g., dehydration with secondary signs, exhaustion secondary to starvation, or other problem likely to interfere with the individual's ability to survive), Wellpath legal assistance should

be sought as soon as possible. In most circumstances, application will be made to the appropriate court for permission to feed forcibly. Unless a health emergency develops, forcible feeding is not to be provided until the court has considered the circumstances and rendered a decision. The development of a health emergency should be met with forcible treatment if a court decision is pending.

6.4. Monitor the patient as necessary and take steps as necessary to maintain order in the facility.

6.4.1. Initial monitoring is described above. To reiterate, minimum health care documentation for monitoring a hunger strike includes periodic vital signs including orthostatics, weight, urine for specific gravity and ketones, and, if in an inpatient unit, intake of food and drink. These assessments should occur daily.

6.4.2. If a hunger strike not initially deleterious to the individual's health becomes deleterious because of its duration or because of other considerations, the frequency of monitoring should be increased. The response should be individualized.

6.4.3. Routine bloodwork during a hunger strike is rarely useful, except in the case of suspected dehydration. In this case, evaluation of kidney function may be useful, provided the information can be ascertained in a timely manner. Definitive treatment interventions should not be delayed awaiting results of lab work. The use of labs should be individualized based on the individual patient's presentation.

6.4.4. Sometimes a hunger strike can trigger other facility problems. If this appears to be occurring, health care staff should work with other facility personnel as necessary to maintain order.

6.5. Intervene as appropriate

6.5.1. Health care staff should, when assessing a patient on a hunger strike, ensure that the patient understands the consequences of the strike, and document in the health record repeated counseling regarding the effects of a hunger strike.

6.5.2. Admission to an inpatient unit is necessary only if the physical condition deteriorates and close monitoring cannot be accomplished in a different setting, or if concurrent illness dictates inpatient management.

6.5.3. Demands for special foods or special treatment should not be met.

6.5.4. Forcible intervention, absent a health emergency (physical or psychiatric), is to be limited to treatment(s) ordered by a court. In the presence of health emergency, treatment may be forced, unless a properly executed Advance Directive has been filed with the medical staff, where appropriate by state law.

6.5.5. During a hunger strike, health care and custody staffs must maintain regular communication regarding the status of the patient. In addition to frequent conversations, case management meetings may be helpful, and such meetings should be documented in the health record.

6.6. Consider legal action

6.6.1. Contact the Wellpath Legal Department for guidance before proceeding.

6.6.2. In general, a competent patient may refuse food and drink as long as he or she remains competent. However, staff are well advised to seek the intervention of the local court sooner rather than later in the hunger strike process. It is important to note that the decision of the court may be to allow the patient to continue to refuse food and/or drink. Health care staff should be accepting of the decision of the court, regardless of their level of agreement with that decision.

Reporting

6.7. A Critical Clinical Event (CCE) Notification is initiated by the site to announce the onset of a hunger strike.

6.7.1. The RHA/HSA initiates daily hunger strike tracking utilizing forms: *Hunger Strike Monitoring* and appropriate monitoring forms. The RHA/HSA maintains the hunger strike as a “white board” item for purposes of staff communication at the site.

6.7.2. Daily reports relating to the patient's Hunger Strike are made to the Regional Medical Director (RMD), Regional Director of Operations, and/or Regional Vice President for Operations, as applicable.

6.8. The Regional Director of Operations, as applicable, ensures the daily completion of the log by the RHA/HSA.

6.9. The RMD contacts the Site Responsible Physician / Medical Director to discuss active cases, as clinically necessary, but no less than once per week.

6.10. The CQI Program Manager will classify each hunger strike patient reported via CCE per the following:

6.10.1. Lower Risk for complications: Hunger strikes that have been resolved prior to the weekly CCE Work Group meeting, and hunger strikes involving patients with no complicating medical or mental health concerns.

- Reporting requirements: A minimum of weekly, the RHA/HSA/DON updates the CCE notice using the Hunger Strike Report.

6.10.2. Intermediate risk for complications: Hunger strikes that are ongoing and involve patients who have medical and/or mental health issues that are in good to fair control.

- Reporting requirements: A minimum of twice weekly, the CCE notice is updated using the Hunger Strike Report (the reports will be made by the RHA/HSA/DON, and one will be made by the RMD).

6.10.3. Higher risk for complications: Hunger strikes that are ongoing and involve patients who have medical and/or mental health issues that are in poor control, or patients who are refusing liquids. This would also include patients where legal consultation or intervention may be considered.

- Reporting requirements: The CCE notice is updated each business day using the Hunger Strike Report. The RHA/HSA/DON will be responsible for these updates, with the exception that, on a weekly basis, at least one (1) of the updates will be by the RMD, and at least one (1) will be by the Mental Health Director/Coordinator. Should Wellpath not be responsible for mental health per contract, the RHA/HSA/DON will provide this update as well, based upon collaboration with the mental health service provider.

Multidisciplinary conference calls between the site level providers, regional staff, and corporate staff will be scheduled on each of these patients.

6.11. The CQI Program Manager will inform the RHA/HSA, RMD, and Mental Health Director/Coordinator (if applicable) which classification applies to the events at their respective sites, as well as the monitoring and reporting requirements.

6.12. The CCE Work Group will also monitor all ongoing (unresolved) hunger strikes on a weekly basis, with the purpose of ensuring appropriate follow-up and assessing need for change to a higher or lower classification.

6.13. All hunger strikes within a region are reviewed weekly during the Regional Conference Call that includes the Regional Director of Operations and/or Vice President for Operations, as applicable, the Regional Medical Director, and Regional Director of Mental Health. Any lapses in site level reporting will be addressed during this weekly regional meeting.

7. REFERENCES

HCD-100_A-12 Critical Clinical Events

ACA Standards / 2016 Standards Supplement

- 4-ALDF-1C-05 Facility Security – Hunger Strikes (M)

Forms

- Hunger Strike Monitoring Form

1. PURPOSE

This policy is intended to ensure that patients are transported safely and in a timely manner for medical, dental, and mental health clinic appointments both inside and outside the facility.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Custody staff transport patients for both on-site and off-site health care encounters. Facility procedures regulating the time and method of transport will be followed. Health care staff arrange outside provider appointments and communicate dates, times, and locations of the appointments to the appropriate custody staff.

The Responsible Health Authority (RHA) / Health Services Administrator (HSA) tracks completed and missed appointments, both in the health care unit and for outside appointments. Patients returning from off-site appointments are seen by the on-site provider in a timely manner.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

6. PROCEDURE

6.1. Wellpath maintains a system that ensures health care staff communicate on a daily basis with custody staff regarding patients who need to be brought to the medical unit for care.

6.2. Health care staff schedule outside appointments and notify custody staff of off-site transportation needs and accommodations needed during the transport process, including instructions for administration of necessary medications.

6.2.1. A transportation system that ensures timely access to services that are available only outside the facility is required. Such a system addresses the following issues: prioritization of medical needs, urgency (e.g., ambulance versus standard transport), and transfer of medical information.

6.3. Any conflicts that arise regarding off-site consultation trips will be communicated between the custody staff responsible for transportation and the RHA/HSA or designee to coordinate modifications as needed.

6.3.1. The RHA/HSA will keep a log of missed appointments to determine if problems with transportation are impeding patients' access to care.

6.4. The patient's confidentiality is maintained during transport. Medical records that are to be given to the receiving treatment provider are in a sealed envelope labeled "Confidential." Additionally, another envelope marked "Confidential" is placed in the envelope to ensure that returning medical information remains confidential to the patient. Confidential patient information is to be given to custody and returned immediately to the medical unit upon completion of the off-site medical appointment.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Ancillary Health Care Services: J-D-06 Patient Escort (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Ancillary Health Care Services: P-D-06 Patient Escort (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-08 Patient Escort (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-06 Transportation
- 1-HC-1A-06 Transportation

1. PURPOSE

This policy is intended to ensure that the facility provides 24-hour emergency medical, dental, and mental health services.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Emergency medical, mental health, and dental services are provided 24 hours per day. Wellpath staff members respond to all emergencies upon notification. An emergency on-call schedule is maintained in the health clinic.

Nursing staff respond by reporting to the area of the emergency with necessary emergency equipment and supplies. Custody and health care personnel are trained to respond to health-related situations within four (4) minutes. Emergency equipment and supplies are regularly maintained and checked on either a daily or per-shift basis; replenished after each use; and accessible to health care staff.

Custody staff will provide emergency services until qualified health care professionals arrive. Notification of on-call physicians and mental health staff will be accomplished as soon as the situation allows.

Facility staff will ensure request for an ambulance has been accomplished.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions.

RHA/HSA – Responsible Health Authority / Health Services Administrator

On-Call Provider – The responsible provider for a facility when an on-site provider is not physically present or available on-site.

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. A written plan includes arrangements for the following, which are carried out when necessary:

6.1.1. Emergency transport of the patient from the facility

6.1.2. Use of an emergency medical vehicle

6.1.3. Use of one or more designated hospital emergency departments or other appropriate facilities

6.1.4. Emergency on-call physician, mental health, and dental services when the emergency health care facility is not nearby

6.1.5. Security procedures for the immediate transfer of patients for emergency medical care

6.1.6. Notification to the person legally responsible for the facility

6.2. Health care staff are oriented to emergency services at the time of their initial orientation as a new employee. Annual training is conducted as part of the in-service training program for all health care staff. The training includes, at a minimum:

6.2.1. Location of emergency equipment and medications

6.2.2. The 911 process

6.2.3. Recognition of signs and symptoms and knowledge of action that is required in potential emergency situations

6.2.4. Administration of basic first aid

6.2.5. Certification in cardiopulmonary resuscitation (CPR) in accordance with the recommendations of the certifying health organization

6.2.6. Methods of obtaining assistance

6.2.7. Signs and symptoms of mental illness, violent behavior, and acute chemical intoxication and withdrawal

6.3. The RHA/HSA is responsible for ensuring that a current list of names, addresses, and phone numbers of all persons and agencies to be notified in the case of an emergency is available to health care staff at all times.

6.4. Emergency medications, equipment, and supplies are readily available at all times, replenished after each use, and checked on a regular basis.

6.4.1. First Aid Kits are available in designated areas of the facility as determined by contract. The RHA/HSA in conjunction with the Facility Administrator approves the contents, number, location, and procedures for monthly inspection of the kit(s) and written protocols for use by nonmedical staff. Additionally, an automatic external defibrillator is available for use at the facility.

6.5. Ambulances are accessed by calling 911 by medical personnel.

6.6. All emergency encounters are documented in the health record.

6.7. Non-emergency patients will be controlled by custody staff in accordance with guidelines outlined in the emergency plan.

6.8. The correctional supervisor will be contacted and informed of any emergency.

6.9. Decisions requiring treatment and the need for emergency transportation are made by health care staff.

6.10. Whenever possible, the on-call provider is notified prior to transporting the patient to the hospital. However, **in the event of a life- or limb-threatening emergency, the patient is sent to the hospital in the most expedient way possible which may require notifying the physician after transport.**

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Ancillary Health Care Services: J-D-07 Emergency Services and Response Plan (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Ancillary Health Care Services: P-D-07 Emergency Services and Response Plan (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-06 Emergency Services (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-1C-01 Emergencies (M)
- 4-ALDF-4C-08 Emergency Plan (M)
- 4-ALDF-4D-09 First Aid
- 1-HC-1A-08 Emergency Plan (M)
- 1-HC-2A-13 Emergency Plans (M)
- 1-HC-2A-14 Emergency Response (M)
- 1-HC-2A-15 First Aid

TITLE: HCD-100_D-07A Emergency Response Plan -- Mecklenburg NC	REFERENCE: 59951
	PAGE: 1 OF 4 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that health care staff are prepared to implement the health aspects of the facility's emergency response plan.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath maintains policies and procedures for health care services in the event of a human-made or natural disaster, riot, or internal/external disaster. Custody and health care personnel are trained to respond to health-related situations within four (4) minutes.

This policy is to be used in conjunction with the site-specific Emergency Disaster Plan. The health aspects of the emergency response plan are approved by the Responsible Health Authority (RHA) / Health Services Administrator (HSA), and Facility Administrator, and include, at a minimum:

- Responsibilities of health care staff
- Procedure for triage for multiple casualties
- Predetermination of the site for care
- Telephone numbers and procedures for calling health care staff and the community emergency response system (e.g., hospitals, ambulances)
- Procedures for evacuating patients
- Alternate backups for each of the plan's elements
- Time frames for response

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. The RHA/HSA will coordinate the disaster drill with the Facility Administrator or designee.

6.2. The RHA/HSA shall coordinate at least one mass disaster drill annually for each shift where health care staff are regularly assigned, to include all satellite facilities, so that over a three (3) year period health care staff on each shift have participated. Critique of the drills is documented and shared with all health care staff and recommendations for health staff are acted upon. Copies of the critique will be kept on file by the RHA/HSA.

6.3. The emergency man-down drill is practiced once a year on each shift where health staff are regularly assigned, including satellite facilities.

6.4. The proper management of a disaster will require the following activities:

6.4.1. Notification and/or recall of staff

6.4.2. Central location for the injured persons

6.4.3. Triage by medical staff

6.4.4. Evacuation process

6.4.5. Community emergency response notification system

6.4.6. Notification to pharmacy vendor

6.4.7. Alternate backups for each of the plan's elements

6.5. Treatment and/or transfer of the injured:

6.5.1. Health care staff will be the sole authority for determining the extent of injury and appropriate level of care. On the recommendation of health care staff, the injured may be transferred to an outside facility, retained in the triage area for on-site treatment of minor injuries, or cleared from health care staff monitoring.

6.5.2. It is not the responsibility of health care staff to provide adequate security to those individuals transferred to an outside health care facility.

6.6. Health care staff will maintain adequate medical supplies in a locked container for response to a mass disaster emergency.

6.6.1. The contents of the mass disaster emergency supply container are updated as necessary.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Ancillary Health Care Services: J-D-07 Emergency Services and Response Plan (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Ancillary Health Care Services: P-D-07 Emergency Services and Response Plan (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Governance and Administration: MH-A-07 Emergency Response Plan (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-1C-01 Emergencies (M)
- 4-ALDF-4C-08 Emergency Plan (M)
- 4-ALDF-4D-08 Emergency Response (M)
- 1-HC-1A-08 Emergency Plan (M)

- 1-HC-2A-13 Emergency Plans (M)
- 1-HC-2A-14 Emergency Response (M)
- 1-HC-2A-15 First Aid

TITLE: HCD-100_D-08 Hospitals and Specialty Care -- Mecklenburg NC	REFERENCE: 59952
	PAGE: 1 OF 3 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that hospitalization and specialty care are available to patients in need of these services.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Patients who require hospital or specialized ambulatory care are provided appropriate and timely access to such care in a facility that meets state licensure requirements.

Wellpath has made arrangements with local hospitals and specialty providers to ensure that all levels of care are available to meet the health care needs of the patient population. These include, but are not limited to:

- EMS/FD/911 Ambulance
- Medical Center
- Atrium & Novant Health

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers)

6. PROCEDURE

6.1. When patients require specialty care that is not available on-site, they are sent for specialist-provided health care off-site.

6.1.1. Off-site appointment requests are sent for approval to the Wellpath Chief Clinical Officer or designee prior to appointments being scheduled.

6.2. When patients are referred for outside care, written or verbal communication about the patient and the specific problems to be addressed must be communicated to the outside entity.

6.3. Contracts or letters of agreement are completed with hospitals and specialized ambulatory care providers.

6.3.1. The agreements require that the off-site facilities or specialized ambulatory care clinics provide a summary of the treatment given and any follow-up instructions. This information is to accompany the patient upon return to the facility.

6.3.2. The health record contains results from off-site visits or attempts by health care staff to obtain these results.

6.4. When a patient is sent to the Emergency Room:

6.4.1. The nurse will notify the provider and the Responsible Health Authority (RHA) / Health Services Administrator (HSA)

6.4.2. Transportation is arranged through the custody staff. The patient will be transported via either custody vehicle or ambulance as needed.

6.5. When a patient is admitted to the Emergency Room, via Direct Admit, or from a Scheduled Outpatient Appointment:

6.5.1. Site health care staff will notify the Corporate Utilization Review Nurse

6.5.2. The Corporate Utilization Review Nurse will enter updates on the patient's status as indicated by acuity.

6.6. The site will maintain appropriate certificates and licenses for on-site specialty services that are regularly used for medical, dental, and mental health care.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Ancillary Health Care Services: J-D-08 Hospitals and Specialty Care (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Ancillary Health Care Services: P-D-08 Hospitals and Specialty Care (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Mental Health Care Services and Support: MH-D-05 Inpatient Psychiatric Care (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-05 Referrals
- 4-ALDF-4D-20 Transfer
- 1-HC-1A-04 Continuity of Care
- 1-HC-1A-05 Referrals
- 1-HC-4A-07 Transfers

1. PURPOSE

This policy is intended to ensure that upon arrival to the facility, patients are informed of the availability of health care services and how to access them.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Information regarding the availability of health care services, including how to access services and co-payments, shall be communicated verbally and in writing to patients upon their arrival at the facility. Provisions shall be made to communicate this information in a language and format the patient can understand.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Written Information – May take the form of a facility handbook, a handout, or posting in kiosks and/or housing areas

6. PROCEDURE

6.1. Verbal explanations of the sick call procedure shall be communicated to all patients at the time of booking. Direct referrals to health care staff shall be made in any case of an immediate health need upon booking or as soon as possible after the patient enters the facility.

6.2. A sign in English and Spanish explaining how to access health care services is posted in the intake/processing area and in common areas of the living units.

6.3. Within 24 hours of arrival and prior to being placed in the general population, the patient is given written, electronic, or video information on how to access health care services. The information includes:

- How to access emergency and routine medical, dental, and mental health services
- Facility-based fee for services program, if one exists
- The grievance process for health-related complaints
- Description of services, programs, and eligibility requirements

6.4. The Inmate Handbook contains information concerning health care services and access thereto. The handbook is translated into those languages spoken by significant numbers of inmates.

6.5. Information is provided to inmates about sexual abuse/assault. The information is communicated orally and in writing upon arrival at the facility, in a language clearly understood by the inmate and includes:

6.5.1. Prevention/intervention

6.5.2. Self-Protection

6.5.3. Reporting sexual abuse/assault

6.5.4. Treatment and counseling

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-01 Information on Health Services (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-01 Information on Health Services (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-01 Information on Mental Health Services (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-2A-27 Orientation
- 4-ALDF-2A-28 Orientation
- 4-ALDF-2A-29 Orientation
- 4-ALDF-4C-01 Access to Care (M)
- 4-ALDF-4C-02 Co-Payments
- 1-HC-1A-01 Access to Care (M)
- 1-HC-1A-02 Co-Payments

1. PURPOSE

This policy is intended to ensure receiving screenings are performed on all patients upon arrival at the intake facility to ensure that emergent and urgent health needs are met.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The receiving screening is performed on all patients as soon as possible upon arrival at booking to ensure that emergent and urgent health needs are met. The receiving screening is documented on the Receiving Screening Form, which is approved by the Responsible Health Authority (RHA) / Health Services Administrator (HSA).

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Medical Clearance – A clinical assessment of physical and mental status before an individual is admitted into the facility. The medical clearance may come from the on-site health care staff or may require sending the individual to the hospital emergency room. The medical clearance is to be documented in writing.

Receiving Screening – A process of structured inquiry and observation intended to identify potential emergency situations among new arrivals and to ensure that patients with known illnesses and those on medications are identified for further assessment and continued treatment.

Medication Assisted Treatment – The use of medications in combination with counseling and behavior therapies to provide a "whole patient" approach to the treatment of substance use disorders.

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

RHA/HSA – Responsible Health Authority / Health Services Administrator

MVA – Motor Vehicle Accident

6. PROCEDURE

Medical Clearance

6.1. Reception personnel ensure that persons exhibiting the following medical conditions will be referred to the Emergency Department for evaluation and treatment:

6.1.1. Unconscious or Semiconscious (e.g., unable to walk under their own power)

6.1.2. Bleeding (e.g., significant external bleeding, symptoms of possible internal bleeding, or abdominal bleeding)

6.1.3. Mentally unstable

6.1.4. Severely intoxicated

6.1.5. Signs of acute alcohol or drug withdrawal

6.1.6. Otherwise urgently in need of medical attention (e.g., obvious fractures, signs of head injury, pregnant women in labor, having or recently had convulsion, recent MVA without subsequent medical evaluation)

6.2. If the patient is referred to a community hospital and then returned, his or her admission to the facility is predicated on documented evidence of evaluation, treatment, and medical clearance from the hospital. This documented evidence will become part of the patient's health record.

Receiving Screening

6.3. A receiving screening is performed on patients, including transfers, as soon as possible upon arrival at the facility, but no later than 24 hours after arrival and prior to housing, in order to identify health conditions requiring immediate or ongoing interventions, including separation from the rest of the population because of communicable diseases and/or active substance withdrawal. This screening is performed by health care staff when staffing permits, but it may also be performed by health-trained custody staff.

6.4. The receiving screening serves the following purposes:

6.4.1. Identifies patients whose health condition is such that they should not be accepted into the facility without first receiving medical evaluation and care (usually from an emergency room)

6.4.2. Identifies patients who will require immediate care upon being accepted into the facility

6.4.3. Identifies patients who will require care after being accepted into the facility, but will not require it immediately

6.4.4. Identifies patients whose placement in the facility will require consideration of their physical or mental health status

6.4.5. Identifies patients who may have potentially infectious diseases

6.4.6. Identifies patients with the potential of sexually aggressive/violent behaviors/tendencies

6.5. The receiving screening includes inquiry into the following:

6.5.1. Current and past illnesses, health conditions, or special health requirements (e.g., dietary needs, hearing impairment, visual impairment, wheelchair, walker, and sleep apnea machine)

6.5.2. Past infectious disease

6.5.3. Past and recent communicable illness symptoms (e.g., chronic cough, coughing up blood, lethargy, weakness, weight loss, loss of appetite, fever, night sweats)

6.5.4. Past or current mental illness, including hospitalizations

6.5.5. History of or current suicidal ideation

6.5.6. Dental problems (e.g., decay, gum disease, abscess)

6.5.7. Allergies

6.5.8. Prescription medications (including type, amount, and time of last use)

6.5.9. Use of alcohol, legal, and/or illegal drug use (including type, method, amount, and date/time of last use)

- Ingestion or placement of a “baggie” of medication/drugs into a body cavity
- History of problems which may have occurred after ceasing use (e.g., seizures, shakes)
- If a female reports current opiate use, she is immediately offered a test for pregnancy to avoid opiate withdrawal risks to the fetus

6.5.10. Current or prior withdrawal symptoms

6.5.11. Possible, current, or recent pregnancy

- A pregnancy test is offered to all females upon arrival, and the patient is referred to health care staff within 48 hours for testing.
- If a female is pregnant, an opiate history is obtained.

6.5.12. Type and time of most recent sexual encounter and use of contraception and condoms, in order to screen for emergency contraception eligibility

6.5.13. Victimization by recent sexual assault, in order to screen for emergency contraception eligibility

6.5.14. Sexually transmitted diseases (e.g., chlamydia, gonorrhea, HIV, and syphilis) testing is offered to all patients when clinically indicated, consistent with national guidelines.

6.5.15. Other health problems as designated by the Responsible Physician / Medical Director

6.6. The receiving screening includes staff observation of the following:

6.6.1. Appearance (e.g., sweating, tremors, anxious, disheveled)

6.6.2. Behavior and conduct (e.g., disorderly, appropriate, insensible)

6.6.3. State of consciousness (e.g., alert, responsive, lethargic)

6.6.4. Mental status (e.g., affect, mood, hallucinations)

6.6.5. Ease of movement (e.g., body deformities, gait, need for assistive devices)

6.6.6. Breathing (e.g., persistent cough, hyperventilation)

6.6.7. Condition of skin (e.g., lesions, jaundice, rashes, infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse)

6.6.8. Slowness in speech or lack of comprehension suggestive of developmental disabilities

6.6.9. Characteristics of potentially being at-risk for victimization (e.g., age, small stature, femininity, first time offender, passive or timid appearance)

6.7. The receiving screening form includes a record of the disposition of the patient, which is appropriate to the findings of the receiving screening and may include:

- An emergent, urgent, or routine referral to a medical, dental, or mental health practitioner depending on the disposition of the patient

- Guidance to the facility regarding housing placement, including placement in general population or special housing appropriate for patient need
  - ➢ All potentially infectious patients are isolated from the general population
- Guidance to the facility regarding activity limitations and work assignment
- Timely continuation of essential medication
- Other individual observations and recommendations

6.8. Any patient who is suspected or confirmed to have a developmental disability is referred to his or her case worker (e.g. the local regional center) for purposes of identification or treatment within 24 hours of identification, excluding holidays and weekends.

6.9. The receiving screening forms are dated and timed immediately upon completion and include the printed name, signature, and title/credentials of the person completing the form.

6.10. Prescribed medications are reviewed and appropriately maintained as clinically indicated. See policy *HCD-100_E-09A Medication Verification*

6.11. When health-trained correctional personnel perform the receiving screening, they are trained by the Responsible Physician / Medical Director or designee in the early recognition of medical, dental, or mental health conditions requiring clinical attention. Training is based on a curriculum approved by the Responsible Physician / Medical Director and contains instructions on completing the receiving form and when to contact health staff to determine appropriate disposition of the patient.

6.11.1. Subsequent review by licensed health care staff of any positive finding will be completed within the next day or at the next scheduled RN shift, whichever comes first.

6.12. Health care staff regularly monitor receiving screenings to determine the safety and effectiveness of this process.

6.13. Patients refusing to cooperate with the screening process, including refusal to answer questions related to suicidality, will be considered suicidal and placed on appropriate suicide precautions.

6.13.1. Health care staff will continue to attempt completion of the intake screening at each patient encounter at twice a shift, with no more than six (6) hours between attempts, until successful. Each attempt will be documented in the patient's health record.

7. REFERENCES

HCD-100_E-09A Medication Verification

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-02 Receiving Screening (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-02 Receiving Screening (E)

NCCH Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-02 Receiving Screening for Mental Health Needs (E)

ACA Standards / 2016 Standards Supplement

- 4-ADLF-4C-22 Health Screens (M)
- 4-ADLF-4C-29 Mental Health Screen (M)
- 1-HC-1A-19 Health Screens (M)
- 1-HC-1A-27 Mental Health Screen (M)

Forms

- Receiving Screening Form

TITLE: HCD-100_E-03 Transfer Screening --Mecklenburg NC	REFERENCE: 59955 PAGE: 1 OF 3 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that patients who are transferred within the same correctional system continue to receive appropriate health care services.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

In order to ensure that patients transferred between facilities continue to receive appropriate health care services for health needs already identified, each incoming patient will receive a health screening by health care staff within 12 hours of arrival at the facility or as determined by contract. Findings are recorded on a form approved by the Responsible Health Authority (RHA) / Health Services Administrator (HSA).

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

6. PROCEDURE

6.1. A QHP will review each transferred patient's health record or summary within 12 hours of arrival, or as determined by contract, to ensure continuity of care and medications.

6.2. When transferred from an intake facility, patients who do not have initial medical, dental, or mental health assessments will be evaluated at the receiving facility in a timely manner.

6.3. Documentation in the health record demonstrates continuity of health care and medication administration.

6.4. Non-emergency patient transfers require the following:

6.4.1. Summaries, originals, or copies of the health record accompany the patient to the receiving facility. Health conditions, treatments, and allergies are included in the record.

6.4.2. Confidentiality of the health record

6.4.3. Determination of suitability for travel based on medical evaluation, with particular attention given to communicable disease clearance

6.4.4. Written instructions, separate from the medical record, for transporting officers regarding medication or health interventions required en route

6.4.5. Specific precautions to be taken by transportation officers, including universal precautions and the use of masks and/or gloves

6.5. A medical summary sheet is required for all inter- and intra-system transfers to maintain continuity of care. Information included does not require a release-of-information (ROI) form.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-03 Transfer Screening (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-03 Transfer Screening (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-03 Transfer Screening (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-22 Health Screens (M)
- 4-ALDF-4C-23 Intrasystem Transfers (M)
- 4-ALDF-4D-27 Transfers
- 1-HC-1A-19 Health Screens (M)
- 1-HC-1A-20 Intrasystem Transfers (M)
- 1-HC-1A-21 In-Transit Offenders

1. PURPOSE

This policy is intended to ensure that patients receive an initial health assessment in the appropriate time frame.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The medical history and physical examination are part of the initial database for the total comprehensive plan of care, which is delivered according to the philosophy and objectives of Wellpath. It is the goal of Wellpath to prevent deterioration of the patient's health during incarceration and to improve vital functions whenever possible.

Patients are offered a Health Assessment completed by qualified health care staff within appropriate time frames.

NCCHC:

- Jails: as soon as possible, but no later than 14 calendar days after admission to the facility.
- Prison: as soon as possible, but no later than seven (7) calendar days after admission to the facility

ACA:

- Jails/Prisons: completed within 14 days after arrival at the facility, excluding intra-system transfers

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

6. PROCEDURE

6.1. The Responsible Physician / Medical Director determines the components of an initial health assessment.

6.2. The health evaluation will include at least the following:

- Review of the receiving screening results
- A qualified health care professional collecting additional data to complete the medical, dental, and mental health histories, including any follow-up from positive findings obtained during receiving screening and subsequent encounters
- A qualified health care professional recording of vital signs (including height, weight, pulse, blood pressure, and temperature)
- A physical examination (as indicated by the patient's gender, age, and risk factors) – inspection, palpation, auscultation, and percussion of a patient's body to determine the presence or absence of physical signs of illness
- Laboratory and/or diagnostic tests for communicable diseases such as tuberculosis and syphilis, if not completed at the time of receiving screening,

unless there is documentation from the health department that the prevalence rate does not warrant it

- Immunizations when appropriate
- Completion of other clinically indicated tests and examinations
- Initiation of appropriate treatment when indicated or ordered by the physician
- When applicable, development and implementation of a treatment plan, including recommendations for housing, job assignments, and program participation
- When clinically indicated, a pelvic exam, or referral for pelvic exam, with or without a Pap smear *(PRISONS ONLY)*

6.3. Positive findings (e.g., history and physical screening, and laboratory) are reviewed by the provider. Specific problems are integrated into an initial problem list. Diagnostic and therapeutic plans for each problem are developed as clinically indicated.

6.4. HIV testing will be offered to patients, with their consent, who have related symptoms, high-risk behaviors, or request that they be tested.

6.5. A physician, physician assistant, nurse practitioner, or appropriately trained registered nurse completes the hands-on portion of the health assessment. The Responsible Physician / Medical Director documents his or her review of the health assessment when positive finds are present.

6.6. If the health assessment is deferred because of a documented health assessment within the last 12 months (or 90 days for ACA accredited facilities), documentation in the health record must confirm that the new receiving screening shows no change in health status.

6.6.1. If the receiving screening shows a change in health status, the initial health assessment is repeated.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-04 Initial Health Assessment (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-04 Initial Health Assessment (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-04 Mental Health Assessment and Evaluation (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-24 Health Appraisal (M)
- 4-ALDF-4C-25 Health Appraisal
- 1-HC-1A-22 Health Appraisal (M)
- 1-HC-1A-23 Health Appraisal

Forms

- Initial Health History and Physical Assessment Form

TITLE: HCD-100_E-05 Mental Health Screening and Evaluation --Mecklenburg NC	REFERENCE: 59957
	PAGE: 1 OF 6 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 06/01/2019 REVIEWED: 06/01/2019

1. PURPOSE

This policy is intended to ensure a mental health screening is performed to ensure that urgent mental health needs are met.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Patients receive a mental health screening during the initial health assessment. This screening is a follow-up to the mental health screening that is included as part of the intake/receiving screening process. The mental health screening is carried out by qualified health care or mental health care professionals. When findings are positive, the patient is referred to a Qualified Mental Health Professional (QMHP) for a mental health initial evaluation, unless the screening was carried out by a mental health professional. A QMHP will provide training as needed when the mental health portion of the receiving screening or initial health assessment is completed by a health care professional, providing instruction in identifying and interacting with patients in need of mental health services.

3.1. The initial mental health screening includes a structured interview with inquiries into, at a minimum:

3.1.1. A history of:

- Psychiatric hospitalization and outpatient treatment
- Substance use hospitalization
- Withdrawal seizures
- Detoxification and outpatient treatment

- Suicidal behavior
- Violent behavior
- Victimization
- Special education placement
- Cerebral trauma
- Sexual abuse
- Sex offenses

3.1.2. The status of:

- Psychotropic medication
- Suicidal ideation
- Drug or alcohol use
- Drug or alcohol withdrawal or intoxication
- Orientation to person, place, and time

3.1.3. Emotional response to incarceration

3.1.4. Screening for intellectual functioning (e.g., mental retardation, developmental disability, learning disability)

The results of the evaluation, with documentation of referral or initiation of treatment, when indicated, are retained in the health record.

If the mental health needs of the patient exceed the capabilities of the facility, steps are taken to transfer the patient to a location where the patient's needs can be met. Such transfers must typically follow due-process procedures as they relate to sending patients to outside agencies such as local hospitals. Generally, outside community mental health providers address the due-process requirements.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Mental Health Screening – The portion of the receiving screening form focused on mental health history and findings completed as soon as possible upon arrival by a Qualified Health Professional (QHP) or trained non-licensed staff so that the timeliness of referral mitigates negative mental health consequences.

Mental Health Assessment – Refers to the mental health history portion of the 14-day or sooner health assessment based on a referral from staff or patient self-referral to Mental Health Services.

Mental Health Evaluation – A comprehensive mental health evaluation completed by a QMHP in response to positive findings on mental health assessment, referral from QHP or custody staff, or patient request for Mental Health Services. The mental health evaluation shall be completed within 30 days of the positive screen.

Psychiatric Evaluation – A comprehensive mental health evaluation completed by a Psychiatrist or Psychiatric Nurse Practitioner in response to positive findings on mental health screening/assessment, referral from a QHP or custody staff, or patient request for Mental Health Services.

Suicide Risk Assessment – A comprehensive suicide risk questionnaire completed by a QHP and/or QMHP to assess suicide potential including, but not limited to: current mental status, affect, cognition, judgment/insight, speech, mood, hallucinations, memory, plan, history, etc.

Qualified Mental Health Professional (QMHP) – Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have

consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

On-Call Provider – The responsible provider for a facility when an on-site provider is not physically present or available on-site.

6. PROCEDURE

6.1. As part of the initial health screening process, a qualified health care professional or mental health professional conducts a mental health screening within 14 days of admission to the facility for both jails and prisons.

6.2. Results of the screening assessment are documented in the patient's health record.

6.3. Responses of a positive or concerning nature will result in a referral to mental health staff for additional assessment. If mental health staff conducted the mental health section of the initial health assessment, the staff member will either schedule a follow-up or conduct a more in-depth assessment as part of the initial health assessment.

6.3.1. If the patient has already seen a mental health professional to complete the Psychiatric Evaluation Form, that process does not need to be repeated. However, if a new issue was elicited during the initial health assessment, the patient is seen for additional assessment of the new issue.

6.4. Any referrals by a QHP will be triaged and assigned for follow-up. As a priority, emergent and urgent referrals will be addressed first, while routine referrals will be seen within seven (7) days for sites with 40 hours-a-week mental health coverage, within 10 days at sites with less than 40 hours-a-week coverage, and within 14 days at sites with less than 10 hours-a-week coverage.

6.4.1. If an emergent referral to a QMHP occurs after hours, the on-call provider shall be contacted. The on-call provider will determine whether the patient needs to be transferred to another facility, as clinically indicated.

6.5. Patients assessed to have serious mental health needs who have not already been identified as such will be reviewed by mental health staff, and the level of mental health services considered necessary to assist the patient in maintaining adequate functioning in the facility will be determined.

6.5.1. Patients who require acute mental health services beyond those available in the facility are transferred to an appropriate facility.

6.5.2. The Mental Health Coordinator/Director, in consultation with the Psychiatric Provider, will determine those patients in need of transfer to an appropriate mental health facility and will communicate with appropriate custody staff about transfer arrangements.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-05 Mental Health Screening and Evaluation (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-05 Mental Health Screening and Evaluation (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-04 Mental Health Assessment and Evaluation (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-27 Mental Health Program (M)
- 4-ALDF-4C-29 Mental Health Screen (M)
- 4-ALDF-4C-30 Mental Health Appraisal (M)
- 4-ALDF-4C-31 Mental Health Referrals
- 4-ALDF-4C-34 Mental Illness and Developmental Disability
- 4-ALDF-4D-20 Transfer of Mentally Ill or Developmentally Disabled
- 1-HC-1A-25 Mental Health Program (M)
- 1-HC-1A-27 Mental Health Screen (M)
- 1-HC-1A-28 Mental Health Appraisal (M)
- 1-HC-1A-29 Mental Health Evaluations (M)
- 1-HC-1A-31 Mental Illness and Developmental Disability
- 1-HC-3A-11 Transfer of Mentally Ill or Developmentally Disabled

Forms

- Psychiatric Evaluation Form

- Initial Health History and Physical Assessment Form

1. PURPOSE

This policy is intended to ensure that patients' dental needs are addressed.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Dental services are provided under the direction and supervision of a dentist licensed in the state. Care is timely and includes expedited access for urgent or painful conditions. A system will be followed that establishes priorities for care when, in the dentist's judgment, the patient's health would otherwise be adversely affected. A dentist performs an oral examination within 12 months from admission for jails and 30 days from admission for prisons, supported by diagnostic X-rays if indicated.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

NONE

6. PROCEDURE

6.1. Oral screenings by the dentist, or qualified health care professionals with documented training by the dentist, are performed within 14 days of admission for jails and within seven (7) days of admission for prisons.

6.2. Instruction in oral hygiene and preventive oral education is provided to patients within 14 days from admission for jails and within 30 days from admission for prisons.

6.3. Oral treatment, not limited to extractions, is provided according to a treatment plan based upon a system of established priorities for care when, in the dentist's judgment, the patient's health would otherwise be adversely affected.

6.3.1. Priority One – To be treated as emergency

- Patients having severe pain affecting regular activity
- Fractured mandibles
- Avulsed teeth
- Abscessed tooth/teeth with signs of swelling
- Cellulitis
- Suspected neoplasms
- Other emergent needs as determined by the dentist

6.3.2. Priority Two

- Oral conditions which, if left untreated, are subject to cause pain in the immediate future
- Non-painful lesions
- Periodontal disease of an advanced nature
- Prosthodontic patients in need of appliance for proper mastication
- Other serious dental issues as determined by the dentist

6.4. An individualized treatment plan will be developed for each patient receiving dental care.

6.4.1. For patients with less than 12 months' detention, treatment plans will include treatment of dental pain, sedative fillings, extractions of non-restorable teeth, gross debridement of symptomatic areas, and repair of partials and dentures.

6.4.2. For patients with more than 12 months' detention, treatment plans will also include X-rays.

6.4.3. A defined charting system identifies the oral health condition and specifies the priorities for treatment by category.

6.4.4. Consultation through referral to oral health care specialists is available as necessary.

6.4.5. Radiographs are appropriately used in the development of the treatment plan.

6.5. Each patient has access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the needs of the individual.

6.6. Extractions are performed in a manner consistent with community standards of care and adhering to the American Dental Association's clinical guidelines.

6.7. When oral care is provided on-site, contemporary infection control procedures are followed.

7. REFERENCES

Infection Control Procedures
American Dental Association's Clinical Guidelines

NCCHC Standards for Health Services in Jails 2018
- Section: Patient Care and Treatment: J-E-06 Oral Care (E)

NCCHC Standards for Health Services in Prisons 2018
- Section: Patient Care and Treatment: P-E-06 Oral Care (E)

ACA Standards / 2016 Standards Supplement
- 4-ALDF-4C-20 Dental Care
- 1-HC-1A-17 Dental Care

1. PURPOSE

This policy is intended to ensure that patients' non-emergent health care needs are met.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Patients have the opportunity to request health care daily. Their requests will be documented, triaged, and referred as appropriate. Qualified health care professionals conduct sick call and providers' clinics on a scheduled basis to ensure that patient requests are responded to in a timely manner.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Clinical Encounters – Interactions between patients and health care staff that involve an assessment, examination, treatment, and/or exchange of Protected Health Information (PHI)

Clinical Setting – Refers to an examination or treatment room appropriately supplied and equipped to address the patient's health care needs

Daily – Seven (7) days per week, including holidays

Health Care Liaison – May be a correctional officer or other person without a health care license who is instructed by the Responsible Physician / Medical Director or designee in limited aspects of health care coordination. The health care liaison generally carries out the following duties: reviews receiving screening forms for follow-up attention, reviews nonemergency health care requests as instructed by the Responsible Physician / Medical Director, helps carry out prescribers' orders, and maintains patients' privacy.

Provider's and Nursing Clinic – Designated time and place for physicians, nurse practitioners, physician's assistants, dentists, nurses, and/or mental health clinicians to respond to health services requests

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients

Responding to Health Care Requests – The medical, dental, and/or mental health evaluation and treatment of an ambulatory patient in a clinical setting by a QHP

Triage – The sorting and classifying of patients' medical, dental, and mental health requests to determine priority of need in the proper place for health care to be rendered

6. PROCEDURE

6.1. All patients receive information on how to access health care services as part of the receiving process. Additionally, this information is posted in each housing unit and written in the inmate handbook.

6.1.1. Direct referral to the QHP for further evaluation shall be made in any case of immediate health need identified upon booking.

6.2. All patients can access health care services daily, either by oral or written requests for health care, regardless of housing assignment. All patients have access to regularly scheduled times for nonemergency health services (i.e., sick call). Health care request forms are readily available to all patients.

6.3. The frequency and duration of response to health services requests are sufficient to meet the health needs of the patient population.

6.4. Qualified health care professionals pick up health service requests daily.

6.5. Health care requests are reviewed and prioritized daily by qualified health care professionals or the health care liaison, if applicable.

6.5.1. The resulting disposition from triage is noted on the patient's health request form. This includes the time, signature, and licensure of the staff member documenting the disposition.

6.6. A face-to-face encounter for a health care request is conducted by a qualified health care professional, or the health care liaison (if applicable), within 24 hours of receipt by health care staff.

6.6.1. All requests that are triaged as emergent shall be seen immediately. Urgent requests shall be scheduled for the next provider's sick call.

6.6.2. Patients experiencing urgent or emergent conditions shall be seen upon determination of emergency and are not required to complete a health services request form.

6.6.3. Off-Site Specialty Clinics and Hospital Emergency Departments are available as referred and clinically indicated.

6.7. Clinical services are available to patients in a clinical setting at least five (5) days a week.

6.8. Qualified health care professionals make timely evaluations. Qualified health care professionals provide intervention according to clinical priorities or, when indicated, schedule patients for the next available providers' clinic.

6.9. All aspects of the health care request process, from review and prioritization to subsequent encounters, are documented, dated, and timed. This includes, but is not limited to, when a patient request is triaged, rescheduled, or provided with self-care information.

6.10. The confidentiality of a patient's request for sick call, as well as the patient's medical issues are maintained.

6.11. A patient refusing treatment or receiving incomplete treatment during a face-to-face clinical encounter shall sign a Refusal of Examination and/or Treatment form. See *HCD-100_G-05 Informed Consent and Right to Refuse*.

6.12. Patients in segregated or restrictive housing shall have the same access to health care as patients in general population. See *HCD-100_G-02 Segregated Inmates*.

7. REFERENCES

HCD-100_G-05 Informed Consent and Right to Refuse
HCD-100_G-02 Segregated Inmates

Inmate Handbook

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-07 Nonemergency Health Care Requests and Services (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-07 Nonemergency Health Care Requests and Services (E)

NCCH Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-05 Nonemergency Health Care Requests and Services (E)

ACA Standards / 2016 Standards Supplement

- 4-ADLF-4C-03 Clinical Services
- 1-HC-1A-03 Clinical Services

Forms

- Health Services Request Form
- Informed Consent
- Refusal of Clinical Services

1. PURPOSE

This policy is intended to ensure that nursing assessment protocols (Wellpath Professional Nursing Protocols) and procedures are appropriate to the level of competency and preparation of the nursing personnel who will carry them out and comply with relevant state practice acts.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath Professional Nursing Protocols are utilized by nursing staff, are appropriate to the level of competency and preparation of the nurses who will carry them out, and comply with the state practice act in the facility's jurisdiction. Wellpath Professional Nursing Protocols are accessible to all nursing staff.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Nursing Assessment Protocols (Wellpath Professional Nursing Protocols) – Written instructions or guidelines that specify the steps to be taken in evaluating a patient's health status and that guide documentation in the health record. Such protocols may include first-aid procedures for

the identification and care of ailments that ordinarily would be treated by an individual through self-care. They also may address more emergent symptoms, such as chest pain or shortness of breath. They provide a sequence of steps to be taken to evaluate and stabilize the patient until a provider is contacted and orders are received for further care.

SOAPE – Documentation which indicates the sequence of how items should appear when charting: subjective, objective, assessment, plan, and evaluation.

6. PROCEDURE

6.1. Development and Approval of the Wellpath Professional Nursing Protocol

6.1.1. The Wellpath Professional Nursing Protocols were developed through collaboration of Wellpath Corporate Clinical and Operations.

6.1.2. The Wellpath Professional Nursing Protocols are reviewed annually, at a minimum, and as needed. They may be revised, modified, changed, or deleted at any time by consent and collaboration of the Wellpath Chief Clinical Officer, the on-site Responsible Physician / Medical Director, and the on-site responsible administrative and nursing representatives.

6.2. Requirements for Nurses

6.2.1. Only those nurses that are trained and approved by the Responsible Physician / Medical Director, are approved by the responsible Clinical and Operations representatives of Wellpath, and are allowed under the scope of their licensure may use and implement the Wellpath Professional Nursing Protocols.

6.2.2. Education and Training

- Any nurse using a Wellpath Nursing Assessment Protocol must hold an active license applicable in the state in which the Wellpath Nursing Assessment Protocols will be used.

- Wellpath trains nursing personnel on the use of the clinical pathways. The training is documented and includes:

  ◊ Evidence that all new nursing staff are trained

- ◊ Demonstration of knowledge and competency for the protocol and procedures that are applicable to their scope of practice
- ◊ Evidence of annual review of competency
- ◊ Evidence of retraining when pathways are introduced or revised

6.3. Method for Documentation

6.3.1. Each professional encounter between a patient and the nurse shall be documented in the patient health record. All documentation shall use Wellpath Professional Nursing Protocols whenever possible. If a Wellpath Professional Nursing Protocol is not applicable or available, the nurse will use the SOAPE format to document.

6.3.2. The date, time of occurrence, printed name, and signature (complete with type of license) are mandatory with all documentation.

6.4. When indicated, the patient is referred to a provider to be evaluated. In general, when a patient presents for nonemergency health services more than two (2) times with the same complaint and has not seen a provider, he or she will be referred to the provider.

6.5. Wellpath Professional Nursing Protocols include over-the-counter medications only and do not include the use of prescription medications, except for those covering emergency, life-threatening situations (e.g., nitroglycerin, epinephrine, Narcan). Emergency administration of these medications must include immediate communication with a provider and requires a subsequent clinician's order.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-08 Nursing Assessment Protocols and Procedures (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-08 Nursing Assessment Protocols and Procedures (I)

1. PURPOSE

This policy is intended to ensure patient medical, dental, and mental health care is coordinated and monitored from admission to discharge.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath provides continuity of care to patients who are receiving health care services. Patients receive medical, dental, and mental health services from admission to discharge per prescribers' recommendations, orders, and evidence-based practices. This includes referrals to community-based providers, when indicated. A written list of referral sources includes emergency and routine care, and this list is reviewed and updated annually.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

NONE

6. PROCEDURE

6.1. Diagnostic tests and specialty consultation ordered by providers are completed in a timely manner. Clinic procedures are in place to ensure that medications and other treatments are given as ordered and clinic appointments are met.

6.2. A complete Health Assessment is completed within the appropriate time frame.

6.3. Individual treatment plans are based on information collected during the intake and health assessment processes as necessary. Treatment plans are modified as clinically indicated by diagnostic tests and treatment results. Treatment plans, including test results, are shared and discussed with the patient.

6.4. If deviations from evidence-based practices are indicated, clinical justification for the alternative treatment plan while in custody is documented.

6.5. Diagnostic tests are reviewed by the provider in a timely manner.

6.6. Clinician orders are evidence based and are implemented in a timely manner. Every effort will be made to obtain health information and records from previous health care providers, with consent of the patient when required, when the patient has a medical problem that was treated prior to incarceration.

6.7. Upon transfer to another facility, a medical discharge summary of the patient's current condition, medications, and treatment plan will be forwarded to the receiving facility in a sealed envelope to maintain confidentiality. Transport instructions related to universal precautions officers will be written on the outside of the transfer envelope.

6.7.1. Written instructions regarding medication or health interventions required en route for transporting officers is separate from the health record.

6.8. Requests for health information from community providers are provided with the patient's consent, when consent is required by local regulations.

6.9. When patients are sent out of the facility for emergency or specialty treatment, written information regarding the patient's current medical status and treatment accompany the patient. Upon return to the facility, patients are seen by a qualified health care professional or health care liaison, if appropriate. Recommendations from specialty consultations are reviewed for appropriateness of use in the correctional setting. A provider is contacted in a timely manner to ensure proper implementation of any orders and to arrange appropriate follow-up. Typically, a patient's medication regimen is not

modified upon return from the hospital unless it is clinically indicated. If changes in treatment recommendations are clinically indicated, justification for the alternative treatment plan is documented and shared with the patient. Appropriate and timely follow-up will be made as required.

6.9.1. When a patient is returned from an emergency room visit, the patient is brought to the clinic before returning to the housing unit for review of discharge orders and follow-up.

6.9.2. When a patient returns from hospitalization, the discharge is coordinated with on-site health care staff, and discharge instructions are reviewed. Appropriate orders are written for housing and follow-up treatment.

6.10. Provider clinical chart reviews are of a sufficient number and frequency to ensure that clinically appropriate care is ordered and implemented.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-09 Continuity, Coordination, and Quality of Care During Incarceration (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-09 Continuity, Coordination, and Quality of Care During Incarceration (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-09 Continuity and Coordination of Mental Health Care During Incarceration (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-04 Continuity of Care
- 4-ALDF-4C-05 Referrals
- 4-ALDF-4D-27 Transfers
- 4-ALDF-5B-18 Release
- 1-HC-1A-04 Continuity of Care
- 1-HC-1A-05 Referrals
- 1-HC-3A-11 Transfer

1. PURPOSE

This policy is intended to ensure that there is a process in which to verify reported medications and community prescribers' active prescriptions and communicate this information to an authorized Wellpath prescriber who will make a determination to continue, substitute, or discontinue based on clinical necessity.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Medication verification is a process through which an outside prescriber's active prescriptions are attempted to be confirmed and reported to a credentialed Wellpath prescriber or authorized prescriber for determination of continuance, substitution, or discontinuation based on clinical need.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

6. PROCEDURE

6.1. Medication verification includes the following information at a minimum:

- Patient identification
- Community prescriber identification
- Medication name and dosage dispensed
- Directions for the use of the medication
- Stop date for the prescription
- Date on which the prescription was last filled and quantity dispensed

6.2. Sites are to use a medication verification log to document this process.

6.3. Reported medications, both those verified and unable to be verified, will be discussed with the provider within one (1) day for decision to continue the verified order, not continue the verified order, substitute another medication, start medication that was unable to be verified, modify the dosage of a verified order, or not start a verified (or unverified) order. The provider can use the information presented by the nurse from the medication verification process, or if the medication was unable to be verified, can continue the medication verification process for up to two (2) additional business days.

6.4. No medications will be started without an order from a Wellpath QHP.

6.5. The option to decline should be invoked whenever a medication is thought to be unnecessary or inappropriate based upon diagnosis, usage, drug type, drug indication, dosage, etc. The decision must be documented in the health record. The following bullet points provide some guidance on decision making.

- When a patient reports current use of a medication and the verification process succeeds in contacting the prescriber or dispensing pharmacy, but the medication is not current or was never provided, the medication should not be considered as

a continuing medication, and the patient is generally considered as not currently receiving treatment with the identified medication.

- When a patient reports that he or she received medications by using medication from a friend or family member and cannot have their usage verified, the patient should not be considered as receiving medication from a legitimate source. Site QHPs must be consulted for direction.

- When a patient reports current use of a medication and the medication cannot be verified because the agency is unavailable, or the verification cannot be completed timely (in time either for a High-Priority or in time to initiate a routine medication within time frames outlined below), a QHP should be consulted for direction.

- When a patient reports current use of nonstandard medication (experimental, off-label, non-FDA approved, etc.) and the medication is verified, special efforts should be made to determine whether the medication must be continued and how to accomplish continuity of care. Although incarcerated patients generally do not participate in experimental protocols, care should be taken when interrupting protocol participation, especially in short-stay instances.

- When patients are received from hospital settings, there must be a timely review of the discharge medication regimen and it must be adjusted to the correctional setting, being mindful of providing care in a continuous manner. Formulary substitutions, decisions not to continue one or more medications, and other medication modifications are common at this juncture. As previously mentioned, such decisions are documented in progress notes and orders in the health record.

6.6. Medications should generally be initiated within 48 hours of notification of the medication to health care staff. During this period the medication should be verified and a supply obtained. Options for obtaining medication include stock supply, contract pharmacy supply, local pharmacy, or in rare instances patient supply (see *HCD-100_E-09B Timely Initiation of Medication Upon Arrival).* The expectation that routine medications will be initiated within 48 hours is tempered with the recognition that the site QHPs have the authority to determine if the medication is clinically indicated. When a decision that a medication is not clinically indicated is made, the decision and the reason for it is documented in the health record and the decision communicated to the patient by health care staff, either the same day or on the next day when the health care staff is on site.

6.7. A separate policy directive, *HCD-100_E-09B Timely Initiation of Medication Upon Arrival,* addresses medications for which continuation within 48 hours is insufficient, and for which efforts should be made to avoid missing even a single dose, *HCD-100_E09B* should be considered a companion to this policy directive.

7. REFERENCES

HCD-100_E-09B Timely Initiation of Medication Upon Arrival

Forms

- Medication Verification Form

1. PURPOSE

This policy is intended to ensure that discharge planning is provided for patients with serious health needs whose release is imminent.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Health care staff work with custody staff to ensure patients who have impending release dates and who have serious medical, dental, or mental health needs are connected with community providers, utilizing scheduled appointments or providing information sufficient for the patient to seek out community providers once released. Discharge planning may also include provision of release medications to address the period between release and the next contact with a community provider.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. For patients with serious medical, dental, or mental health needs, arrangements or referrals are made for follow-up services with community providers, including exchange of clinically relevant information.

6.1.1. Referrals will be made to the facility's identified discharge planning specialist. If no position exists, the need for transition planning is noted on the treatment plan.

6.2. With the patient's written consent, health care staff will:

- Share necessary information with outside providers
- Arrange for follow-up appointments
- Arrange for transfer of health summaries and relevant parts of the health record to community providers or others assisting in planning or providing for services upon release

6.3. Referral to public health and/or community clinics for follow-up care and treatment will be made as appropriate to need and availability for patients who are released prior to resolution of a continuing medical/mental health condition.

6.4. All aspects of discharge planning will be documented in the patient's health record.

6.5. Patients released to the community will be provided with written instructions for the continuity of essential care, including, but not limited to, name and contact information of community providers for follow-up appointments, prescriptions, and/or adequate supply of medication for psychiatric patients.

6.6. The facility has a process to assist patients with health insurance applications prior to release. (*PRISONS ONLY*)

6.7. Release Medications:

6.7.1. Upon notification of a patient's pending release, nursing staff will review the patient's Medication Administration Record to determine if the patient is currently receiving prescribed medications for medical or mental health conditions.

6.7.2. Whenever it is possible and safe to do so, Wellpath will provide a specific amount of necessary medications as determined by the contract. Otherwise, a minimum of three (3) days' and maximum of 14 days' worth of medication will be provided to the patient being released.

6.8. For facilities that do not call-in prescriptions to the pharmacy, the instructions below for providing release medications will be followed.

6.8.1. Nurses are not permitted to remove medication from one package, label another package, and place it in that package for subsequent use. That process is called "dispensing" and is limited to pharmacists and certain other licensed professionals. Nurses may label and fill packages for subsequent use if a doctor, pharmacist, or other authorized professional verifies the dispensing and maintains dispensing records in accordance with pharmacy regulations. (Because of record-keeping regulations, this last option may not be available on site.)

6.8.2. If a medication envelope is labeled by the patient for whom the medication is intended and then filled by the nurse, this is not considered dispensing.

6.8.3. If the quantity in the blister package is greater than the quantity to be provided to the patient, the entire package may be provided to the patient.

- If the quantity in the blister package is greater than the quantity to be provided to the patient, the patient may be requested to label an envelope with directions for medication usage. The nurse may then place the appropriate quantity of medication in the envelope for the patient's use.

6.8.4. If the medication in the patient's personal property is usable and appropriate, it may be provided to the patient as a substitute for medication from the facility blister packages.

6.8.5. If medication is provided upon release via medication envelope or blister package, nursing staff will ensure completion of a release for medication that indicates that medications are not in a childproof container.

6.8.6. If the medication appears to be a necessary medication and it is clear that the medication available for safe delivery to the patient is inadequate, the prescriber may provide a single prescription adequate in length to carry the patient to the next appointment. If that cannot be accomplished safely, the patient is advised regarding timely care.

6.9. For facilities that utilize **InMedRx**, the procedure below will be followed:

6.9.1. Wellpath has contracted with InMedRx for pharmacy management services to provide release medications through their network of local pharmacy providers. Wellpath provides anywhere from a minimum of three (3) days' to a maximum of 14 days' worth of medication consistent with contract requirements.

6.9.2. **Patient Prescription Eligibility Form** – Upon notification that a patient has been or will be released from custody and requests his or her medications upon discharge, nursing staff will confirm there are current medication orders and complete a Patient Prescription Eligibility Form.

6.9.3. **Controlled Substances and Medications Subject to Abuse** – If the medications are controlled substances, psychoactive medications, or medications subject to abuse for other reasons, the nurse will contact an appropriate prescriber to obtain direction for release of these medications and to determine the appropriate amount to have dispensed.

6.9.4. **Education** – Patients are informed of the process for receiving a prescription for essential medications upon release from the system. Information is communicated at intake and during sick call and chronic care encounters.

6.9.5. **Designated Pharmacy** – Each site shall establish one or more designated pharmacies. Patients will be informed of the Discharge Medication process along with the name and location of the established pharmacy.

6.9.6. **Patient Release Process** – Upon receiving notice that a patient has been or will soon be released, nursing staff will review the patient's health record to

determine if he or she is currently receiving prescribed medications for medical or mental health conditions.

- Nurse shall fill out the Patient Prescription Eligibility Form to include:
  - ◊ New Patient Number will consist of a maximum of an 18-digit code to be composed of the 4-digit site code + the patient number up to 15 digits.
  - ◊ Group number will be WP + the Region number.
  - ◊ Medication, indication, and instructions for use
  - ◊ Number of days' supply based on contract, not to exceed 14 days. Prescription exceeding the contracted number of days' supply or 14 days' supply (whichever comes first) will need additional authorization.
- The completed Patient Prescription Eligibility Form will then be faxed to InMedRx at 888-363-1013 to initiate eligibility.
- The current medication order along with the completed Patient Prescription Eligibility Form is faxed to the designated pharmacy.
- Patient will be advised that release medications are available at the pharmacy and length of eligibility of prescription not to exceed three (3) days.
- The completed Patient Prescription Eligibility Form is filed in the patient's health record.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Patient Care and Treatment: J-E-10 Discharge Planning (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Patient Care and Treatment: P-E-10 Discharge Planning (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-10 Discharge Planning (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-04 Continuity of Care
- 4-ALDF-5B-13 Release
- 4-ALDF-5B-18 Release
- 1-HC-1A-04 Continuity of Care

Forms

- Patient Prescription Eligibility Form

1. PURPOSE

This policy is intended to ensure that patients with chronic disease, other significant health conditions, and disabilities are identified and receive ongoing multidisciplinary care aligned with evidence-based standards.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Patients are evaluated via the receiving screening, health assessment, and on an ongoing basis for chronic diseases requiring close medical supervision and/or multidisciplinary care. When patients are determined to have special needs (e.g., dialysis, frail, elderly, psychiatric illnesses, developmental or physical disabilities, seizures, diabetes), there will be collaboration and consultation between the Facility Administrator and the Responsible Physician / Medical Director or designees prior to certain actions being taken for those patients including housing assignments, program/work assignments, disciplinary measures, admissions to and transfers within the system or to another jurisdiction, and discharge planning. There shall be a proactive plan for the care and treatment of special needs patients who require close medical supervision or close medical care.

Medical and dental orthoses, prostheses, and other aids to impairment are supplied in a timely manner when the health of the patient would otherwise be adversely affected, as determined by the Responsible Physician / Medical Director or Dentist.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Aids to Reduce Effects of Impairment – Include, but are not limited to, eyeglasses, hearing aids, canes, crutches, sleep apnea machines, and wheelchairs

Chronic Illness – Any health problem/condition lasting at least six (6) months, which has the potential to, or does, impact an individual's functioning and long-term prognosis. Such conditions may include, but are not limited to, cardiovascular disease, asthma, diabetes mellitus, hyperlipidemia, gynecological disorders, sickle cell, chronic infectious diseases including HIV, chronic pulmonary diseases including asthma, seizure disorders, and psychiatric disorders.

Chronic Care Clinic – Routinely scheduled encounters between a mid-level provider or MD and a patient with an identified chronic medical or mental condition for treatment planning, monitoring the patient's condition and therapeutic regimen while in custody. Such encounters shall be scheduled at least every 90 days, but may occur more frequently at the discretion of the medical provider. Routinely scheduled Chronic Care Clinic monitoring shall apply to the following conditions: diabetes, cardiac disorders, hypertension, seizure disorders, communicable diseases, respiratory disorders, and psychiatric disorders. Other conditions may be included as appropriate at the discretion of the medial provider.

Mental Health Special Needs – Patients designated Mental Health Special Needs may include, but are not limited to, those who are diagnosed with severe mental illness (including Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, moderate to severe Major Depression, mood disorders, and Post Traumatic Stress Disorder), diagnosed with Developmental Disability, Gender Dysphoria, juveniles in adult custody, and those who are prescribed antipsychotic medications to treat psychosis

Special Needs – Patients designated as special needs may include, but are not limited to, frail or elderly, terminally ill whose life expectancy is less than a year, the chronically ill, those with special mental/mental health needs, developmentally disabled individuals, patients diagnosed with Gender Dysphoria, pregnant patients, dialysis, physically handicapped patients (e.g., amputations, para or quadriplegia, wheelchair bound, etc.), and individuals diagnosed with a communicable disease.

Treatment Plan – A series of written statements specifying a patient's course of therapy and the roles of qualified health care professionals in carrying it out

6. PROCEDURE

6.1. The Responsible Physician / Medical Director establishes and annually approves clinical protocols consistent with national clinical practice guidelines. These clinical protocols for the identification and management of chronic diseases or other special needs include, but are not limited to, the following:

- Asthma
- Diabetes
- HIV
- Hyperlipidemia
- Hypertension
- Mood disorder
- Psychotic disorders

6.2. Upon a patient's arrival at the facility, health care staff will determine if the patient has a chronic disease. In the case a chronic disease, special need, or mental health special need is determined, the nurse will:

6.2.1. Complete a focused assessment

6.2.2. Document and verify all current medications

6.2.3. Notify the provider for medication orders

6.2.4. Schedule the patient to be seen on the next available medical or mental health provider clinic, as appropriate for condition.

6.3. Individualized treatment plans are developed at the time the condition is identified and updated when warranted. These are developed collaboratively between the physician, mid-level provider, nurses, and mental health staff.

6.4. Documentation in the health record confirms that providers are following chronic disease protocols and special needs treatment plans as clinically indicated by:

- Determining the frequency of follow-up for medical evaluation based on disease control, not to exceed 90 days between visits
- Monitoring the patient's condition (e.g., poor, fair, good) and status (e.g., stable, improving, deteriorating) and taking appropriate action to improve patient outcome
- Indicating the type and frequency of diagnostic testing and therapeutic regimens (e.g., diet, exercise, medication)
- Documenting patient education regarding diet, exercise, medication, etc.
- Clinically justifying any deviation from the protocol

6.5. Chronic illnesses and other special needs requiring a treatment plan are listed on the master problem list.

6.6. Patients designated as Mental Health Special Needs will be monitored by mental health staff.

6.7. Patients may be considered for removal from the Chronic Disease/Special Needs designation if they meet either of the following:

6.7.1. The condition is considered resolved

6.7.2. Active treatment is no longer needed (e.g., antipsychotic medications, essential medications)

6.8. Juveniles housed in adult facilities must remain on the Special Needs list for the duration of the incarceration.

6.9. The Collaborative Safety Planning (CSP) interventions are utilized for patients who have a history of self-harm ideation or behaviors (either suicidal or non-suicidal self-injury)

even if the patient is not presenting current suicidal ideation or self-harming behaviors. The CSP should be considered a preventive intervention when used in these cases.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Special Needs and Services: J-F-01 Patients with Chronic Disease and Other Special Needs (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Special Needs and Services: P-F-01 Patients with Chronic Disease and Other Special Needs (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Special Mental Health Needs and Services: MH-G-06 Behavioral Consultation (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-07 Treatment Plan
- 4-ALDF-4C-19 Chronic Care (M)
- 4-ALDF-4C-35 Prostheses and Orthodontic Devices
- 4-ALDF-6B-07 Inmates with Disabilities
- 1-HC-1A-16 Chronic Care (M)
- 1-HC-1A-32 Prostheses and Orthodontic Devices
- 1-HC-3A-06 Special Needs

1. PURPOSE

This policy is intended to describe the evaluation, treatment planning, and treatment process for individuals with Gender Dysphoria (GD).

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath endorses a multidisciplinary team approach for assessing and treating Gender Dysphoria. Wellpath also has a Gender Dysphoria Review Committee (GDRC) that provides decision support for practitioners who are evaluating and treating GD.

Wellpath will not discontinue GD treatment regimens due to admission to a correctional setting. Treatment may be suspended if a health care provider determines that treatment presents a health risk to the patient. If treatment is suspended, a multidisciplinary case review will be convened to review and determine a next course of action. Wellpath has developed a Decision Support Monograph for the Gender Incongruent Person, Information Sheets, and Consent Forms for Masculinizing and Feminizing Hormone Therapy that provide additional information and resources on this topic.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Gender Dysphoria (GD) – Described in the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5)* as marked incongruence between experienced/expressed gender and

assigned gender of at least six (6) months' duration and clinically significant distress or impairment in social, school (for children)/occupational (for adults), or other important areas of functioning.

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

Qualified Mental Health Professional (QMHP) – Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

RHA/HSA – Responsible Health Authority / Health Services Administrator

GDRC – Gender Dysphoria Review Committee

CCE – Critical Clinical Event

6. PROCEDURE

6.1. When an individual describes symptoms consistent with GD, the health care or mental health professional will alert the department supervisor.

6.1.1. The department supervisor or designee will notify the Responsible Health Authority (RHA) / Health Services Administrator (HSA) and the Security Supervisor so that security accommodations can be made, if necessary.

6.1.2. The department supervisor or designee will send out a notice of a potential GD patient admission via Critical Clinical Event (CCE) notification.

6.1.3. Referrals from custody or other staff will be managed in the same manner as if the report has been made directly to health care or mental health care staff by the patient.

6.2. If the patient reports receiving hormone treatment at the time of incarceration, health care staff will attempt to verify the prescription with the community provider or pharmacy and will also ask the patient to complete a Release of Information form (ROI) to allow them to obtain medical records supporting the diagnosis and treatment program.

6.3. While awaiting verification, health care staff will contact a health care provider, who will determine if the current medication dose is appropriate and should be continued pending receipt of outside verification and records. Based on patient needs, the health care provider may choose to continue or alter the dose, order an alternative treatment, or temporarily stop the medication until the patient can be evaluated.

6.4. If the hormonal treatment is verified and the health care provider does not believe that potential health risks outweigh potential benefits, the medication should be continued pending receipt of additional information. This decision is documented in the health record.

6.5. A referral will be sent to Mental Health or Psychiatry for an evaluation related to the report of GD. The purpose of the evaluation is to establish whether a diagnosis of Gender Dysphoria is present and assist in establishing a plan of care for the individual.

6.6. Upon receipt of a referral based on gender incongruence, the Mental Health Director/Coordinator, Psychiatric Provider, or QMHP under the director of the RHA/HSA (if the site does not have a Mental Health Director/Coordinator) will begin the evaluation process, which includes the following steps:

6.6.1. Obtain ROIs for community providers who completed prior evaluation or treatment of GD (unless this has already been accomplished)

6.6.2. Review community records received

6.6.3. Complete an evaluation that may include a clinical interview, mental status exam, and psychological/cognitive assessment. Develop treatment recommendations to include referral to Psychiatry for mental health issues that require psychiatric evaluation (unless a Psychiatrist is completing the evaluation)

6.6.4. The GD Evaluation should be reviewed with the Regional Director of Mental Health, who can assist in diagnosis and treatment recommendations. It is recommended that a provisional diagnosis of GD be given until the diagnosis is reviewed with the GDRC, after which a final diagnosis will be made.

6.7. If psychological assessment, cognitive assessment, or both appear indicated for the purpose of the patient's evaluation, and if there are no mental health professionals at the facility licensed to provide psychological and/or cognitive assessment, the Regional Director of Mental Health should be contacted for direction.

6.7.1. When a provisional diagnosis of GD is given, the site Responsible Physician / Medical Director, the Mental Health Director/Coordinator, and the RHA/HSA will develop a preliminary, individualized treatment plan that will include proposed placement of the patient on the site's Special Needs list. The treatment plan will address the anticipated interventions necessary to treat GD. The treatment plan should be sent to the Regional Director of Mental Health for review and should be sent to the Chair of the GDRC.

6.7.2. If a diagnosis of GD is not reached as a result of the evaluation process, an individualized treatment plan will be developed to address other issues noted during the evaluation, if needed.

6.8. Upon receipt of a GD assessment and/or proposed treatment plan, the Chair of the GDRC will convene the GDRC. The GDRC is a subcommittee of the Wellpath Corporate Continuous Quality Improvement Committee and include the VP of Behavioral Health, the Chief Psychiatric Officer, and the Chief Clinical Officer or their designees. The GDRC meets monthly, or more frequently as needed, to discuss individual patients or related areas of concern.

6.8.1. To be placed on the GDRC agenda, the RHA/HSA or designee or the Regional Director of Mental Health should email the Chair of the GDRC, attaching relevant documentation including assessments, progress notes, and treatment plans related to gender incongruence and gender dysphoria. The GDRC can provide better clinical support if contacted when a GD diagnosis is being considered, but consultation with the GDRC is available throughout the process.

7. REFERENCES

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)
World Professional Association of Transgender Health Guidelines, 2011 Edition

Decision Support Monograph for the Gender Incongruent Person

Forms

- Informed Consent
- Release of Information (ROI)

TITLE: HCD-100_F-02 Infirmary-Level Care --Mecklenburg NC	REFERENCE: 59967
	PAGE: 1 OF 4 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that infirmary-level care, when provided, is appropriate to meet the health care needs of the patient population.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Infirmary-level care is for patients who require more intensive care than can be provided in general population and for a period of 24 hours or more. It is not a physical location that defines infirmary-level care, but the scope of care provided. Patients requiring continuous skilled nursing services or acute medical or mental health services shall be transferred and evaluated for admission to an appropriate licensed health care facility.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Infirmary-Level Care – Care provided to patients with an illness or diagnosis that requires daily monitoring, medication and/or therapy, or assistance with activities of daily living at a level needing skilled nursing intervention.

Infirmary – An area in the facility accommodating patients for a period of 24 hours or more, expressly set up and operated for the purpose of caring for patients who need skilled nursing care but do not need hospitalization or placement in a licensed nursing facility and whose care cannot be managed safely in an outpatient setting. It is not the area itself but the scope of care provided that makes the bed an infirmary bed.

Observation Beds – Beds designated for medical or mental health observation for specific purposes, such as watching the patient's response to a change in medication regimen. Patients can be placed in observation beds to prevent them from eating or drinking before a medical test that requires such restriction, to allow patients to recover from day surgeries or medical procedures, or to watch the general behavior of patients whose mental stability appears questionable.

Sheltered Housing – Provides a protective environment that does not require 24-hour nursing care. The beds can be in the infirmary itself or other designated areas. Sheltered housing is equivalent to home care for those not confined to an institutional setting.

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions.

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

MAR – Medication Administration Record

6. PROCEDURE

6.1. Licensed nursing staff are available to assist patients housed under infirmary-level care 24 hours per day, seven (7) days per week.

6.2. A health care provider is on-call 24 hours per day, seven (7) days per week.

6.3. Patients who need infirmary-level care are always within sight or hearing of a health-trained (CPR and First Aid certified) custody staff member, and a QHP can respond in a timely manner.

6.4. The number of sufficient and appropriate QHPs is based on the number of patients, the severity of their illnesses, and the level of care required for each.

6.5. The frequency of physician and nursing rounds for patients who need infirmary-level care is specified based on clinical acuity and the categories of care provided.

6.6. At least daily, a supervising RN ensures that care is being provided as ordered.

6.7. A manual of nursing care procedures is consistent with the state's nurse practice act and licensing requirements.

6.8. Admission to and discharge from infirmary-level care occurs only on the order of a physician (or other clinician where permitted by virtue of credentials and scope of practice). Physician orders direct the care provided to patients housed in the infirmary, observation unit, or sheltered housing.

6.9. A complete inpatient health record is kept for each patient and includes:

- Initial clinical note that documents the reason for infirmary-level care and outlines that treatment and monitoring plan
- Complete documentation of the care and treatment given
- The Medication Administration Record (MAR)
- A discharge plan and discharge notes

6.10. If the inpatient record is retained separately from the outpatient record, a copy of the discharge summary from the infirmary-level care is placed in the patient's outpatient chart.

6.11. Observation patients may be placed by a QHP other than a physician; however, a physician's order is needed to keep them longer than 24 hours.

6.12. When a patient is admitted for mental health reasons, the patient's mental health care is supervised by mental health clinicians.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Special Needs and Services: J-F-02 Infirmary-Level Care (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Special Needs and Services: P-F-02 Infirmary-Level Care (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Special Mental Health Needs and Services: MH-G-02 Mental Health Programs and Residential Units (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-09 Infirmary Care (M)
- 4-ALDF-4C-10 Washbasins
- 4-ALDF-4C-11 Bathing Facilities
- 4-ALDF-4C-12 Toilets
- 1-HC-1A-09 Infirmary Care

1. PURPOSE

This policy is intended to ensure that mental health services are available for all patients who require them.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Patients' mental health needs are addressed on-site or by referral to appropriate alternative facilities.

A wide scope of activities can fall under the purview of a mental health program. These activities can include, but are not limited to, the following:

- Screening/identification, referral, and diagnostic evaluation
- Treatment of serious mental illnesses, including psychotropic medication management (when needed), individual counseling, group counseling, and psychosocial / psychoeducational programs
- Assessing for personality disorders
- Suicide prevention
- Crisis intervention
- Treatment documentation and follow-up
- Segregation rounds

- Treatment of severe adjustment disorders
- Discharge planning services
- Sex offender counseling and management/treatment
- Substance abuse counseling/treatment
- Competency evaluation and restoration (generally viewed as a forensic assignment not carried out by treating mental health staff)

The Responsible Health Authority (RHA) / Health Services Administrator (HSA) and Mental Health Coordinator/Director or designee work together to develop local procedures to ensure that activities required by the site contract are provided in an efficient and professional manner by Qualified Mental Health Professionals (QMHPs). Additionally, the RHA/HSA and Mental Health Coordinator/Director or designee collaborate to ensure that there are appropriate and timely referral procedures in place in the event that a patient requires a service provided by another entity within the facility or outside agency.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Suicide Progress Note – A suicide watch progress note that is completed after all encounters by a QMHP for patients currently housed in suicide watch/safety cell.

Treatment Plan – A patient-specific individualized mental health treatment plan for special needs patients with input and documentation including, but not limited to: QHP, QMHP, custody staff, community resources, etc., when available.

Mental Health Discharge Planning – A patient-specific individualized mental health discharge plan with input and documentation including, but not limited to: QHP, QMHP, custody staff, community resources, etc., when available.

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

Qualified Mental Health Professional (QMHP) – Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

Extreme Isolation – Refers to situations in which inmates encounter staff or other inmates fewer than three (3) times per day.

Segregated Inmates – Those isolated from the general population and who receive services and activities apart from other inmates. Facilities may refer to such conditions as administrative segregation, protective custody, disciplinary segregation, or a supermax tier. Some facilities, such as a supermax or lockdown, have all inmates in a segregated status. For the purposes of this policy, the living and confinement conditions defined the segregated status, not the reason an inmate was placed in segregation.

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Mental health, medical, and substance abuse services are sufficiently coordinated such that: patient management is appropriately integrated; medical and mental health needs are met; and the impact of these conditions on each other is adequately addressed.

6.2. All patients receive a mental health appraisal within 14 days of admission.

6.3. Patients may be referred to Mental Health through a variety of avenues, including, but not limited to, the receiving screening process, the mental health evaluation process,

self-referral, and/or staff referral. QMHPs respond to all referrals in a timely manner and initiate appropriate treatment services as clinically indicated.

6.3.1. All patient self-referrals will be seen by a QHP within 24 hours.

6.3.2. Response time frames to referrals from sources other than patient self-referrals depend on the nature of the referral (Emergent, Urgent, or Routine) as determined by the triaging health care staff and in accordance with local policy regulations.

- All **Emergent** referrals are addressed immediately.
- All **Urgent** referrals are addressed within 24 hours and as soon as possible by a QHP.
- All **Routine** referrals from other referral sources are responded to within seven (7) calendar days by a QMHP at sites with 40 hours or more per week of mental health staffing. At sites with less than 40 hours per week of mental health staffing, routine referrals will be responded to by a QMHP within 10 days, and within 14 days for sites with less than 20 hours per week mental health staffing.

6.3.3. If the patient has engaged in prior community mental health treatment, the patient is asked to complete a Release of Information (ROI) form in order to obtain past treatment records. If past records cannot be obtained, the patient is referred to the appropriate clinical professional to assess current treatment needs, regardless of the ability to obtain prior records.

6.3.4. Patients determined to be in need of ongoing mental health and/or substance abuse services after their release from jail will be provided with information about community mental health and/or substance abuse treatment resources, and arrangements for more comprehensive mental health care will be made, provided Wellpath staff are given adequate notice of an upcoming release date.

6.4. Patients who enroll in mental health treatment, including psychiatric medication management, are provided with information regarding the risks and benefits to treatment.

6.4.1. A treatment plan is established for all patients enrolled in the Mental Health Special Needs Program. At a minimum, the Mental Health Special Needs Program will include patients in the following categories:

- Diagnosed with severe mental illness (including Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, moderate to severe Major Depression, and Post Traumatic stress Disorder)
- Diagnosed with a Developmental Disability
- Diagnosed with Gender Dysphoria
- Prescribed antipsychotic medications to treat psychosis
- Juveniles in adult custody

6.4.2. The treatment plan includes and is not limited to the following:

- Diagnostic information
- Individual risk and protective factors
- Program participation plan such as individual and group treatment, as well as unstructured programming
- Recommendations concerning housing
- Job assignment

6.4.3. Mental Health Special Needs patients will be seen by mental health staff as directed by the treatment plan, and no less than every 30 days for at least a 90-day duration. After the first 90 days, if it has been determined that the patient is meeting the goals and objectives on the treatment plan, the Special Needs visits may occur no later than every 45 days, unless otherwise contractually specified.

- Juveniles housed in adult facilities will continue to be seen at a frequency of no less than every 30 days, without exception.

- A visit with the Psychiatric Provider will be noted as satisfying the monthly follow-up requirement.

6.4.4. Patients may be considered for removal from the Special Needs list if: Their condition is considered resolved; active treatment, including psychotropic medication, is no longer prescribed; and the patient's functioning is above baseline for at least 90 days. Patients who refuse treatment, including psychotropic medication that is considered clinically indicated, will continue enrollment in the Special Needs program. Patients receiving antipsychotic medication and juveniles housed in adult facilities must remain on the Special Needs list for the duration of the incarceration event.

6.4.5. Psychiatric and Special Needs treatment plans will be reviewed every 180 days, at a minimum.

6.4.6. Patients who present to mental health staff with notable difficulty adjusting to the correctional environment, but who are not diagnosed with a serious mental illness, will be considered for appropriateness of mental health treatment, including enrollment in the Special Needs program for a clinically indicated period of time. Additionally, it will be determined whether the need exists for mental health staff to work with jail administrative staff in a multidisciplinary manner to address issues beyond mental health that may be impacting the patient's ability to adjust to incarceration.

6.5. Health care staff will utilize a site-specific suicide prevention program to ensure the safety of patient's who present with a risk of self-harm.

6.5.1. Particular attention will be paid to those patients housed in a segregated setting, regardless of placement reason. Any patient housed in such settings may be referred to mental health staff for follow-up if concerns arise regarding the patient's ability to function in an isolated/restrictive setting.

6.6. If mental health staff have concern about the level of mental health services required to manage a patient in the facility, the Mental Health Coordinator/ Director or designee, the Psychiatric Provider, and/or the RHA/HSA will be notified.

6.6.1. In conjunction with the site Psychiatric Provider, the Director of Mental Health Services or designee will determine the need to request that a patient be

transferred to a community agency more equipped to handle the patient's psychiatric needs.

6.6.2. The Director of Mental Health Services or designee will notify appropriate custody staff of the request to transfer the patient to a community agency.

- Due process is ensured prior to a transfer in accordance with procedures that comply with federal, state, and local laws/regulations. In emergency situations, a hearing is held as soon as possible after the transfer.

6.6.3. Until such transfer can be accomplished, the patient is safely housed and adequately monitored through collaboration between health care and custody staff.

6.6.4. The case review and disposition of the patient will be documented in the patient's health record.

6.7. Patients determined to need substance abuse treatment services will be informed of the facility programs available to them and will be given information about community substance abuse treatment resources.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Special Needs and Services: J-F-03 Mental Health Services (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Special Needs and Services: P-F-03 Mental Health Services (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Special Mental Health Needs and Services: MH-G-01 Basic Mental Health Services (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-27 Mental Health Program (M)
- 4-ALDF-4C-28 Mental Health Program
- 4-ALDF-4C-30 Mental Health Appraisal (M)
- 4-ALDF-4C-31 Mental Health Referrals
- 4-ALDF-4C-32 Suicide Prevention and Intervention (M)
- 4-ALDF-4C-34 Mental Illness and Developmental Disability
- 4-ALDF-4D-20 Transfer of Mentally Ill or Developmentally Disabled

- 1-HC-1A-25 Mental Health Program (M)
- 1-HC-1A-26 Mental Health Program
- 1-HC-1A-28 Mental Health Appraisal (M)
- 1-HC-1A-29 Mental Health Evaluations (M)
- 1-HC-1A-30 Suicide Prevention and Intervention (M)
- 1-HC-1A-31 Mental Illness and Developmental Disability
- 1-HC-3A-11 Transfer of Mentally Ill or Developmentally Disabled

Forms

- Release of Information (ROI)

1. PURPOSE

This policy is intended to ensure that patients who are intoxicated or undergoing withdrawal are appropriately managed and treated.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath has established clinical guidelines for the identification and management of patients who are under the influence of or undergoing withdrawal from alcohol, sedatives, opioids, and/or other substances.

Patients are screened for abuse or dependency on alcohol and other drugs (AOD) during the intake screening, health assessment, and other health encounters.

Any patient incarcerated under the influence of alcohol or drugs shall be housed by custody in as safe a manner as possible and kept under close observation as clinically indicated. Referrals will be made to the appropriate practitioner for those patients who have a medical condition that would be significantly impacted by alcohol and/or drug use. Juveniles housed in adult facilities who are evaluated and found to be in need of medically managed detox will be transferred to an outside hospital to receive these services.

Depending on the nature of the governing contract, other agencies or entities within the facility may have primary responsibility for diagnostic evaluations, evaluation of treatment need, and provision of counseling or self-help groups for patients with substance abuse or dependence problems. The site Responsible Health Authority (RHA) / Health Service Administrator (HSA) will have responsibility for ensuring the appropriate referral avenues are in place to communicate and coordinate care provision for these patients. For sites at which Wellpath plays a role in providing evaluation and/or treatment services for the substance dependent population, the site RHA/HSA

and Mental Health Coordinator/Director will develop specific processes for provision of the services. If no substance abuse treatment services are offered within the facility, patients may be referred to community providers for evaluation and treatment upon release.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

AOD – Alcohol and Other Drugs

HCP – Health Care Practitioner

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. The protocols for intoxication and medically supervised withdrawal are approved by the Responsible Physician / Medical Director annually and are consistent with nationally accepted treatment guidelines.

6.2. Established clinical guidelines are followed for the identification and management of patients who are under the influence of AOD and displaying symptoms of intoxication.

6.3. Consideration of a patient's level of intoxication shall be taken into account when evaluating the patient in any area of the facility.

6.3.1. In the intake setting, the patient's level of intoxication and appropriateness for acceptance into the facility shall be taken into consideration. Patients who exhibit any of the following shall not be accepted into the facility:

- Unconscious or semiconscious
- Unable to maintain own airway
- Mentally unstable
- Danger to self or others
- Aggressive/unable to control behavior
- Severely intoxicated
- In alcohol or drug withdrawal
- Bleeding
- Urgently in need of medical attention
- Otherwise clinically unstable

6.3.2. Whether in the intake setting or another area of the facility, any time patients exhibit any of the above they should be sent via ambulance to a licensed acute care facility/emergency room for evaluation and treatment.

6.3.3. Narcan administration shall be considered for potential/actual opiate/opioid overdose. Reference Wellpath Policy *HCD-100_F-04A Narcan Use for Possible Opiate Overdose*.

6.4. Established clinical guidelines are followed for the identification and evaluation of patients who are at risk for withdrawal from AOD and those experiencing symptoms of withdrawal from AOD.

6.4.1. During the receiving screening/intake process the patient is questioned about use of AOD by following the Substance Use Screening section of the Wellpath Receiving Screening.

6.4.2. For patient encounters in other areas of the facility and/or after the receiving screening has been completed, the Wellpath Professional Nursing Protocol *Alcohol and Other Drugs* will be utilized to gather information about substance

use and guide identification and evaluation of those at risk for or experiencing withdrawal from AOD.

- Patient is asked about both alcohol use and legal/illegal drug use. The minimum information regarding AOD use should be:
  - ◊ Type of substance
  - ◊ Amount of substance used
  - ◊ Frequency of use
  - ◊ Time of last use
- Patients who report regular, frequent AOD use are considered to be at risk for withdrawal. Further evaluation and initiation of withdrawal monitoring is based on risk and patient report/history and is completed utilizing the appropriate clinical evaluation tool:
  - ◊ Patients who report alcohol and/or benzodiazepine use are evaluated utilizing the CIWA-AR Score Sheet.
  - ◊ Patients who report opiate/opioid use are evaluated utilizing the COWS Score Sheet.
  - ◊ Patients who report Synthetic Drug use will be evaluated utilizing the Wellpath Synthetic and Other Drug Monitoring Flowsheet.
  - ◊ Patients reporting poly-substance use will be evaluated with all coordinating clinical evaluation tools.
    a. Alcohol and opiate use: CIWA-Ar and COWS
    b. Opiate and benzodiazepine: CIWA-Ar and COWS
    c. Alcohol and Synthetic: CIWA-Ar and Synthetic Drug Use Monitoring Flowsheet

◊ There is no minimum score required to initiate withdrawal monitoring and medications, as initiation is based on risk and patient report/history.

◊ The Health Care Practitioner (HCP) is consulted immediately when a female patient who is suspected to be pregnant or has a positive urine pregnancy test reports any substance use.

6.5. Established clinical guidelines are followed for the evaluation and management of patients who have been identified as at risk for withdrawal from AOD and those experiencing symptoms of withdrawal from AOD.

6.5.1. At each encounter, the patient is offered a minimum of eight ounces (8 oz.) of electrolyte replacement drink.

6.5.2. Qualified health care staff complete the evaluation and monitoring of patients at risk for withdrawal from AOD as outlined in the table below:

Type of withdrawal	Monitoring Tool	Frequency	Duration	Medication
Alcohol and/or Benzodiazepine	CIWA-Ar	No more than every 8 hours – more frequently if clinically indicated	Minimum 5 days	CIWA-Ar Practitioner Order Sheet
Opiate/Opioid	COWS	No more than every 8 hours – more frequently if clinically indicated	Minimum 5 days – Short acting opiates minimum of 5 days – Long acting opiates (methadone, buprenorphine) minimum of 10 days	COWS Practitioner Order Sheet
Synthetic	Synthetic Drug Monitoring Flowsheet	No more than every 8 hours – more frequently if clinically indicated	Minimum 5 days	Synthetic Drug Practitioner Order Sheet

Type of withdrawal	Monitoring Tool	Frequency	Duration	Medication
Polysubstance	Combination of all indicated	No more than every 8 hours – more frequently if clinically indicated	Minimum 5 days	Combination of all indicated; special attention to not duplicating or utilizing contraindicated medications

6.5.3. Every effort shall be made to complete the entire evaluation. If the patient refuses to answer questions or allow vital signs and/or medication administration, then visual observation of the patient's condition is documented and the refusal is documented on the Wellpath refusal form.

6.5.4. A patient with altered mental status or displaying signs of advanced withdrawal must be evaluated immediately by the HCP or sent via ambulance to a licensed acute care facility or emergency room for evaluation and treatment.

6.5.5. Monitoring/evaluation and/or medications are not discontinued prior to the time frame indicated in the chart above.

- If the CIWA-Ar score is eight (8) or above at the final evaluation, then the HCP is contacted for guidance.

- If the COWS score is 11 or above at the final evaluation, then the HCP is contacted for guidance.

6.5.6. Medication administration is completed based on clinical guidelines.

- Every effort shall be made to initiate the Librium for alcohol and/or benzodiazepine withdrawal management within four (4) hours of risk identification. A practitioner order is necessary for initiation.

- Every effort shall be made for medication administration to occur at the same encounter as withdrawal monitoring.

6.6. Pregnant patients require individualized treatment plans to manage withdrawal from AOD.

6.6.1. The HCP is notified as soon as possible for clinical guidance and the appropriate clinical monitoring tool is initiated (CIWA-Ar, COWS, etc.).

6.6.2. If a pregnant patient reports opiate/opioid use or participation in a community treatment program (including methadone and buprenorphine), every effort is made to continue the current maintenance program and/or appropriate treatment provided.

6.6.3. The patient will be referred to the treatment center below:

McLeod Center
521 Clanton Rd.
Charlotte NC 28217
7043329001

6.6.4. If the treatment center listed above will not accept the patient, the site Responsible Physician / Medical Director will contact the Regional Medical Director for consultation.

6.6.5. In the event Methadone is not available or cannot be obtained in a timely manner, the patient will be referred to the local hospital for treatment.

Atrium Health
1000 Blythe Blvd
Charlotte NC 28203
704-355-2000

6.6.6. In the event that the local hospital defers treatment to the site Responsible Physician / Medical Director, the Regional Medical Director should be consulted to contact a Wellpath addictionologist.

6.7. Juveniles who are determined to be in need of medically supervised detox will be transferred to the local hospital for these services.

6.7.1. The HCP should be notified as soon as possible for any necessary orders to manage the patient's clinical presentation until transfer to the local hospital occurs.

6.8. Parameters for STAT, urgent, and routine notification of the HCP and/or evaluation in an emergency room are outlined by clinical guidelines, including vital signs and symptoms.

6.9. Health care staff receive education on AOD and withdrawal management during the New Hire Onboarding process and on an annual basis.

6.10. Medically supervised withdrawal is done under practitioner supervision.

6.11. Patients entering the facility on medication-assisted treatment will have their treatment continued according to Wellpath policy *HCD-100_F-04B Medication-Assisted Treatment*.

6.11.1. Juveniles entering the facility on medication-assisted treatment will be immediately triaged to the site HCP for direction on the plan of care. Telephonic contact will occur if the HCP is not on site.

6.12. Any patient suspected of substance dependency will be triaged by health care staff, and appropriate referrals will be made. Disorders associated with AOD (e.g., HIV, liver disease) are recognized and treatment plans are formulated.

6.13. Communication and coordination between medical, mental health, and substance abuse staffs regarding AOD care occurs routinely.

6.14. Assessments, treatment, and referrals will be documented in the health record.

7. REFERENCES

HCD-100_F-04A Narcan Use for Possible Opiate Overdose
HCD-100_F-04B Medication Assisted Treatment

NCCHC Standards for Health Services in Jails 2018

- Section: Special Needs and Services: J-F-04 Medically Supervised Withdrawal and Treatment (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Special Needs and Services: P-F-04 Medically Supervised Withdrawal and Treatment (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Special Mental Health Needs and Services: MH-G-05 Patients with Alcohol and Other Drug Problems (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-13 Pregnancy Management (M)
- 4-ALDF-4C-22 Health Screens (M)
- 4-ALDF-4C-36 Detoxification (M)
- 4-ALDF-4C-37 Management of Chemical Dependency (M)
- 4-ALDF-5A-04 Substance Abuse Programs
- 4-ALDF-5A-06 Substance Abuse Programs
- 4-ALDF-5A-07 Substance Abuse Programs
- 1-HC-1A-10 Pregnancy Management (M)
- 1-HC-1A-19 Health Screens (M)
- 1-HC-1A-33 Detoxification (M)
- 1-HC-1A-34 Management of Chemical Dependency

FORMS

- Wellpath Professional Nursing Protocol: Alcohol and Other Drugs
- CIWA/Ar Score Sheet: Alcohol and Benzodiazepine Withdrawal
- Alcohol and Benzodiazepine Withdrawal Practitioner Order Sheet
- COWS Score Sheet: Opiate/Opioid Withdrawal
- Opiate Opioid Withdrawal Practitioner Order Sheet
- Synthetic and Other Drug Monitoring Flowsheet
- Synthetic and Other Drug Monitoring Practitioner Order Sheet
- Receiving Screening
- Refusal of Clinical Services

1. PURPOSE

This policy establishes guidance for the use of naloxone (Narcan).

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Each facility will stock the equipment necessary to administer emergency naloxone (Narcan) to patients, visitors, or staff who have been identified as likely to be experiencing current opioid overdose and meet clinical criteria defined in this procedure, unless explicitly contraindicated. Naloxone (Narcan) will be used in the event of an emergency for at-risk patients or anyone who is suspected of having an opiate/opioid overdose. Specifically, any patient found to be unresponsive with unknown cause, or pulseless or apneic, should be given naloxone (Narcan) as soon as possible as part of the resuscitative process. All appropriately trained staff are authorized to administer Narcan in emergency situations.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

EMS – Emergency Medical Services Transport

Patient – Any inmate, custody staff, health care staff, or visitor to a Wellpath facility

SBAR – Situation, Background, Applicable Nursing Data, Recommendation/Request. Provides a framework for communication between members of the health care team.

CCE – Critical Clinical Event

6. PROCEDURE

6.1. Naloxone (Narcan) will be stocked in each facility with emergency response supplies/bag.

6.1.1. The preferred naloxone (Narcan) stock is the 4mg/0.1ml concentration prefilled intranasal spray.

6.1.2. The intranasal route is Wellpath's preferred route of naloxone (Narcan) administration. In the event the intranasal spray is not available or a Health Care Practitioner order indicates administration via alternate route, the facility can stock naloxone (Narcan) in a vial of 4mg/mL concentration or pre-filled 2mL syringe in 1mg/mL concentration.

6.2. Naloxone (Narcan) should be administered as soon as possible to individuals who fall into the administration criteria below:

6.2.1. Known or suspected opiate/opioid overdose

- Signs of possible opiate/opioid overdose:
  - ◊ Respiratory depression
  - ◊ Decreased respiratory rate of <12/min
  - ◊ Altered mental status of unknown origin; from mild to unresponsive
  - ◊ Constricted/pinpoint pupils
  - ◊ Low to normal heart rate and/or low blood pressure
- Unresponsive with unknown cause
- Pulseless or apneic

6.2.2. Anyone receiving naloxone (Narcan) should be prepared for EMS transport.

6.3. The preferred naloxone (Narcan) route of administration is intranasal followed by, in order of preference: Intravenous (IV/IVP), intramuscular (IM), and subcutaneous (SC).

6.3.1. Intravenous (IV/IVP) Routes will be used if initiation and administration of IV/IVP medications is within the responding health care staff's scope of practice in the state in which they are licensed or certified. If IV/IVP administration is not within the responding health care staff's scope of practice and intranasal is contraindicated for the situation, the next preferred route would be intramuscular (IM) followed by subcutaneous (SC).

6.4. The following additional assessment findings will be obtained and documented as part of ongoing evaluation:

- Oxygen saturation
- Finger Stick Blood Glucose (FSBG) test result

6.5. The dose and frequency of administration will be based on route of administration:

- Intranasal spray - 4mg/0.1mL dose in one nostril; may be repeated in alternating nostril every 2 to 3 minutes as needed until EMS arrives
- Initial dose by the intravenous (IV/IVP), intramuscular (IM), or subcutaneous (SC) route is 0.4mg to 2mg; may be repeated every 2 to 3 minutes as needed until EMS arrives. The patient is reassessed after each dose to determine effect of medication and need for subsequent dosing.

6.6. If there is minimal or no response when reassessed, then subsequent doses will be administered per guidelines above.

6.7. Upon completion of any emergency event and the administration of naloxone (Narcan) to any patient, the Health Care Practitioner will be contacted and full patient status report provided in SBAR (Situation, Background, Applicable Nursing Data, Request/Recommendation) format, and complete documentation of the event is entered in the health record.

6.8. The administration of naloxone (Narcan) will be entered as a Critical Clinical Event (CCE) per the Wellpath CCE policy. The number of doses administered will be included in the report.

6.9. Emergency response supply of naloxone (Narcan) will be reordered and maintained using the “profile only” process with the Wellpath contracted pharmacy.

6.10. Each licensed practitioner and licensed nurse will be provided with the Clinical Skill Competency Evaluation: Narcan Administration Supplement Sheet. Unlicensed Assistive Personnel (UAP), including EMT and paramedics, will also be provided with the information sheet based on state statutes and scope of practice.

6.11. Licensed nurses and UAP will be evaluated for knowledge of clinical competence to administer Naloxone (Narcan) as measured by the Clinical Skill Competency Evaluation NUR CSC Narcan Administration, based on state statutes and scope of practice.

7. REFERENCES

HCD-100_A-12 Critical Clinical Events
HCD-100_F-04 Medically Supervised withdrawal and Treatment

Forms

- Clinical Skill Competency Evaluation

TITLE: HCD-100_F-04B Medication-Assisted Treatment -- Mecklenburg NC	REFERENCE: 59971
	PAGE: 1 OF 10 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 06/01/2019 REVIEWED: 06/01/2019

1. PURPOSE

This policy is intended to ensure that patients who have Opioid Use Disorder (OUD), and are willing to receive Medication Assisted Treatment (MAT), do so based on feasibility per facility rules and Practitioner's waiver to prescribe. This policy also addresses those with Alcohol Use Disorder who are willing to receive MAT (naltrexone) for that diagnosis.

Practitioners should be notified of pregnant patients who have a history of active opiate use as soon as possible, such that significant withdrawal does not take place. Pregnancy requires continued opioid substitution to prevent withdrawal complications for the fetus.

Medications for MAT are only indicated for patients 16 years of age and older. Any patients younger than this who come into the facility already on MAT or seem to have a clinical need for this intervention should be referred to the site medical director.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

During the Initial Health Assessment, patients will be screened by the Registered Nurse or Practitioner for OUD. Patients who are willing and are appropriate candidates in facilities wherein buprenorphine is allowed by security policy, and Practitioners who have special dispensation from the Drug Enforcement Agency in the form of a DEAx waiver to prescribe, may be offered continuation or induction of MAT while incarcerated. Similar patients who enter facilities where buprenorphine is not allowed by security policy, or where practitioners do not have a DEAx waiver to prescribe, will be safely withdrawn and educated on resources available in the community. Options other than buprenorphine will be presented to the patient where available. These other options include methadone, naltrexone, and abstinence. Likewise, patients who enter correctional facilities on MAT will have these medications continued as clinically indicated.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

MAT – Medication Assisted Treatment

Opioid Use Disorder (OUD) – A diagnosis requiring a pattern of using opioids causing clinically significant impairment or distress that meets at least two (2) of the following criteria:

- Taking the opioid in larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do it
- Spending a lot of time obtaining the opioid
- Craving or a strong desire to use opioids
- Repeatedly being unable to carry out major obligations at work, school, or home due to opioid use
- Continuing use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Recurrently using opioids in physically hazardous situations
- Consistently using opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
- *Being tolerant for opioids as defined by either a need for markedly increased amounts to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount
- *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

6. PROCEDURE

6.1. For patients who are receiving buprenorphine in the community, who enter facilities where buprenorphine is allowed by security policy, and the practitioners have a DEAx waiver to prescribe:

6.1.1. Attempts will be made to verify buprenorphine use (and, if possible, patient compliance) per policy *HCD-100_E-09A Medication Verification*. However, the practitioner should be contacted prior to the time of the next dose, based on patient history.

6.1.2. The practitioner (or the practitioner's designee if allowable) will search for the patient in a Prescription Drug Monitoring Program, if available in that state.

6.1.3. A urine drug screen and urine pregnancy test (as applicable) should be done prior to the first dose of buprenorphine. If the urine drug screen is positive for a drug other than buprenorphine, the case should be discussed with the patient's community practitioner and/or Regional Medical Director.

6.1.4. This medication will be ordered by the Practitioner at a clinically appropriate dose.

6.1.5. The patient's personal supply of buprenorphine should not be used.

6.1.6. In the event that the MAT cannot be verified in a timely manner, the decision to continue MAT will be made by the practitioner on a case-by-case basis.

6.2. For patients receiving methadone as MAT in the community, who enter facilities where this is allowed by security policy and the facility is not an Opioid Treatment Program (OTP):

6.2.1. Attempts will be made to verify methadone use (and, if possible, patient compliance) per policy *HCD-100_E-09A Medication Verification*. However, the practitioner should be contacted prior to the time of the next dose, based on patient history.

6.2.2. The practitioner (or the practitioner's designee if allowable) will search for the patient in a Prescription Drug Monitoring Program, if available in that state.

6.2.3. A urine drug screen and urine pregnancy test (as applicable) should be done prior to the first dose of methadone. If the urine drug screen is positive for a

drug other than methadone, the case should be discussed with the patient's community practitioner and/or Regional Medical Director.

6.2.4. Upon verification of this medication, the patient will be referred to the local OTP. The site practitioner can order the methadone at a fixed, once-daily dose for no more than three (3) days.

6.2.5. The patient's personal supply of methadone should not be used.

6.2.6. In the event that the MAT cannot be verified in a timely manner, the decision to continue MAT will be made by the practitioner on a case by case basis.

6.3. For patients receiving methadone as MAT in the community, who enter facilities where this is allowed by security policy and the facility is an Opioid Treatment Program (OTP):

6.3.1. Attempts will be made to verify methadone use (and, if possible, patient compliance) per policy *HCD-100_E-09A Medication Verification*. However, the Practitioner should be contacted prior to the time of the next dose, based on patient history.

6.3.2. The practitioner (or the practitioner's designee, if allowable) will search for the patient in a Prescription Drug Monitoring Program, if available in that state.

6.3.3. A urine drug screen and urine pregnancy test (as applicable) should be done prior to the first dose of methadone. If the urine drug screen is positive for a drug other than methadone, the case should be discussed with the patient's community practitioner and/or Regional Medical Director.

6.3.4. Upon verification of this medication, the practitioner will order the methadone per the procedure in the facility's OTP policy.

6.3.5. The patient's personal supply of methadone should not be used.

6.3.6. In the event that the MAT cannot be verified in a timely manner, the decision to continue MAT will be made by the practitioner on a case by case basis.

6.4. For patients who are receiving naltrexone in the community, who enter facilities where naltrexone is allowed by security policy:

6.4.1. Attempts will be made to verify naltrexone use (and, if possible, patient compliance) per policy *HCD-100_E-09A Medication Verification*. However, the

Practitioner should be contacted prior to the time of the next dose, based on patient history.

6.4.2. The practitioner (or the practitioner's designee if allowable) will search for the patient in a Prescription Drug Monitoring Program, if available in that state.

6.4.3. A urine drug screen and urine pregnancy test (as applicable) should be done prior to the first dose of naltrexone. If the urine drug screen is positive for a drug of abuse, the case should be discussed with the patient's community practitioner and/or Regional Medical Director.

6.4.4. Upon verification of this medication, the practitioner will order the naltrexone for the patient, as clinically indicated.

6.4.5. The patient's personal supply of naltrexone should not be used.

6.4.6. In the event that the MAT cannot be verified in a timely manner, the decision to continue MAT will be made by the practitioner on a case by case basis.

6.5. Patients who are receiving any of the recognized forms of MAT who enter facilities where that medication is not allowed by security policy:

6.5.1. Withdrawal from substance of abuse will occur per policy *HCD-100_F-04 Medically Supervised Withdrawal and Treatment*, except in the case of pregnant patients.

6.5.2. Should the patient meet the diagnostic criteria for OUD, they will be referred to an appropriately trained mental health clinician to discuss this diagnosis. Patients will be provided a list of treatment options that are available in the community after release.

6.6. For potential OUD patients NOT receiving MAT in the community, who enter facilities where buprenorphine, methadone, and/or naltrexone is permitted by facility policy, with a practitioner with a DEAx waiver to prescribe (buprenorphine only):

6.6.1. Withdrawal from substance of abuse will occur per policy *HCD-100_F-04 Medically Supervised Withdrawal and Treatment*.

6.6.2. Beginning the day after withdrawal has been completed, mental health or nursing staff will conduct daily wellness checks for three (3) days. Patients who answer affirmatively to any of the wellness questions should be placed on

suicide watch and referred to the mental health professional (if watch initiated by nursing) or psychiatric practitioner.

6.6.3. Upon presentation for the Initial Health Assessment, the nurse will screen for interest in MAT using the DAST 10 tool. Patients with a negative DAST 10 should be educated on drug abuse and given information regarding resources in the community, asked to sign an agreement for abstinence and scheduled for follow-up in chronic care clinic every six (6) months. Patients with a positive DAST 10, should be referred for a DSM 5 OUD screening interview.

6.6.4. Personnel conducting the DSM 5 OUD screening interview will review the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for OUD. Patients with ≤ 1 criterion should be educated on drug abuse and given information regarding resources in the community, asked to sign an agreement for abstinence and scheduled for follow-up in chronic care clinic every six (6) months. Patients with ≥ 2 criteria should be referred to a mental health practitioner (MHP) to confirm the diagnosis.

6.6.5. Upon evaluation by the MHP, the diagnosis of OUD should be assessed. If this diagnosis is not supported, the patient should be educated on drug abuse and given information regarding resources in the community. If the diagnosis is confirmed, the patient should be referred to the DEAx waived practitioner to discuss treatment options.

6.6.6. The DEAx waived practitioner will see patients who meet the criteria for OUD in chronic care clinic. During this initial chronic care clinic visit, the confirmation of the diagnosis of OUD should be reviewed. Available treatment options should be discussed. These include abstinence, naltrexone, methadone (if Opiate Treatment Program (OTP) is available in the community), and buprenorphine.

6.6.7. Patients who choose **abstinence** will be provided with a list of community resources that will be available to them upon release. An agreement for abstinence should be obtained. They should be seen in chronic care clinic every 90 days to re-evaluate their desire to start MAT. The use of the sick call process should be encouraged should the patient reconsider MAT prior to their 90 day follow-up visit. Upon reconsideration of MAT in a patient who initially declined, MAT initiation should not occur with less than seven (7) days left on the patient's sentence. Substance abuse counselling should be offered on an ongoing basis.

6.6.8. Patients who choose **methadone** should be referred to the local OTP for management. If an OTP is not available locally, then this should not be considered as a viable alternative for MAT. Patients should be seen in chronic care clinic every 30 days and labs (CBC and Complete Metabolic Profile (Diagnostic Profile II)) should be obtained on an annual basis. EKG should be considered in any patient receiving ≥30mg of methadone daily. Records from the OTP should be reviewed at each chronic care clinic visit. Substance abuse counselling should be offered on an ongoing basis. For sites that are accredited OTPs, please refer to the local policy manual for information on that program.

6.6.9. **Naltrexone** candidates should be managed as follows:

- Screening labs (CBC & Complete Metabolic Panel (Diagnostic Panel II), Urine Drug Screen, Urine Pregnancy Test (as applicable)) should be done at the first chronic care visit.

- Patient should be seen back in chronic care clinic to review labs. If no contraindications are noted in the lab work, a consent for naltrexone and a treatment agreement should be signed by the patient.

  ◊ If labs are not amenable to start naltrexone, formulate a treatment plan that addresses abnormal lab values with appropriate F/U schedule. Discuss available MAT options again with patient in light of abnormal lab values.

- Oral naltrexone 50mg PO daily should be started during this follow-up visit. This medication can be given in the housing units during regular medication pass.

- Follow-up chronic care clinic visits should occur every 30 days and documented on appropriate follow-up chronic care exam forms. Labs (CBC and Complete Metabolic Profile (Diagnostic Panel II)) should be obtained on an annual basis.

- Substance abuse counselling/Mental Health follow-up should be offered on an ongoing basis as available.

- Referral to discharge planning should be done.

- One (1) week prior to anticipated release date, the patient should receive their first intramuscular injection of naltrexone (Vivitrol). Oral naltrexone

should be discontinued. If the patient opts to continue with oral naltrexone after release, he or she should be educated on the sub-optimal clinical results of this treatment modality. Should the patient still opt to continue the oral formulation, the naltrexone injection should not be given. The oral naltrexone should be continued and appropriate follow-up made for after release.

- A follow-up appointment for additional naltrexone injections in the community should be given to the patient during the clinic visit where the first injection of naltrexone was given.

- Please note that naltrexone can also be used for the treatment of alcohol dependency. Should a patient meet the criteria for this diagnosis, the above naltrexone procedure would be applicable to them as well. Patients with both OUD and alcohol dependency should be treated with the same dose of naltrexone as described above.

6.6.10. Patients who choose **buprenorphine** should be managed as follows:

- Screening labs (CBC & Complete Metabolic Panel (Diagnostic Panel II), Urine Drug Screen, Urine Pregnancy Test (as applicable)) should be done at the first chronic care visit.

- Patient should be seen back in chronic care clinic to review labs. If no contraindications are noted in the lab work, a consent for buprenorphine and a treatment agreement should be signed by the patient.

    ◊ If labs are not amenable to start buprenorphine, formulate a treatment plan that addresses abnormal lab values with appropriate F/U schedule. Discuss available MAT options again with patient in light of abnormal lab values.

- Induction onto buprenorphine should be offered.

- Follow-up chronic care clinic visits should occur every 30 days and documented on appropriate follow-up chronic care exam forms. Labs (CBC and Complete Metabolic Profile {Diagnostic Panel II}) should be obtained on an annual basis.

- Substance abuse counselling/Mental Health follow-up should be offered on an ongoing basis as available.

- Discharge planning should be done to ensure that the patient has an appointment with their community MAT practitioner as well as a sufficient supply of medication upon release.

6.7. Patients receiving MAT in the community, who enter facilities where buprenorphine is Not allowed by security policy, or the Practitioners do NOT have a DEAx waiver to prescribe:

6.7.1. Buprenorphine use will be verified per policy (and, if possible, patient compliance) *HCD-100_E-09A Medication Verification*.

6.7.2. The practitioner (or their designee, if allowed) will search for the patient in a Prescription Drug Monitoring Program, if available in that state.

6.7.3. Patients will be referred to the local, contracted MAT practitioner as soon as possible to continue this medication. These patients should also receive counseling either on or off-site as appropriate.

6.8. For patients with OUD, but are NOT receiving MAT in the community, and who enter facilities where buprenorphine is NOT allowed by security policy, or the practitioners do NOT have a DEAx waiver to prescribe:

6.8.1. Withdrawal from substance of abuse will occur per policy *HCD-100_F-04 Medically Supervised Withdrawal and Treatment*, except in the case of pregnant patients.

6.8.2. Should the patient meet the diagnostic criteria for OUD, they will be referred to an appropriately trained mental health clinician to discuss this diagnosis. Patients will be provided a list of treatment options that are available in the community after release.

7. REFERENCES

HCD-100_E-09A Medication Verification
HCD-100_F-04 Medically Supervised Withdrawal and Treatment

American Society of Addiction Medicine (ASAM). The ASAM National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine. June 1, 2015

Substance Abuse and Mental Health Services Administration (SAMHSA). Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Rockville, MD: Center For Substance Abuse Treatment. Treatment Improvement Protocol Series, No. 40, USDHHS Publication (SMA) 04-3939. 2004b

Substance Abuse and Mental Health Services Administration (SAMHSA). Use of Buprenorphine in the Pharmacologic Management of Opioid Dependence: A Curriculum for Physicians. *Substance Abuse and Mental Health Services Administration.* 2001

1. PURPOSE

This policy is intended to ensure that pregnant patients are given comprehensive counseling and care in accordance with national standards and their expressed desires regarding their pregnancy.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Counseling and health education are provided to all patients. Counseling and assistance are provided to women with nondirective counseling about pregnancy preventions as well as emergency contraception. Prenatal care including diet, regularly scheduled obstetric monitoring provisions for lactating women, management of the chemically dependent pregnant patient, and monitoring for postpartum depression are provided.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

MAT – Medication Assisted Treatment

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. Counseling and assistance are provided in accordance with the pregnant patient's expressed desires regarding her pregnancy, whether she elects to keep the child, use adoption services, or have an abortion.

6.2. At intake, all females shall be queried regarding pregnancy, recent delivery, miscarriage, abortion, and whether they are currently taking prescribed injectable, implanted, or oral contraceptives as part of the intake health screening completed upon admission to the facility.

6.3. All women of reproductive age shall have a pregnancy assessment and urine pregnancy test completed within 24 hours of booking, and before medications are started. Women who refuse a test will not be given medication that may be harmful to the fetus without consultation with the medical provider.

6.4. Signs advising patients of their pregnancy and abortion rights, including the prohibition of the use of restraints, along with the availability of family planning and lactation support will be posted in English and Spanish in all female housing units.

6.5. When a pregnancy is determined, the pregnancy protocol, including prenatal vitamins, will be initiated, and the patient will be scheduled for routine OB care. Wellpath will follow the treatment plan provided by the Responsible Physician / Medical Director or designee – including management of those with diabetes.

6.5.1. Pregnancy diet – medical diets are provided by the kitchen and have been formulated or established by the dietician to meet applicable guidelines. If there is a special need, the dietician is available to modify the diet to meet the patient's specific needs.

6.5.2. Prenatal and postnatal care shall be provided in accordance with the treatment plan provided by the Responsible Physician / Medical Director or designee or an established OB/GYN specialist. Wellpath will draw labs and complete testing as clinically indicated by the treatment plan provided by the OB/GYN; other

medical and mental health conditions will be managed by the on-site providers as appropriate.

6.5.3. Laboratory and diagnostic tests shall be ordered in accordance with national guidelines including offering HIV testing and prophylaxis (infection control) when indicated.

6.5.4. Orders and treatment plans documenting clinically indicated levels of activity, nutrition, medications, housing, and safety precautions shall be determined and shared with those responsible.

6.5.5. Counseling and administering recommended vaccines in accordance with national standards shall be offered.

6.5.6. Custody restraints are not used during labor and delivery. Custody restraints, if used at other points of pregnancy and the postpartum period, shall be limited to handcuffs in front of the body.

- A pregnant patient in labor, during delivery, or in recovery after delivery shall not be restrained by the wrist, ankles, or both unless deemed necessary for the safety and security of the patient, staff, or public.

- Restraints shall be removed when a professional who is currently responsible for the medical care of a pregnant patient during a medical emergency, labor, delivery, or recovery after delivery determines that the removal of restraints is medically necessary.

- A pregnant patient, upon confirmation of her pregnancy, shall be advised, orally and in writing, of the standards and policies governing pregnant patients and the services available while in custody.

6.5.7. Postpartum care for incarcerated patients is documented in the patients' health record. Postpartum care includes and exam at two (2) weeks after caesarean, six (6) weeks after vaginal delivery, or as specified by hospital staff.

6.6. It is Wellpath policy that lactating patients will be handled according to the agency's policy. If no agency policy exists, Wellpath will collaborate to create a policy.

6.6.1. Patients who wish to breastfeed after release should be allowed to use a breast pump to express their milk if their incarceration period is short enough where this is clinically feasible. In this case, the milk should not be stored but should be discarded. In the event that this process in not clinically feasible, the patient should be provided with a breast binder or similar device.

6.7. Pregnant patients will be provided educational information and counseling to include exercise, nutrition (including the prevention of Listeria exposure/infection), personal hygiene, safety precautions, and other appropriate health education materials.

6.8. Pregnant patients desiring termination of pregnancy shall be scheduled for counseling and follow-up at an appropriate community provider who is able to provide termination and counseling services.

6.9. Family planning services are offered to each female prior to release. Oral or injectable contraceptives may be obtained and provided through the contracted pharmacy. IUD and other contraceptive services may be obtained through an OB/GYN specialist.

6.10. Emergency delivery kits are available in the facility, and training of what is in the kit is conducted.

6.11. Pregnant patients with active opioid use disorder receive evaluation upon intake, including offering and providing medication-assisted treatment (MAT). See policy *HCD-100_F-04 Medically Supervised Withdrawal and Treatment* for applicable procedures.

6.11.1. If a female patient screens positive for opiate use during the receiving/booking process, she will be immediately referred to health care staff for further evaluation.

6.11.2. The intake nurse shall perform a urine pregnancy test. If positive, the nurse will complete the Pregnancy Assessment section of the Intake Screening form to determine childbearing status and the date of last menstrual period.

- Individuals refusing urine testing shall be counseled regarding the possible risks associated with such a refusal. A signed and witnessed refusal of medical treatment form shall be completed and entered in the patient's medical record.

6.11.3. Patient Monitoring:

- Vital signs and fetal heart rate shall be monitored and recorded as ordered by the responsible OB specialist or medical provider until OB specialist is contacted.

  *** **NOTE**: Fetal heart rates may not be audible in pregnancies of less than 16 weeks without a Doppler.

- Mother and fetus shall be monitored closely for signs of early labor and/or fetal distress.

  ◊ Signs of early labor:

  a. Low abdominal (uterine) pain

  b. Low back pain

  c. Vaginal discharge

  d. Leaking membranes

  e. Bloody show

  ◊ Signs of fetal distress

  a. Lack of fetal movement

  b. Irregularity of fetal heart rate

  c. Fetal heart rate more than 160/min or less than 120/min

6.11.4. The Responsible Physician / Medical Director shall be kept apprised of patient's status.

6.11.5. Positive signs of early labor and /or fetal distress: The Responsible Physician / Medical Director shall be notified and the patient transferred to a hospital emergency department.

7. REFERENCES

HCD-100_F-04 Medically Supervised Withdrawal and Treatment

NCCHC Standards for Health Services in Jails 2018

- Section: Special Needs and Services: J-F-05 Counseling and Care of the Pregnant Inmate (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Special Needs and Services: P-F-05 Counseling and Care of the Pregnant Inmate (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Special Mental Health Needs and Services: MH-G-07 Counseling and Care of the Pregnant Inmate (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4C-13 Pregnancy Management (M)
- 1-HC-1A-10 Pregnancy Management (M)

Forms

- Refusal of Clinical Services
- Receiving Screening (Pregnancy Assessment Section)

1. PURPOSE

This policy is intended to ensure that victims of sexual abuse receive appropriate intervention, and the facility has written policy and procedures regarding the detection, prevention, and reduction of sexual abuse consistent with federal law.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Wellpath has a zero-tolerance policy with regard to sexual abuse, sexual harassment, and sexual misconduct. All allegations of sexual abuse, sexual harassment, sexual misconduct with or without consent, or staff voyeurism will be promptly and thoroughly reported to the facility administration and will be handled in compliance with state and federal law. Prompt and appropriate health intervention will take place in the event of a sexual abuse in an effort to minimize medical and psychological trauma.

Information on sexual abuse is located in the inmate handbook, and patients are provided with PREA information at the time of their initial medical screening. Treatment services are provided free of charge to every victim of sexual abuse, regardless of whether the victim discloses the name of the abuser or fails to cooperate with any investigation arising out of the incident.

Sexual conduct between staff and detainees, volunteers or contract personnel and detainees, regardless of consensual status, is prohibited and subject to administrative and criminal disciplinary sanctions.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

At Risk – The following minimum criteria for risk are provided as general information for health care staff who have patient contact:

- **Risk for victimization criteria (minimum)**
  - ◊ Mental or physical disability
  - ◊ Young age
  - ◊ Slight build
  - ◊ First incarceration in jail or prison
  - ◊ Nonviolent history
  - ◊ Prior convictions for sex offenses against adult or child
  - ◊ Sexual orientation of gay or bisexual
  - ◊ Gender nonconformance (e.g., transgender or intersex identity)
  - ◊ Prior sexual victimization
  - ◊ Self-reported perception of vulnerability

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

Qualified Mental Health Professional (QMHP) – Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

SART – Emergency Department Sexual Assault Response Team

Sexual Abuse – An unwanted sexual act that is coercive or assaultive in nature, and that occurs with or without the use or the threat of force.

Preserving Physical Evidence – For the purpose of this policy, evidence is not contaminated or destroyed. It does not refer to collecting or handling physical evidence.

6. PROCEDURE

Training / Orientation

6.1. Upon hire, and annually thereafter, Wellpath employees receive training and instruction that relates to the prevention, detection, response, and investigation of staff-on-patient and patient-on-patient sexual abuse, as well as how to preserve physical evidence of sexual abuse. This training is an adjunct to the initial and ongoing training provided by the facility.

6.2. Training includes, but is not limited to:

6.2.1. Delineation of health care staff's role in the facility's sexual abuse policy and procedures

6.2.2. Role-specific training in the detection and assessment of sexual abuse

6.2.3. Effective and professional response to victims and abusers

6.2.4. Preservation of physical evidence

6.2.5. How to elicit, receive, and forward reports of allegations or suspicions of sexual abuse

6.2.6. Confidentiality requirements

6.2.7. Documentation of training content and attendance will be maintained.

Reporting / Duty to Report

6.3. Employees, regardless of title, have a duty to report any sexual contact, sexual abuse, sexual threat, staff voyeurism, or information regarding inappropriate relationships

between an employee and a patient. Such duty to report will include any allegations, knowledge, or reasonable belief regarding such conduct.

6.3.1. At the initiation of services with medical or mental health providers, all patients are informed of this duty to report.

6.4. Whenever an employee knows, suspects, or receives an allegation from any source regarding patient sexual abuse, the employee will immediately notify the Responsible Health Authority (RHA) / Health Services Administrator (HSA), and Facility Administrator.

6.5. All information related to sexual victimization or abusiveness that occurred in the institutional setting will be strictly limited to health care staff and other staff to inform treatment plans and security/management decisions, as required by federal, state, and local law.

6.6. Consent of the patient, 18 years of age or older, is required before reporting an incident of sexual abuse that occurred prior to incarceration, except when the incident occurred in another correctional institution or in the event that the patient is under 18 years of age, as permitted by law.

6.7. A report is made to facility administration to effect a separation of the victim from the abuser in their housing assignments.

Screening for Risk of Sexual Victimization and Abusiveness

6.8. Receiving Screening

6.8.1. Patients identified as being at-risk for sexual victimization or abusiveness and for whom custody staff believe there is a need for immediate medical and/or mental health assessment shall be referred for immediate medical and/or mental health assessment at the time of the intake screening.

- Patients reporting recent, unreported sexual assault shall be evaluated by the Emergency Department SART. In cases where facility health care staff become aware of an incident of sexual assault occurring within 72 hours that has not been previously reported to custody, custody staff shall be alerted for referral to SART for immediate evaluation, medical treatment, and crisis intervention services. The patient will be instructed to take no

actions that could destroy physical evidence until the SART forensic examination takes place.

6.8.2. Patients identified as being at-risk for sexual victimization or abusiveness with no identified, immediate medical and/or mental health needs will be referred for medical/mental health screening within 14 days of intake.

- Custody staff is responsible for the initial at-risk screening. However, health care staff shall be alert for the presence of at-risk criteria in all ongoing interactions with patients.

Medical and Mental Health Screening – History of Sexual Abuse

6.9. 14-Day Health Assessment and Annual Physical Exam

6.9.1. All patients will be screened within 14 days of intake for risk potential and/or history of sexual victimization or abusiveness and need for treatment as a component of the health history and assessment conducted by qualified health care staff. Prior facility health records, when applicable, will be reviewed for evidence of sexual victimization or abusiveness history.

6.9.2. Longer-stay patients will be screened for recent signs/history of victimization or abusiveness as part of the annual physical exam by qualified health care staff.

6.9.3. Patients exhibiting or self-reporting physical or mental health concerns related to sexual victimization or abusiveness shall be referred to a qualified medical or mental health professional for follow-up evaluation.

- For cases in which the incident occurred within 72 hours, QHP shall:
  - ◊ Notify the custody shift supervisor
  - ◊ Prepare the patient for transfer to the SART, with patient's consent
  - ◊ Instruct the patient in the preservation of evidence
  - ◊ For cases in which the incident occurred more than 72 hour before reporting to health care staff OR the patient refuses the initial forensic

exam, a referral is made to a QHP or QMHP for evaluation and follow-up.

- In all cases, health care staff will obtain consent to release all information regarding sexual abuse, that occurred in the community, to essential personnel who will investigate, treat, and manage the patient's care.

6.10. Other Health Care Encounters

6.10.1. All health care providers and staff will be alert for signs of sexual victimization or abusiveness during all scheduled and non-scheduled health encounters.

6.10.2. Referrals for follow-up evaluation by QHP or QMHP will be made as indicated by physical and mental status findings.

Response / Intervention

6.11. When health care staff are notified of an incident occurring within the last 72 hours:

6.11.1. QHP will complete a baseline history and assessment to determine time and date of incident and current presenting physical and mental status, and QHP will stabilize the patient for transport to the designated SART hospital.

- Communication with staff at the designated SART hospital includes, but is not limited to: alert of impending arrival; prior medical/mental health history; current treatment, medications, and allergies; any actions/treatments taken related to the sexual assault; and what, if anything, will be sent with the patient.

6.11.2. QHP will prepare the patient for the forensic exam by describing who will perform the exam, the process, the purpose, where the exam will be conducted, the presence of an advocate and custody staff during the exam, confidentiality of information, and reporting mandates.

6.11.3. QHP will obtain consent from the patient for transfer for the forensic exam.

- NOTE: Patients have a right to refuse the exam. It cannot and will not be performed unless the patient consents. If a patient refuses the exam, do

not transfer to the hospital. If needed, consult with the SART staff at the hospital.

6.11.4. QHP maximize the preservation of evidence by:

- Instructing the patient not to take any of the following actions: showering or washing, brushing teeth, urinating, defecating, changing or removing clothes, or drinking or eating until the exam has been completed.

- If clothing must be removed for any reason, bag it and send it with the patient to the exam facility.

6.12. Defer cleaning or treating wounds. If necessary, the wound may be covered with a sterile, dry dressing. If cleaning or treating any wound is necessary, save all materials used in a sealed, plastic bag and send with the patient to the exam facility. Report any treatment done prior to transport to the SART staff.

6.13. An employee who receives an allegation or information that a patient is the victim of an incident of sexual abuse, sexual threats, or staff voyeurism must be aware of the sensitive nature of the situation. The patient must be treated with due consideration for the effects of sexual abuse.

6.14. Prophylactic treatment and follow-up care for sexually transmitted or other communicable diseases (e.g., HIV, Hepatitis B) are offered to all victims, as appropriate.

6.15. Emergency contraception is available to female victims of sexual abuse.

Documentation

6.16. All screening, assessment, evaluation findings, referrals, and treatment plans shall be documented in the patient's health record.

6.17. An Incident Report Form is completed and pertinent information is obtained, noting who, what, where, when, how, name of reporting person, patients involved (if applicable), and the sexual abuse allegedly committed.

6.18. All case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling

evaluation findings, and recommendations for post-release treatment and/or counseling are retained in accordance with an established schedule.

Ongoing Medical and Mental Health care for Sexual Abuse Victims and Abusers

6.19. Sexual Abuse Victims

6.19.1. Continued evaluation and treatment of medical and mental health needs related to sexual abuse will be provided in accordance with the patient's desire for treatment and the community standard of care. Services may be provided through sick call, chronic care clinics, and regular annual health examinations.

6.19.2. After any emergency treatment is provided, heath care staff will notify mental health staff of the event. An immediate telephone referral, including after hours, is the preferred referral format in case of an abuse.

- If after-hours mental health issues are handled by health care staff at the facility, the evaluating heath care staff member will assess need for immediate crisis-based interventions. The on-call psychiatrist may be contacted for consultation if such is deemed necessary.

6.19.3. If needed, a treatment plan will be developed regarding any additional medical follow-up required.

6.19.4. Mental health staff will assess need for crisis intervention, and provide those services as necessary.

- Mental health staff will offer ongoing follow-up services. If the patient refuses such services, the patient will be informed that a mental health staff member will follow up in 14 days to determine if the patient is functioning adequately and offer any follow-up services. All encounters will be documented in the patient's health record, including any refusals of follow-up services.

6.19.5. When necessary and appropriate, post-release information and instructions will be provided for continuity of care. All discharge planning actions/instructions will be documented. One copy will be given to the patient and the other copy will be filed in the patient's health record.

6.20. Sexual Abusers / Perpetrators

6.20.1. If the facility identifies an alleged perpetrator of the abuse (through means such as placement in a Segregation Unit, issuing a disciplinary report, or filing of criminal charges), a mental health staff member will follow up with this individual and assess adjustment to his or her current situation. If the individual is placed in Segregation, mental health staff will continue to monitor adjustment issues at least weekly via the Segregation rounds process. The staff member assigned to this duty shall not be the same person assigned to any ongoing follow-up with the victim of the abuse.

6.20.2. With signed consent, or where permitted by law, medical information may be obtained from the alleged perpetrator so that appropriate medical intervention can be initiated for the victim.

6.20.3. Post-release instructions, contact information, and referrals will be provided as deemed necessary and appropriate by a QMHP and with the patient's consent. All discharge planning actions/instructions will be documented. One copy will be given to the patient and the other copy will be filed in the patient's health record.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Special Needs and Services: J-F-06 Response to Sexual Abuse (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Special Needs and Services: P-F-06 Response to Sexual Abuse (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Safety: MH-B-04: Federal Sexual Abuse Regulations (E)
- Section: Safety: MH-B-05: Response to Sexual Abuse (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-22 through 4-ALDF-4D-22-8 Sexual Assault section (M)
- 1-HC-3A-13 Sexual Assault

Forms

- Refusal of Clinical Services
- Informed Consent

Code of Federal Regulations (CFR), Title 28, Part 115- Prison Rape Elimination Act National Standards

TITLE: HCD-100_F-07 Care for the Terminally Ill -- Mecklenburg NC	REFERENCE: 59974
	PAGE: 1 OF 4 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that the facility addresses the needs of terminally ill patients, including protecting their rights regarding end-of-life decisions.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

A program to address the needs of terminally ill patients, including pain management and palliative care, has been developed to protect the patients' rights regarding end-of-life decisions. When the Responsible Physician / Medical Director determines that care in a community setting is medically preferable, he or she will notify the Responsible Health Authority (RHA) / Health Services Administrator (HSA), who will notify and recommend to the facility the patient's transfer, early release, or activation of other legal resources, as appropriate.

Patients have the right to make informed decisions regarding health care, including the right to refuse care. Patients approaching the end of life are permitted to appoint a Durable Power of Attorney for Health Care and execute advance directives, including living wills, health care proxies, and do-not-resuscitate (DNR) orders. These directives will be signed only after the patient receives appropriate information regarding the meaning and consequences of such decisions. All DNR orders must be consistent with state law.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Palliative Care – Medical care and support services aimed at providing comfort, including adequate pain management. Treatment is focused on symptom control and quality-of-life issues rather than attempting to cure conditions.

Early Release – The release from custody before the end of the patient's sentence, or prior to adjudication of charges, because of the patient's terminal condition. In some states, this is known as medical parole or compassionate release.

Advance Directives – Expressions of the patient's wishes as to how future care should be delivered or declined, including decisions that must be made when the patient is not capable of expressing those wishes. Advance directives are useful for terminally ill patients but can be used be any patient regardless of health status.

RHA/HSA – Responsible Health Authority / Health Services Administrator

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

6. PROCEDURE

6.1. Consistent with states regulations, QHPs initiate or facilitate the early release of terminally ill patients in a timely manner.

6.2. If there is an on-site palliative care program:

6.2.1. Enrollment is a patient's informed choice.

6.2.2. QHPs working in the program have received training in palliative care and techniques.

6.2.3. Inmate workers or volunteers providing services in the program are properly trained and supervised.

6.3. Appropriate documentation of palliative therapies for terminally ill patients is maintained in the health record.

6.4. Advanced directives, health care proxies, and DNR orders are available when medically appropriate.

6.4.1. Advance directives are written protocols that specify end-of-life decisions and that:

- Ensure that such patient decisions are voluntary, un-coerced, and based on medical information that is complete and comprehensible to the patient
- Include the process to follow when the patient is judged to be lacking capacity to make end-of-life decisions

6.4.2. Advance directives will be offered as a standard part of the chronic care process and/or during acute care for those who choose to address advance care planning issues.

6.4.3. In the event a patient shows interest or desires to execute an advance directive, he or she is informed about the diagnosis, prognosis, care options, the consequences of choosing an advance directive, and the availability of palliative care services.

6.4.4. Patients desiring to execute advance directives will be referred to Mental Health for an evaluation of clinical capacity to make such decisions.

- Those determined to be lacking capacity to make end-of-life decisions will be referred to the court system through the facility mental health coordinator.

6.4.5. Patients are encouraged to appoint family members or close friends as their health care proxy.

- Members of the Wellpath health care staff are prohibited from serving as proxies for patients.

- Before a health care proxy or living will is used as the basis for withholding or withdrawing care there will be an independent review of the patient's course of care and prognosis by a physician not directly involved in the patient's treatment.

6.4.6. DNR orders are reviewed by a medical professional not directly involved in the patient's treatment

6.5. Health care staff discuss and coordinate implementation of this policy with facility administration. In the event the patient's condition changes or death occurs, appropriate notifications will be made in accordance with current facility policy.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Special Needs and Services: J-F-07 Care for the Terminally Ill (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Special Needs and Services: P-F-07 Care for the Terminally Ill (I)

1. PURPOSE

This policy is intended to ensure that when restraints are used for clinical or custody reasons, the patient is not harmed by the intervention.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Health care staff order clinical restraints and seclusion only for patients exhibiting behavior dangerous to self or others as a result of medical or mental illness. Except for initial clearance and ongoing monitoring of patients' health status, health care staff do not participate in the physical restraint of patients ordered by custody staff.

Patients may be considered for clinically ordered restraints or seclusion if care is urgently required or when their behavior is believed to be a product of medical or mental illness and puts themselves and/or others at imminent risk of physical harm. The following provisions are adhered to anytime clinically ordered restraints or seclusion are used in patient care.

3.1. They are not used for punishment or for the convenience of staff.

3.2. The least restrictive interventions possible will be used.

3.3. Custody staff is trained in the proper use of restraints.

3.4. An order, verbal or written, must be obtained from a Physician or other qualified health care professional, where permitted by law, prior to initiating therapeutic restraints or seclusion, except in emergency situations.

3.4.1. If the order is verbal, it must be signed within 24 hours or on the next business day when the provider is available.

3.5. Clinically ordered restraints shall only be applied and removed by qualified custody staff.

3.6. Patients are not restrained in a position that could jeopardize their health.

3.7. Patients will be released from therapeutic restraint or seclusion status as soon as it is clinically determined that the patient is no longer at imminent risk to engage in acts of self-harm or harm to others.

3.8. A formal treatment plan is utilized for clinically ordered restraint or seclusion events.

For clinically ordered restraints, Wellpath encourages the utilization of a bed, if available, designed to accept therapeutic restraints. The utility of restraint chairs is more limited based on the recommended length of time they can be used.

Wellpath does not participate in custody-ordered restraints outside of notifying custody staff of any medical contraindications for restraint and conducting health monitoring while a patient is in custody-ordered fixed restraints. (No review is provided for simple use of restraints during transfer or patient movement).

The use of clinically ordered restraint and seclusion will comply with applicable laws and regulations of the jurisdiction. An audit of written policy, procedures, and actual practice of the use of restraints will be conducted jointly by the RHA/HSA and Facility Administrator or designees at a minimum of annually.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Clinically Ordered Restraint (Therapeutic Restraint) – A therapeutic intervention initiated by medical or mental health staff to use devices designed to safely limit a patient's mobility.

Clinically Ordered Seclusion (Therapeutic Seclusion) – A therapeutic intervention initiated by medical or mental health staff to use rooms designed to safely limit a patient's mobility. Communicable disease isolation is not considered seclusion for the purpose of this policy.

Custody-Ordered Restraints – Measures or conditions initiated and applied by custody staff that keep patients under control.

Ordering Provider – Includes individuals who, where permitted by state law, are authorized to order restraints and/or seclusion.

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

Qualified Mental Health Professional (QMHP) – Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

RHA/HSA – Responsible Health Authority / Health Services Administrator

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions.

CCE – Critical Clinical Events

6. PROCEDURE

6.1. Therapeutic Restraint or Seclusion may be utilized for: (a) those patients with serious mental illness whose symptom presentation causes them to be at imminent risk for harming themselves or others and such behavior has not been successfully addressed by other less restrictive interventions, and/or (b) when the behavior puts the patient or others at such risk of harm that other less restrictive interventions cannot safely be attempted.

NOTE: If the patient appears at imminent risk for suicide, the patient will be managed according to Wellpath Policy and Procedure *HCD-100_B-05 Suicide Prevention and Intervention Program*, and a suicide watch status will be commenced according to that policy.

6.2. Any staff member may alert health care staff or mental health staff about patients who appear at risk to harm themselves or others when the staff member believes that the threat may be a product of mental illness. Upon such notification, a member of the mental health staff (including the Psychiatrist if on site) will conduct a face-to-face assessment of the patient to determine if the patient is suffering from a mental illness and evaluate the most appropriate method of addressing the patient's need for safety.

Therapeutic Seclusion

6.3. Ordering Therapeutic Seclusion

6.3.1. A Physician or QMHP, where permitted by law and local regulations, may recommend to custody staff the use of therapeutic seclusion based on a face-to-face assessment with the patient and a determination that less restrictive measures for maintaining the safety and security of the patient are insufficient.

6.3.2. Patients shall be placed in seclusion only with the approval of the Facility Administrator or designee. Continued retention in seclusion shall be reviewed by the Shift Supervisor, or higher authority, per facility seclusion procedures.

6.3.3. The clinical use of seclusion requires an order from a Psychiatric Provider or Physician. A patient placed in therapeutic seclusion shall be referred to a Psychiatric Provider for follow-up if the Psychiatric Provider did not initiate the seclusion order.

- The initial order for seclusion will not exceed four (4) hours.
- PRN (as-needed) orders for seclusion are prohibited.

6.3.4. The level of seclusion used shall be reduced as soon as possible to the level of least restriction needed to protect the patient and others.

6.3.5. A face-to-face assessment with a QMHP or Physician shall occur within four (4) hours of the initial seclusion order, prior to the order's expiration, to determine

the need for continued seclusion. An order will be obtained for continued seclusion up to 24 hours. Thereafter, a continuation order may be obtained from the Psychiatric Provider after a face-to-face encounter and shall not exceed an additional 24 hours.

- If no QMHP or Physician is available, a credentialed Registered Nurse will perform the face-to-face assessment in consultation with Psychiatric Provider.

6.4. Placement in Therapeutic Seclusion

6.4.1. Cells predetermined to be safely designed for seclusion purposes and permitting frequent observation shall be utilized. If none of these cells are available, the Psychiatric Provider or RHA/HSA will be consulted for further direction.

6.4.2. Custody staff shall inspect the designated seclusion cell prior to patient placement to ensure no items are available for potential self-harm.

6.4.3. The patient shall be placed in the seclusion cell by custody staff. Health care staff shall remain nearby during the physical placement process.

6.4.4. The patient shall continue to receive prescribed medication as ordered as well any treatment plans initiated prior to his or her seclusion status.

6.4.5. Regular hydration will be provided to the patient.

6.4.6. Meals will be provided to the patient.

6.4.7. A patient's access to personal property while in a seclusion cell shall be determined by the Ordering Provider and be specified in the seclusion order.

6.5. Monitoring Patients in Therapeutic Seclusion

6.5.1. Custody staff will observe the patient at least once every 15 minutes in staggered intervals and document observations on the Seclusion Monitoring Log.

6.5.2. During the initial four (4) hours of seclusion, a QHP or QMHP will communicate with the patient at least once an hour to assess the need for continued seclusion. Health care staff shall instruct the patient on behavior modification criteria that, once exhibited and clinically assessed, will result in the termination of the seclusion for the patient.

6.5.3. A QMHP will meet with the patient on at least a daily basis while the patient is on therapeutic seclusion status. The focus of these visits will be intervention designed to assist the patient in returning to a level of functioning sufficient to obtain release from seclusion status. Mental health staff will document these daily visits in the patient's health record.

- In absence of daily mental health staff, nursing staff will conduct a daily wellness check and document such in a progress note. This wellness check does not replace the evaluation by a mental health professional.

- Any patient placed on seclusion status will be enrolled in the Mental Health Special Needs program.

6.5.4. Mental health staff will consider transfer to an inpatient psychiatric setting if the patient's condition does not stabilize or improve with placement in seclusion.

6.5.5. An order to continue seclusion must be issued every 24 hours by a Psychiatric Provider.

6.5.6. After every 72 hours of continued therapeutic seclusion, a multidisciplinary treatment conference shall occur to determine the effectiveness of this treatment modality. This conference shall address the treatment efforts, responses to treatment, and modifications to treatment that may advance the patient out of therapeutic seclusion.

6.6. Notification of Therapeutic Seclusion

6.6.1. For each use of therapeutic seclusion, the site Psychiatric Provider and Mental Health Director/Coordinator will be notified as soon as possible.

6.6.2. The RHA/HSA, Facility Administrator, and the site Responsible Physician / Medical Director are to be notified on a daily basis of the frequency and use of therapeutic seclusion.

- The RHA/HSA shall forward such reports to the Regional Director of Operations and Regional Director of Mental Health or designees.

6.6.3. A Critical Clinical Event (CCE) report will be submitted by the RHA/HSA.

6.6.4. The Mental Health Director/Coordinator will complete a Quality Improvement screen for each incident of therapeutic seclusion within three (3) business days of the event. The results of the screen will be provided to the RHA/HSA and the appropriate VP of Behavioral Health.

6.7. Documentation of Therapeutic Seclusion

6.7.1. The initial order for seclusion, in addition to the disposition of the patient, shall be documented in the patient's health record, and includes, at a minimum:

- Patient identification information
- Patient behavior leading up to the need for seclusion
- List of interventions attempted by staff prior to decision to place in seclusion
- Clinical justification for placement in seclusion rather than less-restrictive interventions
- Type of clothing and property allowed
- Length of time, not to exceed four (4) hours, for placement in seclusion
- Level of security monitoring required, which cannot be less than every 15 minutes in staggered intervals
- Date/time seclusion initiated
- Medication orders
- The behavior necessary for the patient to achieve release from seclusion status

- If consultation was sought, results of consultation with the Psychiatric Provider, Mental Health Director/Coordinator, and/or Regional Director of Mental Health
- Other special considerations

6.7.2. Each face-to-face assessment shall be documented in the progress notes section of the patient's health record. The progress notes shall be used to document the following information, at a minimum:

- Patient identification information
- Vital signs
- Neurological check (e.g., alert, oriented)
- Indications for continued seclusion
- Justification as to why seclusion is the least restrictive therapeutic modality
- Information conveyed to the patient of demonstrable behaviors needed to justify release from seclusion (at least once daily)
- Ideation (e.g., suicidal, homicidal)
- Patient complaints
- Additional findings

6.7.3. Patient contact during placement in seclusion shall be documented by health care staff. This includes, but is not limited to, medication administration, food intake, and patient behavior.

6.7.4. A log shall be completed of the 15 minute checks and shall be placed in the patient's health record upon completion.

6.7.5. The QMHP's order to remove from seclusion shall be accompanied by a progress note documenting, at a minimum:

- The patient's behavior and clinical justification for removal from seclusion
- Date/time the patient was removed from seclusion
- Follow-up orders, if any

Therapeutic Restraints

6.8. Therapeutic restraint is a treatment modality used to prevent patients from injuring themselves during periods of disorientation, perceptual alterations, and/or impaired decision-making. The level of restraint used will serve to maintain the integrity of essential therapeutic measures (e.g., intravenous therapy and other invasive treatments) which, if disrupted or inadvertently dislodged, may cause harm to the patient.

6.9. Before considering the use of restraints, staff will attempt to assist the patient in gaining control by less restrictive interventions, including but not limited to:

6.9.1. Talking to the patient in a calm manner in an attempt to de-escalate the situation

6.9.2. Placing the patient in a seclusion cell

6.9.3. Offering medication, if ordered by a Physician or Psychiatric Provider

6.10. Ordering Therapeutic Restraints

6.10.1. Any staff member may notify the Director of Nursing (DON) or Charge Nurse regarding the need to initiate a therapeutic restraint. The DON or Charge Nurse will review the patient's health record to ensure there are no medical contraindications to restraint. If such exist, the site Responsible Physician / Medical Director or Ordering Provider will be notified for direction. The Psychiatric Provider will be made aware of the contraindications and the site Responsible Physician's / Medical Director's determination about the issue(s).

- Contraindications to therapeutic restraints include but are not limited to: acute fracture of the limbs, known hypercoagulable state, active anticoagulation therapy (aspirin monotherapy is not considered anticoagulation therapy), osteogenesis imperfecta, deep venous

thrombosis, hemophilia, or limb deformity such that placement of restraint device would be impossible or harmful to the patient.

6.10.2. If therapeutic restraints are considered necessary, they may be ordered by a Physician or Ordering Provider. If a licensed practitioner is not on-site, an order for restraints may be given by a QMHP. If no QMHP is available, a licensed Registered Nurse may initiate therapeutic restraints in an emergency situation.

- An order for restraints shall not exceed two (2) hours for a restraint chair and six (6) hours for a restraint bed, but state and local regulations may vary.
- PRN (as-needed) orders for restraints are prohibited.
- If the therapeutic restraints are initiated by a QMHP or Registered Nurse, the duration of the restraint shall be in effect for one (1) hour only, to allow time to contact the Psychiatric Provider, Physician, or Ordering Provider. The Ordering Provider shall be contacted as soon as possible and advised of the patient's condition. The Ordering Provider will determine if continued therapeutic restraints are a necessity. If the restraints are to be continued, the Ordering Provider will provide an order.

6.10.3. Patients shall be placed in restraints only with the approval of the Facility Administrator or designee. Continued retention in restraints shall be reviewed by the Shift Supervisor, or higher authority, per facility restraint procedures.

6.10.4. The level of restraint used shall be reduced as soon as possible to the level of least restriction needed to protect the patient and others.

6.10.5. Prior to the expiration of the initial order for restraint, health trained personnel or health care staff will review for continued retention in the restraint.

6.11. Placement in Therapeutic Restraints

6.11.1. Only restraints that would be appropriate for use in the community will be used for medical restraints. These include fleece-lined leather, rubber, or canvas hand and leg restraints. Metal or hard plastic devices, like handcuffs and leg shackles, will not be used for medical restraints.

6.11.2. Custody staff will apply restraints with the assistance of QHPs, if requested. Application of restraints will not occur without sufficient custody staff present to adequately manage the patient during the application of restraints.

6.11.3. If force is necessary to apply clinical restraints, only the amount of force that is absolutely necessary is used. It is recommended that any application of therapeutic restraints is videotaped by custody staff.

6.11.4. Health care staff will observe the placement of restraints to ensure the patient's physical condition would not be compromised by placement in the restraints. Medical opinion may be provided by QHPs. A medical opinion on placement and retention shall be secured within one (1) hour from the time of placement.

6.11.5. Potentially harmful objects which might interfere with the restraints will be removed (e.g., watches, rings).

6.11.6. Clothing may be removed if clinically appropriate. Minimally, the patient will be provided a paper gown/sheet.

6.11.7. Staff will encourage patient compliance during the application of the restraints by calmly explaining the restraint procedure, the reasons for the decision to restrain, and the behavior required for terminating the use of restraints.

6.11.8. The patient shall continue to receive prescribed medication as ordered as well any treatment plans initiated prior to his or her restraint status.

6.11.9. Regular hydration will be provided to the patient.

6.11.10. Meals will be provided to the patient but will consist of "finger food." The patient's head will be elevated and turned laterally when given food or liquid to prevent aspiration.

6.11.11. The patient will be offered use of the bathroom at least every two (2) hours.

6.12. Monitoring Patients in Therapeutic Restraints

6.12.1. Patients placed in restraints will be placed in a designated observation area which permits frequent observation by custody staff.

6.12.2. Circulation, movement, and sensation in extremity checks by a QHP are completed every 15 minutes for the first hour, and every two (2) hours thereafter, unless ordered at a higher frequency by the Psychiatric Provider or Physician.

6.12.3. QHPs will also assess mental status, respiratory status, sensory/motor/circulatory exam of involved extremities, and vital signs every 15 minutes for the first hour and every two (2) hours thereafter, unless ordered at a different frequency by the Psychiatric Provider or Physician. Removal of one extremity at a time occurs every two (2) hours for range of motion checks. Sleep does not negate the need to perform these duties.

6.12.4. Each review and check shall be documented on all appropriate logs and in the patient's health record.

6.12.5. A QHP or QMHP will communicate with the patient at least once an hour to assess the need for continued restraint. Health care staff shall instruct the restrained patient (if lucid and rational) on behavior modification criteria that, once exhibited and assessed, will lead to the removal of restraints.

6.12.6. The on-call medical provider will be notified immediately:

- When a patient remains restrained and his or her medical and/or mental status shows no improvement or continues to deteriorate. This includes patients exhibiting escalating, inappropriate, and/or bizarre behavior; patients unable to take fluids; and patients for whom it is impossible to complete a hands-on nursing assessment that includes vital signs.

- When urine dipstick is positive for blood at any time.

6.12.7. Patients who meet the criteria above and patients who have remained in restraints for eight (8) hours will be transported to the hospital for further medical and diagnostic evaluation. Custody staff will be responsible for security and assisting in transporting the patient to the hospital by ambulance.

6.12.8. Monitoring patients in the WRAP:

- As soon as health care staff are alerted that a patient has arrived to the facility in the WRAP, or facility staff have placed a patient in this restraint, an assessment is required.
- Request that the patient be maintained in the upright position to ensure that airway is not obstructed.
- Obtain a full set of vitals.
    - ◊ If the patient arrives in the WRAP and is too combative to obtain vital signs and adequate assessment, the patient is to be refused and transferred to the hospital for evaluation of status.
- Assess mental status and suicide risk.
- If this is a new arrestee, attempt to obtain a medical and mental health history.
- If this is an existing patient, review the health record for any contraindications against use of the WRAP.
- If a decision is made to continue the patient in the WRAP restraint, a full assessment is to be done and documented every hour.

6.13. Renewal of Therapeutic Restraints

6.13.1. Restraint Bed Renewal

- Shortly before the expiration of the restraint order, the Ordering Provider will be contacted and updated on the patient's condition and behavior. The Ordering Provider may reorder the clinical restraints for up to an additional six (6) hours, not to exceed a total of 24 hours.
- The patient's need to remain in therapeutic restraints will be reassessed in a face-to-face evaluation by mental health staff or by health care staff if mental health staff are not on site. The results of the assessment will be provided to the Ordering Provider.

6.13.2. Restraint Chair Renewal

- If the patient has been restrained in a restraint chair, the order may not be renewed immediately. After two (2) consecutive hours in a restraint chair, the patient must be removed from the restraint chair and allowed to walk continuously for at least five (5) minutes (if previously ambulatory) before being returned to a restraint chair. The Ordering Provider must then be updated on the patient's condition, including the behavior displayed during the time out of the restraint chair. A new order for placement in the restraint chair may be given by the Ordering Provider if there is a determination that imminent risk of harm to self or others continues based on this reassessment of risk.

6.14. Removal of Therapeutic Restraints

6.14.1. Therapeutic restraints shall be removed upon the expiration of the order or upon the order of a Psychiatric Provider after either:

- A face-to-face evaluation of the patient; or
- Issuing a verbal order after a consultation with an on-site QHP who has performed a face-to-face evaluation.

6.14.2. Custody staff will remove restraints with the assistance of QHPs, if requested. Sufficient custody staff will be present when restraints are removed to provide patient control, if needed.

6.15. Notification of Therapeutic Restraints

6.15.1. For each use of therapeutic restraint, the site Psychiatric Provider and Mental Health Director/Coordinator will be notified as soon as possible.

6.15.2. The RHA/HSA, Facility Administrator, and the site Responsible Physician / Medical Director are to be notified on a daily basis of the frequency and use of therapeutic restraint.

- The RHA/HSA shall forward such reports to the Regional Director of Operations and Regional Director of Mental Health or designees.

6.15.3. A Critical Clinical Event (CCE) report will be submitted by the RHA/HSA.

6.15.4. The Mental Health Director/Coordinator will complete a Quality Improvement screen for each incident of therapeutic restraint within three (3) business days of the event. The results of the screen will be provided to the RHA/HSA and the appropriate VP of Behavioral Health.

6.16. Documentation for Therapeutic Restraints

6.16.1. The initial order for restraint, in addition to the disposition of the patient, shall be documented in the patient's health record, and includes, at a minimum:

- Patient identification information
- Patient behavior that led to the initiation of the seclusion or restraint episode
- Listing of interventions attempted by staff prior to decision to restrain
- Clinical justification for the use of restraints rather than less restrictive interventions
- Underlying impression/differential diagnosis to be utilized during the seclusion or restraint episode to achieve de-escalation
- The behavior necessary for the patient to achieve release from restraint status
- Level of security monitoring required, which cannot be less than constant observation by custody staff, with logbook notation every 15 minutes
- Type of restraints to be used
- The location to be utilized for restraints, as well as the length of time for the order [not to exceed two (2) hours if the therapeutic restraint is to occur in a restraint chair; use of the restraint bed shall not exceed six (6) hours before the order must be renewed, if necessary]
- Date and time restraint procedure initiated
- Medication orders

- Type of clothing or covering allowed
- If consultation was sought, results of consultation with the Psychiatric Provider, Mental Health Director/Coordinator, and/or Regional Director of Mental Health
- Any other special considerations

6.16.2. Each face-to-face assessment shall be documented in the progress notes section of the patient's health record. The progress notes shall be used to document the following information, at a minimum:

- Patient identification information
- Vital signs
- Neurological check (e.g., alert, oriented)
- Indications for continued restraint
- Information conveyed to the patient of demonstrable behaviors needed to justify release from restraint
- Ideation (e.g., suicidal, homicidal)
- Release of extremities
- Bathroom access
- Medication administration
- Food intake
- Patient complaints
- Additional findings

6.16.3. A log shall be completed of the 15-minute circulation, movement, and sensation checks and shall be placed in the patient's health record upon completion.

6.16.4. The order to remove restraints shall include:

- The patient behavior and clinical justification for removal of restraints
- Date and time restraints were removed

6.17. Pregnant Patients

6.17.1. Upon confirmation of pregnancy, health care staff shall inform the patient of her rights regarding the prohibition of the use of leg irons, waist chains, and handcuffs behind the body while in custody and during transport.

6.17.2. Health care staff have the authority to direct the removal of restraints from pregnant patients. Restraints shall be removed when a professional who is currently responsible for the care of the patient during a medical emergency, labor, delivery, after delivery, or recovery determines that the removal of restraints is medically necessary.

Custody-Ordered Restraints

6.18. Except for monitoring the patient's health status, health care staff do not participate in restraints ordered by custody staff.

6.19. When restraints are used by custody staff for security reasons, health care staff are notified as soon as possible in order to review the health record for any contraindications or accommodations required which, if present, are communicated as soon as possible to appropriate custody staff. This includes mental health related contraindications.

6.20. Health care staff provide initial health monitoring that continues at least once every 15 minutes in staggered intervals. Initial health monitoring includes documentation of any injuries that have occurred during use of force. If the patient's health is at risk, this is immediately communicated to appropriate custody staff.

6.20.1. Monitoring includes, but is not limited to, checks for signs of circulatory, respiratory or other dysfunction, abrasion, irritation, or injury. Extremities will be monitored for color, temperature, and pulse.

6.20.2. Vital signs will be takes and recorded by a QHP at least once every shift.

6.20.3. All monitoring and patient contact is documented in the patient's health record.

6.21. If the patient's behavior that triggered the use of custody ordered restraints is determined to be related to an exacerbation of mental illness, the restraint episode will be converted from a custody ordered restraint to a therapeutic restraint episode, and the management of the event will follow those procedures outlined above for therapeutic restraints. The QMHP making this determination will alert custody as well as medical/nursing staff regarding the change in designation of the event.

6.22. If the restricted patient has a medical or mental health condition, the Responsible Physician / Medical Director is notified as soon as possible, so that appropriate orders can be given.

6.23. If health care staff are not on duty when custody-ordered restraints are initiated, it is expected that health care staff review the health record and initiate monitoring upon arrival.

6.24. When health care staff note what they consider to be improper use of custody-ordered restraints, jeopardizing the health of a patient, they communicate their concerns as soon as possible to the RHA/HSA, who is responsible for communicating it to the Facility Administrator.

7. REFERENCES

HCD-100_A-09B Critical Clinical Events
HCD-100_B-05 Suicide Prevention and Intervention Program

Mental Health Special Needs Program

NCCHC Standards for Health Services in Jails 2018
- Section: Medical-Legal Issues: J-G-01 Restraint and Seclusion (E)

NCCHC Standards for Health Services in Prisons 2018
- Section: Medical-Legal Issues: P-G-01 Restraint and Seclusion (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015
- Section: Medical-Legal Issues: MH-I-01 Restraint and Seclusion (E)

ACA Standards / 2016 Standards Supplement
- 4-ALDF-4D-21 Use of Restraints (M)
- 1-HC-3A-12 Use of Restraints (M)

TITLE: HCD-100_G-02 Segregated Inmates --Mecklenburg NC	REFERENCE: 59976
	PAGE: 1 OF 4 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 06/01/2019 REVIEWED: 06/01/2019

1. PURPOSE

This policy is intended to ensure that when a patient is segregated (confined away from general population no matter the security level), health care staff monitor his or her health to ensure that the patient's health is not adversely affected.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Upon notification that a patient is placed in segregation, health care staff review the patient's health record to determine whether existing medical, dental, or mental health needs require accommodation or preclude safely housing the patient in the proposed segregation setting. When segregation is anticipated to be deleterious to the patient's health, the Facility Administrator or designee is informed and provided with a full explanation. The review and notification are documented in the health record. Also, this review serves to permit health care staff to plan for continued health care delivery during segregation placement.

Segregation rounds are documented on Wellpath segregation observation logs, and include the date and time of the contact, and the signature or initials of the employee making rounds. This is in addition to any facility required documentation. Significant health findings are documented in the patient health record and followed up as necessary.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Segregated Patients – Those isolated from the general population and who receive services and activities apart from other patients. Facilities may refer to such conditions as administrative segregation, protective custody, disciplinary segregation, etc. The living and confinement conditions define the segregated status, not the reason a patient was placed in segregation.

Extreme Isolation – Refers to situations in which patients encounter staff or other patients fewer than three (3) times a day.

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions.

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Upon notification from custody staff that a patient is placed in segregation, the following will occur:

6.1.1. A qualified health care professional will review the patient's health record to determine whether existing medical, dental, or mental health needs contraindicate the placement or require accommodation.

6.1.2. If contraindications or accommodations are noted, the QHP will inform appropriate custody staff.

6.1.3. The review and any subsequent notification are documented in the health record.

6.2. Health care staff complete segregation rounds, and all significant findings are documented in the patient's health record.

6.2.1. Patients under solitary isolation with little or no contact with others are monitored daily by nursing staff and at least once a week by mental health staff.

6.2.2. Patients who are segregated and have limited contact with others are monitored three (3) days a week by medical or mental health staff, but at least one (1) of the visits must be by mental health staff (initial visit shall include suicide risk screening for Special Needs patients).

- For ACA accredited facilities, patients receive a daily visit from a health care provider. The presence of a health care provider in segregation is announced and recorded. The Health Authority determines the frequency of physician visits to segregation units.

6.2.3. Patients on medications will continue to receive as prescribed.

6.2.4. Patients will have access to medical, dental, and mental health services.

6.2.5. Alternative meal service is on an individual basis, is based on health and safety considerations only, meets basic nutrition requirements, and occurs with the written approval of Facility Administrator or designee and the RHA/HSA. The substitution does not exceed seven (7) days.

6.2.6. Health care staff who inspect special management units or counsel patients on behavior use the permanent custody log to record all visits and will include, at a minimum:

- Date and time of contact
- Signature or initials of health care staff making rounds
- Significant findings will be documented in the health record
- Any needed referrals will be made

6.3. Health care staff promptly identify and inform custody staff of patients who are physically or psychologically deteriorating and those exhibiting other signs or symptoms of failing health.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Medical-Legal Issues: J-G-02 Segregated Inmates (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Medical-Legal Issues: P-G-02 Segregated Inmates (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Patient Care and Treatment: MH-E-07 Segregated Inmates (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-2A-45 Special Management Patients (M)
- 4-ALDF-2A-53 Special Management Patients
- 4-ALDF-2A-55 Special Management Patients
- 4-ALDF-2A-56 Special Management Patients
- 1-HC-3A-07 Segregation (M)

Forms

- Segregation Observation Logs

TITLE: HCD-100_G-03 Emergency Psychotropic Medication - -Mecklenburg NC	REFERENCE: 59977
	PAGE: 1 OF 7 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 06/01/2019 REVIEWED: 06/01/2019

1. PURPOSE

This policy is intended to ensure that health care staff follow policies developed for the emergency use of forced psychotropic medications as governed by the laws applicable in the jurisdiction.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Involuntary emergency psychotropic medications will not be given unless a psychiatric emergency exists and the legally authorized Psychiatric Provider or designee issues medical orders for their use in accordance with all applicable laws and regulations. All cases involving the need for involuntary psychiatric medication administration will be reported as a Critical Clinical Event (CCE) for review.

When involuntary emergency psychotropic medication is administered, the following conditions must be met:

- Administration is authorized by a Psychiatric Provider or Physician designee who specifies the duration of therapy.
- Less-restrictive intervention options have been exercised without success, as determined by the Psychiatric Provider or Physician designee
- Details are specified about why, when, where, and how the medication is to be administered.
- The patient is monitored for adverse reactions and side effects.
- Treatment plans are prepared for less-restrictive treatment alternatives as soon as possible.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Psychiatric Emergency – A medical or behavioral health condition, the onset of which is sudden, manifested by symptoms of sufficient severity in which serious bodily harm to the patient or others is occurring or that a prudent layperson could reasonably expect that in the absence of immediate medical attention will result in the health of such person or others to be in serious jeopardy.

Emergency Psychotropic Medication – Defined as the administration of psychotropic medication to a patient without his or her expressed consent in response to a psychiatric emergency in which the main aim of medication is to reduce the dangerousness of such episodes.

Therapeutic Indication – Means that emergency psychotropic medication will never be used as a method of punishment against any patient for the convenience of medical, mental health, or custody staff and never used for the routine management of interpersonal conflicts between patients and staff unrelated to psychiatric illness.

Least-Restrictive Alternative – Refers to always using the least-limiting action which can reasonably be expected to be effective, which will help the behaviorally dangerous patient avoid harm to self or others. Patients exhibiting serious clinical deterioration at any time during involuntary therapy will be transferred immediately to a clinically appropriate treatment facility; patients whose condition indicates the need for psychotropic medications and who continue to refuse to take such medications will be transferred to a clinically appropriate treatment facility.

Specific One-Time Indication – Each instance of involuntary psychotropic treatment administered in an emergency cannot be continued in scheduled repeated doses after the immediate danger has passed unless following the use of involuntary medication the patient provides informed consent for further voluntary treatment.

- Unless an applicable court order allowing involuntary treatment is in effect, emergency psychotropic medication cannot be repeated even if clinically it could prevent another emergency situation. Only the patient has the right to decide whether to continue or not continue ongoing treatment unless overruled by a medically-sound and legally valid court order for non-emergency involuntary psychotropic medication treatment.

Long-Acting Injectable (LAIs) – Formulations of psychotropic medication are not appropriate for emergency medications; the use of involuntary LAIs must be in accordance to medically sound and legally valid court order for non-emergency involuntary psychotropic medication treatment.

Non-Emergency Involuntary Psychotropic Medication Treatment – In jurisdictions where it is legally allowed and regulated, involuntary psychotropic treatment (ongoing treatment without consent or treatment over objection) is to be delivered when there is no psychiatric emergency but legal criteria for such treatment are met and approved by a court. Each facility will develop site-specific procedures that are in accordance with all applicable laws and regulations that govern non-emergency involuntary psychotropic medication administration by first procuring and obtaining a medically sound and legally valid court order.

RHA/HSA – Responsible Health Authority / Health Services Administrator

CCE – Critical Clinical Event

Qualified Mental Health Professional (QMHP) - Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

6. PROCEDURE

6.1. Need for Emergency Psychotropic Medication

6.1.1. If qualified health care staff determine that a psychiatric emergency situation exists and less restrictive means of ensuring the safety of the patient or others have failed or cannot be safely attempted, the site Psychiatric Practitioner or Physician designee will be contacted immediately for consultation as per site-specific established protocols for when the Psychiatric Practitioner is on location

or to the appropriate on-call Psychiatric Practitioner or Physician designee when off the premises.

6.1.2. Upon being consulted, the site Psychiatric Practitioner or Physician designee shall determine the most appropriate course of action, which may include non-pharmacological interventions, referrals for transfer to a higher level of care, and/or the use of emergency psychotropic medication if, in their clinical judgment, the patient presentation meets all criteria set forth by all specific applicable laws and regulations, but which generally require these elements which must be present and described in the health record:

- An immediate threat of serious physical harm to the patient or to others caused by the violent behavior of the patient
- An immediate threat to the patient of deteriorating physical well-being with risk to life or long term health caused by the effects of mental illness, or
- Actual violent behavior by the patient causing substantial property damage.

6.2. **Psychiatric Evaluation**

A contemporaneous personal onsite or telehealth evaluation by the Psychiatric Practitioner or Physician designee of any patient considered for emergency psychotropic medications is preferred, whenever feasible. However, if allowed by state and local laws, such an order may be given by the Psychiatric Practitioner or Physician designee as a telephonic order when he or she is not on-site and/or if the risk is so imminent that any delay in treatment places the patient or others in serious physical jeopardy. The prescriber will follow up those orders by completing an evaluation of the patient as soon as possible or as stipulated by site-specific regulations, typically at the next time that the Psychiatric Practitioner or Physician designee is scheduled for onsite or telehealth clinical services.

6.3. **Application of Emergency Psychotropic Medication**

Documentation for emergency psychotropic medication use is to include descriptions of the actual behavior exhibited by the patient that puts the patient or others at substantial risk of harm or that will cause substantial property damage. Documentation also includes descriptions of actual attempts made to have the patient voluntarily accept the

medication, de-escalate, or reasons as to why it was not appropriate to attempt less-restrictive interventions.

6.3.1. Medication orders for emergency psychotropic medication must include name(s) of the medication(s), route of administration, and one-time STAT descriptor.

6.3.2. Within two (2) hours, the Psychiatric Practitioner or Physician designee will be provided with an update of the patient's condition.

6.3.3. The Psychiatric Practitioner or Physician designee will convey concomitant directions for placement on a constant observation watch status as defined in the site-specific policy, to include housing in a cell approved for such status.

- Patient will remain on the same level of observation status until evaluated by a Qualified Mental Health Professional in consultation with a Psychiatric Practitioner and/or Physician designee or face-to-face evaluation by a Psychiatric Practitioner.

6.3.4. Follow-up by the Psychiatric Practitioner and/or Physician designee may include consideration of transfer of the patient to a community provider more equipped to deal with psychiatric emergencies.

6.4. **Notifications and Follow-Up**

6.4.1. The Responsible Health Authority (RHA) / Health Services Administrator (HSA) will be notified of the intent to medicate under emergency conditions prior to any actions being taken. If the RHS/HSA is not immediately available or if a delay in treatment will create a risk of harm, the Psychiatric Practitioner or Physician Designee may direct staff to implement the order immediately, and notification to the RHA/HSA will occur as soon as possible after the event.

6.4.2. If not already involved, the Mental Health Director/Coordinator will be notified of the situation. This staff member will ensure that a Treatment Plan relevant to the patient's current situation is commenced, to include a plan for immediate mental health monitoring as well as ongoing monitoring if the patient remains at the facility.

6.4.3. If the patient remains at the facility, the patient will be placed on the Mental Health Special Needs list, if not already enrolled in that program.

6.4.4. If the order is given via telephone, the verbal order is cosigned by the Psychiatric Practitioner or Physician designee by no later than the next day the provider is scheduled to conduct clinical services at the site or via telehealth technology.

6.4.5. Patients will remain on the same level of observation status until evaluated by a QMHP in consultation with a Psychiatric Practitioner and/or Physician designee or face-to-face evaluation by a Psychiatric Practitioner.

6.4.6. Any patient who continues to present with a psychiatric emergency after the initial administration will be evaluated for transfer to a community agency more equipped to deal with psychiatric emergencies. The site Psychiatric Practitioner or Physician designee, in consultation with the Mental Health Director/Coordinator, will make this determination. The Mental Health Director/Coordinator will be responsible for notifying the appropriate custody staff of the Psychiatric Practitioner or Physician designee decision regarding need for transfer and will ensure that any steps necessary on the part of Wellpath will be completed in order for the transfer to occur.

6.4.7. Follow-Up Documentation is made by nursing staff at least once within the first 15 minutes, then every 30 minutes until transfer to an inpatient setting or the patient no longer requires monitoring. At each nursing follow-up encounter, at least eight ounces (8oz) of oral hydration is offered to the patient.

6.4.8. A Critical Clinical Event (CCE) report will be submitted by the RHA/HSA, and the QI screen relevant to Emergency Psychotropic Medication will be completed.

7. REFERENCES

HCD-100_A-09B Critical Clinical Events

NCCHC Standards for Health Services in Jails 2018

- Section: Medical-Legal Issues: J-G-03 Emergency Psychotropic Medication (E)

NCCHC Standards for Health Services in Prisons 2018

- Section: Medical-Legal Issues: P-G-03 Emergency Psychotropic Medication (E)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Medical-Legal Issues: MH-I-02 Emergency Psychotropic Medication (E)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-17 Involuntary Administration (M)
- 1-HC-3A-08 Involuntary Administration (M)

1. PURPOSE

This policy is intended to ensure that health care staff protect the integrity of the therapeutic partnership with their patients.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Health care staff do not routinely participate in the collection of forensic information, do not participate in disciplinary action, and are not compelled to provide clinical information solely for the purpose of discipline. Treatments and medications are never withheld as a form of punishment. Segregation and restraints are never clinically implemented as disciplinary action. The position assumed by health care staff is that of a neutral one. Health care is compromised when asked to collect information from patients for use against them.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Custody Staff – Includes line security as well as administration to support the implementation of clinical decisions.

Health Care Staff – Qualified health care professionals as well as administrative and supportive staff (e.g., health records administrators, laboratory technicians, nursing and medical assistants, and clerical workers).

6. PROCEDURE

6.1. Health care staff are not involved in the collection of forensic information (e.g. DNA testing), except when:

- Complying with state laws that require blood samples from patients , so long as there is consent of the patient and health care staff are not involved in any punitive action taken as a result of a patient's nonparticipation in the collection process
- Conducting blood or urine testing for alcohol or other drugs when done for medical purposes by a physician's order
- Conducting patient-specific court ordered laboratory tests, examinations, or radiology procedures with consent of the patient

6.2. It is the responsibility of the Facility Administrator to make the arrangements to have appropriately trained individuals available to collect forensic information.

6.3. Included in the procedures that health staff are prohibited from involvement in are:

- Body cavity searches
- Psychological evaluation for the purpose of use in adversarial proceeding
- Blood drawing for lab studies not ordered by the court or without the patient's consent
- Removal of Taser barbs that are to be retained as evidence by custody staff
- In the case of sexual abuse, gathering evidence from the victim with his or her consent. Victims of sexual abuse will be referred to a community facility or local emergency room for treatment and gathering of forensic evidence.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Medical-Legal Issues: J-G-04 Therapeutic Relationship, Forensic Information, and Disciplinary Action (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Medical-Legal Issues: P-G-04 Therapeutic Relationship, Forensic Information, and Disciplinary Action (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Medical-Legal Issues: MH-I-03 Forensic Information (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-2C-05 Body Cavity Searches

1. PURPOSE

This policy is intended to ensure that patients have the right to make informed decisions regarding health care, including the right to refuse.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Examinations, treatments, and procedures are governed by informed consent practices applicable in the jurisdiction.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

Informed Consent – The agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about the nature, consequences, and risks of the proposed treatment, examination, or procedure; the alternatives to it; and the prognosis if the proposed action is not undertaken.

Qualified Health Care Professional (QHP) – Includes physicians, physician assistants, nurses, nurse practitioners, dentists, dental hygienists, dental assistants, MAs, CNAs, mental health

professionals, and others who by virtue of education, credentials, and experience are permitted by law to evaluate and care for patients.

Qualified Mental Health Professional (QMHP) – Includes licensed psychiatrists, licensed psychologists, licensed psychiatric social workers, licensed professional counselors, licensed psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients. QMHPs have consultation resources available from Regional Directors of Mental Health and the regional psychiatry providers.

6. PROCEDURE

6.1. For procedures, medications, or any treatment where there is some risk to the patient, informed consent is documented on a written form containing the signatures of the patient and health care staff witness.

6.2. The informed consent process includes informing the patient of the benefits, risks, and possible side effects associated with having and not having the procedure.

6.3. Informed consent is obtained and documented in the patient's health record prior to the performing of any procedures and/or treatment governed by informed consent in the jurisdiction.

6.3.1. For juveniles housed in an adult facility, the informed consent of a parent, guardian, or legal custodian applies, when required by law.

6.4. There are exceptions in which it is not necessary to obtain an informed consent. Examples of exceptions are life-threatening conditions that require immediate medical intervention for the safety of the patient, emergency care of patients who do not have the capacity to understand the information given, and certain public health matters. See *HCD-100_G-03 Emergency Psychotropic Medications*.

6.5. Any health evaluation and treatment refusal is documented and must include the following:

- Description of the nature of the service being refused
- Evidence that the patient has been made aware of any adverse consequences to health that may occur as a result of the refusal

- The signature of the patient
- The signature of a health care staff witness

6.6. A blanket refusal for treatment is not permitted. By refusing treatment at a particular time, the patient does not waive the right to subsequent health care. Patients may not be punished by exercising their right to refuse. Patients shall be informed of their right to change their decision to refuse health care and to notify a QHP or QMHP directly and/or by completing a request for health services.

6.7. During a face-to-face encounter, if the patient refuses to sign the refusal, the form will be signed by two witnesses, at least one (1) being qualified health care staff. If there is a concern regarding the patient's decision making capability, the patient will be referred to mental health for an evaluation, especially if the refusal is for critical or acute care.

6.8. In the case of medication refusals, in addition to a signed refusal form, documentation on the MAR will indicate the patient refused the medication.

6.8.1. **Scheduled Routine Medications**

If a patient misses four (4) doses in a seven (7) day period, or establishes a pattern of refusal, the patient is referred to the prescribing provider. The referral is submitted after the fourth missed dose.

6.8.2. **High-Priority Medications**

Health care staff shall make contact (must be documented) with a patient on a High-Priority Medication who does not show to medication pass in order to check patient status and obtain a refusal. Patient will be educated on the dangers of missed medication. If a patient refuses or misses a High-Priority Medication, the patient is referred to the prescribing provider for chart review and the determination of the need for a face-to-face encounter.

6.9. Patients currently receiving mental health treatment services and refusing scheduled treatment after three (3) documented refusals shall be referred to a QMHP.

6.10. Patients refusing emergent off-site Emergency Department care shall be transported immediately and not allowed to refuse transportation under any circumstances.

6.11. As clinically indicated, it is the responsibility of the educating QHP or QMHP to notify the appropriate provider regarding the patient's refusal of health care.

7. REFERENCES

HCD-100_G-03 Emergency Psychotropic Medications

NCCHC Standards for Health Services in Jails 2018

- Section: Medical-Legal Issues: J-G-05 Informed Consent and Right to Refuse (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Medical-Legal Issues: P-G-05 Informed Consent and Right to Refuse (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Medical-Legal Issues: MH-I-04 Informed Consent and Refusal of Mental Health Care (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-15 Informed Consent (M)
- 1-HC-3A-04 Informed Consent (M)

Forms

- Informed Consent
- Refusal of Clinical Services

TITLE: HCD-100_G-06 Medical and Other Research -- Mecklenburg NC	REFERENCE: 59980
	PAGE: 1 OF 2 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that biomedical, behavioral, or other research using inmates as subjects is consistent with established ethical, medical, legal, and regulatory standards for human research.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

The use of patients for medical, pharmaceutical, or cosmetic experiments is prohibited. Patients are not precluded from individual treatment based on the need for a specific medical procedure that is not generally available. Research using inmate data is not prohibited. Facilities electing to perform research will comply with state and federal guidelines. A patient's treatment with a new medical procedure by his or her own physician is undertaken only after the patient has received a full explanation of the positive and negative features of the treatment and only with informed consent.

Special procedures, including the use of a translation service, ensure that patients who have difficulty communicating understand how to access health care services. Any special procedure used shall be documented in the health record to demonstrate effective communication.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

NONE

6. PROCEDURE

6.1. All requests to participate in and/or conduct research will be forwarded to the Wellpath Legal Department for review and guidance.

6.2. When patients who are participants in a community-based research protocol are admitted to the facility, procedures provide for:

- Continuation of participation
- Consultation with community researchers so that withdrawal from the research protocol is done without harming the health of the patient

6.3. Wellpath does not endorse enrolling patients under Wellpath medical management into human research studies. Requests to enroll patients in medical research studies will not ordinarily be approved; however, any requests to enroll a patient into such a study must be approved by the Facility Administrator, Wellpath Chief Clinical Officer, Wellpath Corporate Legal Counsel, and the facility's legal department.

7. REFERENCES

NCCHC Standards for Health Services in Jails 2018

- Section: Medical-Legal Issues: J-G-06 Medical and Other Research (I)

NCCHC Standards for Health Services in Prisons 2018

- Section: Medical-Legal Issues: P-G-06 Medical and Other Research (I)

NCCHC Standards for Mental Health Services in Correctional Facilities 2015

- Section: Medical-Legal Issues: MH-I-05 Research (I)

ACA Standards / 2016 Standards Supplement

- 4-ALDF-4D-18 Research (M)
- 1-HC-3A-09 Research (M)

TITLE: HCD-100_G-07 Executions --Mecklenburg NC	REFERENCE: 59981 PAGE: 1 OF 2 VERSION:1
APPROVER: Kissel, Bill	SUPERSEDES: Not Set EFFECTIVE: 05/30/2019 REVIEWED: 05/30/2019

1. PURPOSE

This policy is intended to ensure that health care staff do not participate in inmate executions.

2. APPLICABILITY

This policy applies to health care staff and other persons providing services at the request of Wellpath.

3. POLICY

Health care staff do not participate in inmate executions.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority or designee to ensure implementation and adherence.

5. DEFINITIONS

RHA/HSA – Responsible Health Authority / Health Services Administrator

6. PROCEDURE

6.1. Executions will not be performed in the medical unit or area.

6.2. Health care staff will not assist, supervise, or contribute to the ability of another individual to directly cause the death of an inmate.

6.3. Health care staff do not participate in determinations of competency to be executed.

6.4. Health care staff will not pronounce death in the setting of an execution.

7. REFERENCES

NCCHC Standards for Health Services in Prisons 2018

- Section: Medical-Legal Issues: P-G-07 Executions (I)

1. PURPOSE

The purpose of a Patient Safety Organization (PSO) is to participate in quality and patient safety initiatives that place the needs of patients first, while affording protections to the patient safety activities and subsequent work product. Membership and participation in a PSO encourage self-critical reflection and collaborative learning in the effort of reducing harm to patients.

2. APPLICABILITY

This policy applies to the PSO workforce, defined below.

3. POLICY

Wellpath and Affiliates (Wellpath) is proactive in participating in quality and patient safety initiatives that place the needs of patients first. In order to share patient safety and quality information in a confidential and protected environment as provided by the Patient Safety and Quality Improvement Act (PSQIA) of 2005[1], this policy defines the organization's patient safety work product (PSWP) for the purpose of reporting to a federally recognized PSO, within a Patient Safety Evaluation System (PSES). The PSES is managed by the Director of Continuous Quality Improvement (CQI) on behalf of the Corporate Office CQI Committee.

4. INTERPRETATION / RESPONSIBILITY

This policy is to be interpreted by the Wellpath Chief Clinical Officer or designee, and it is the responsibility of the Responsible Health Authority to ensure implantation and adherence.

5. DEFINITIONS

Patient Safety Evaluation System (PSES) - The means for the collection, management, analysis, and communication of information for reporting to or by a PSO. The PSES may include information about events, errors, near-misses, quality improvement data, and other patient safety data and information developed by and for the PSES workgroup, and investigated, examined, and analyzed by the workgroup. Wellpath defines its PSES as information and analyses about specific patient safety events, trending, or aggregate data, discussions about the above mentioned (verbal and written, including email), both entered into Wellpath's risk management information system (DataTrkWeb (DTW)/Healthcare Advisor Series (HAS), vendor RiskQual),

and occurring outside of DTW/HAS, unless otherwise specifically deemed to be excluded from the PSES.

Patient Safety Work Product (PSWP) - Documentation that reflects the deliberations and analysis surrounding patient safety and quality improvement activities that are performed within the PSES. PSWP may be data, reports, records, memoranda, analysis, or written or oral statements involved in the development of data and information for reporting to the PSO. Wellpath defines its PSWP as [notes, reports, analyses, and meeting minutes from the Corporate Office CQI Committee and all of its sub-committees (including all meetings of the CQI work group and Patient Safety Committee); critical clinical events (see policy and applicable forms), root cause analyses, morbidity reviews (see policy and applicable forms), mortality reviews (see policy and applicable forms); peer reviews (see policy and applicable forms); daily/weekly safety huddles (white board meetings); program/process/performance improvement teams and their activities (as allowable); site/regional CQI Committees and meetings; sub-committees of the Corporate Office CQI Committee (or other committees providing analyses or opinion on behalf of the Corporate Office CQI Committee); discussions regarding specific patient events for the purpose of analysis and quality improvement (to include verbal discussions via telephone or in person, and email); or any other report placed in Wellpath's risk management information system (currently DTW/HAS, vendor RiskQual)].

- Identifiable Patient Safety Work Product: PSWP that includes identification of any provider that is a subject of the work, or any providers that participate in activities that are a subject of the work. It may also be considered identifiable because it contains patient-identification information which would invoke the HIPAA confidentiality regulations[2] or that identifies the individual who reported information in good faith.

- Non-identifiable Patient Safety Work Product: Anonymous as to provider, de-identified as to protected health information, and contextually de-identified so that the provider, patient or reporter cannot be identified.

    - The following **cannot** be PSWP:

        - The patient's medical record
        - Billing and discharge information
        - Other original patient or provider information
        - Data and reports generated for submission to external agencies to meet mandatory or voluntary reporting requirements
        - Improvements, process and policy changes, and implemented Action Plans made as a result of work within the PSES or the PSO

- Non-PSWP

  - Items that have not been reported to the PSO and are voluntarily removed from the organization's PSES by the Director, Continuous Quality Improvement.
  - Items clearly identified by policy or in writing on the documents as non-PSWP by the Director, Continuous Quality Improvement and submitted to the PSES for reporting to the PSO, or are reported through other channels to the PSO.
  - Information collected, maintained, or developed separately from the PSES
  - Deliberations and analysis performed outside of the PSES, unless it is subsequently submitted to the PSO.

- **Information that is non-PSWP, even if it resides in the PSES or has been reported to the PSO, is not protected.**

- Data and information that is designated as PSWP within the PSES cannot be voluntarily removed from the PSES and re-designated as non-PSWP once deliberations and analyses have begun about the information or events it reflects.

- PSWP is accessible only to members of the Wellpath workforce who need it to perform their job functions.

Patient Safety Activities – Efforts to improve patient safety and the quality of health care delivery, including the collection and analysis of PSWP.

Workforce – Individuals involved in patient safety activities including the Chief Clinical Officer, Patient Safety Officer, staff of the CQI Department, Associate Chief Clinical Officers, Regional Medical Directors, members of the Corporate Office CQI Committee and any sub-committees (including the Patient Safety Committee and the CQI Work Group) of the Wellpath Corporate Office and facilities operated by its affiliates, Executive staff, Regional Operations staff, Regional Behavioral Health Managers, In-house attorneys in the Risk Management division (to include outside counsel on a case-by-case basis), Health Service Administrators, Assistant Health Service Administrators, Site Medical Directors, Directors of Nursing, Mental Health Coordinators/Directors, Risk Managers, Performance Improvement (PI) and Compliance staff, CQI/PI nurses/staff, those staff that may be requested to provide administrative assistance to the Clinical Division on an as needed basis, members of site CQI Committees (including ad hoc members requested to perform patient safety activities on an as needed basis), contractors for patient safety activities on an as needed basis, Wellpath's government client representatives (upon appropriate training and signing of the confidentiality agreement). Information about patient

safety events is reported to the members of the workforce as necessary to meet the expectations for the risk management, quality and safety activities defined by Wellpath.

- Workforce members shall sign a confidentiality agreement specific to PSWP.

PSES Workgroup – Wellpath defines the PSES workgroup as the Corporate Office CQI Committee, CQI Work Group, Patient Safety Committee, site CQI Committees, Performance Improvement teams, and safety huddles/white board teams who routinely perform patient safety and quality analysis and improvement work. Other individuals with special subject matter expertise such as attorneys or liability insurance representatives, may be called upon as deemed necessary by the Director of CQI, or in-house attorney for work on specific events or issues.

- PSES workgroup members shall sign a confidentiality agreement specific to PSWP.

6. PROCEDURE

6.1. SUBMISSION OF INFORMATION TO THE PSES:

Information collected for submission to the PSES is considered to be PSWP at the time it is collected or developed, unless specifically designated as non-PSWP by a member of the CQI Work Group. The data/information is submitted to the PSES as part of the PSO reporting process.

- All clinical Critical Clinical Events (unless specifically made non-PSWP by a member of the CQI Work Group), including those with root case analyses and/or Mental Health Event Reviews, Mortality Reviews, Peer Reviews, CQI Meeting minutes (and sub-committee meetings), CQI Studies, and other patient safety and CQI analyses and trending reports and ad hoc reports, analyses, and trending reports will be submitted to the PSO as PSWP.

- To add activities or work product that is not yet routine to the PSES or to dub activities and/or analyses as Patient Safety Work Product (PSWP), the Corporate Office CQI Committee will review the request and sanction the activity. Between meetings of the Corporate Office CQI Committee, the CQI Director, or another member of the CQI Work Group will present the activity for discussion and consideration by the CQI Work Group. If this is approved, the owner of the activity will be notified and will be instructed on submission requirements, language to label the work product as PSWP, and how to store the activity to promote security.

- Non-PSWP submitted to the PSO must be identified as such and is not protected under the PSQIA[1].

6.2. ACCESS TO INFORMATION WITHIN THE PSES

Identifiable PSWP is accessible only to members of the organization's workforce as needed to perform their job functions.

- Access to electronic PSWP that has been entered or uploaded into the PSO data system will be made available through secure and unique user IDs and passwords.
- Access to other electronic files containing PSWP will be limited by using a designated username and password-protected data system or folder on the designated server.
- Paper PSWP documents will be stored in the offices of the CQI Department in a locked storage file, and is only accessible by a member of the CQI Department, Patient Safety Officer, or Chief Clinical Officer.
- Requests for access to the PSWP and information held within the PSES are determined by the Director of CQI.

6.3. CONFIDENTIALITY AND PROTECTION OF PSWP

Wellpath considers all data and information collected as PSWP to be confidential and protected under the PSQIA[1].

- Individuals defined as workforce members within the PSES will maintain the confidentiality of PSWP.
- Prior to access, individuals must sign a confidentiality agreement pertaining to PSWP and will periodically receive training regarding PSWP confidentiality protections.
- The terms of the applicable confidentiality agreements signed by the workforce will survive after the completion or termination of their relationship with the organization.

6.4. MAINTENANCE OF PSWP WITHIN THE PSES

PSWP will be maintained in designated locations that allow for appropriate confidentiality and security, such as locked file cabinets; and/or secure electronic files and folders, or components of other software programs dealing with risk management, quality and safety, such as incident reporting systems, which are located separately from non-PSWP or otherwise designated as

PSWP. PSWP may also be maintained within the data system provided to the organization by its contracted PSO and designated as a component of Wellpath's PSES.

- The Director of CQI is responsible for maintaining member access privileges to PSWP.

6.5. SUBMISSION OF PSWP TO THE PSO

The Director of CQI or designee will review information contained within the PSES and determine what will be submitted to the PSO. Data and information submitted to the PSO, unless designated as non-PSWP before submission, must be treated as confidential PSWP.

Disclosures: Identifiable PSWP shall not be disclosed except as permitted by the PSQIA[1]. Any disclosure will be managed by the Director of CQI or designee.

Breach of Confidentiality: In the event of an unauthorized disclosure or breach:

- Wellpath will make a good faith effort to notify the parties affected, including each provider identified within the disclosed PSWP, and any patient whose protected health information was disclosed or released through a security breach.
- An investigation will be undertaken by the PSES Workgroup and legal counsel as soon as is possible.
- A notification of the inappropriate disclosure or breach will be made in writing and distributed to affected parties.
- If the PSWP was submitted to the PSO, Wellpath will report the breach or disclosure to the PSO's Executive Director**.**

7. REFERENCES

[1]Patient Safety and Quality Improvement Act of 2005 (PSQIA): (available at http://www.pso.ahrq.gov/statute/pl109-41.pdf) and the Final Regulation, 42 CFR Part 3 (available at http://www.pso.ahrq.gov/rulemaking/nprmtxt01.pdf)

[2] HIPAA **-** Regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 as amended by the American Recovery and Reinvestment Act of 2009, Title XII "Heath Information Technology for Economic and Clinical Health Act".