Health and Sanitation

GRAPH IN THE SERIES

GUIDELINES

GUIDELINES FOR THE ESTABLISHMENT AND OPERATION OF LOCAL DETENTION FACILITIES

STATE OF CALIFORNIA • BOARD OF CORRECTIONS • 1980

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BOARD OF CORRECTIONS

HEALTH AND SANITATION

A Monograph in the series

GUIDELINES FOR THE ESTABLISHMENT AND OPERATION OF LOCAL DETENTION FACILITIES

JULY 1980

STATE OF CALIFORNIA

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Acknowledgment

The Board of Corrections is indebted to the many administrators, managers, and employees of health agencies and local detention facilities in the state who shared with us their problems, solutions, ideas and insights for this publication. It is the hope of this Board that the task of local detention facility and health managers will be made easier by this document.

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INTRODUCTION

The 1980 Minimum Standards for Local Detention Facilities mark the first time there have been comprehensive medical and sanitation standards for California jails. There will be variations in how these standards are seen and implemented, especially since local flexibility was important in the development of the standards and is equally important in the guidelines that follow. These guidelines offer explanations of the standards, suggestions for implementation, and options as to how one might implement. There are many ways to set the standards into motion, many "right" ways to comply. These guidelines offer suggestions from professionals in jail medicine and sanitation as to what jail administrators might do or at least might consider in implementing standards; they are neither mandatory nor limiting nor do they cover every possible contingency. They are intended to assist administrators and others in understanding and feeling comfortable with the standards and applying them to the needs of their particular detention systems.

It is recommended that each sheriff and/or jail administrator check with the medical society or health organization in his/her jurisdiction and continue to be in touch with medical professional associations, the local health department, and interested practitioners in the community for assistance and support to aid the administrator's efforts to provide health care to those in custody consistent with that provided in the community at large. Providing such care is not 'coddling prisoners'; it is meeting the Constitutional protections which are an integral part of any enlightened detention system. An ongoing relationship with outside medical professionals will increase understanding of that fact as well as enhance the provision of services in the facility.

Throughout the standards there is the requirement that "written plans and procedures" be developed. While it may be burdensome to have to write out the procedures and policies which are—or will become—every day realities in your facility, doing so provides some very real benefits; written procedures are good management tools, good training implements, good documentation for budget requests, good support in cases of litigation, and good indicators for inspection teams as they come through your facility. Written policy and procedures afford clarity and consistency of practice and will save time, money, confusion, and perhaps lives in the long run. Of course, well written procedures which are not adhered to will neither improve the health of the inmates in a facility's charge nor protect the facility from damaging lawsuits. Practice must be in accord with procedures.

California's medical standards parallel in part those of the American Medical Association; however, they are not identical and adherence to California standards will not automatically make your facilities eligible for A.M.A. certification.[1] Among the differences between our standards and the A.M.A.'s is that we have no specific standard for medical orientation nor for medical grievance. These concepts are covered in the new jail standards, outside of the medical section. Article 3, Section 1033, Inmate Grievance Procedures, and Article 6, Section 1069, Inmate Orientation, both refer to medical services specifically.[2] As regards

[1] For information regarding A.M.A. certification, contact the California Medical Association's San Francisco office.
[2] Please see Program and Procedures Guidelines to these sections for further discussion.

medical care, it is the intent of these sections that inmates be as fully informed as possible about the medical services available to them in each facility and that they understand they may air and resolve grievances relating to medical issues through the same process used for any other grievance.[3]

While there is no specific standard requiring preventive care, it is assumed that every effort will be made to offer a holistic approach to the health and well being of inmates. Sanitary living conditions, proper food and exercise, and, where possible, education in matters relating to health maintenance will be provided. Professional and volunteer groups and agencies will be able to provide you with printed material if you so desire or send volunteers to the jail to conduct or participate in classes and/or group meetings with inmates. Women's self-help groups can provide a valuable resource to women's jails, and Community Resource Directories, published in most counties, will indicate a variety of other sources of information and assistance which managers are encouraged to incorporate into the total jail health care delivery system.

The guidelines which follow are not light reading. The material covered is so specific, so detailed and so potentially sensitive that it has had to be carefully worded and refined for clarity. It is hoped that the information conveyed will be helpful enough to overcome the dry tone and style. If there are areas of concern to you which the guidelines do not address, please remember that the staff of the Board of Corrections is available to assist you in whatever ways it can, and many of the resources mentioned in this document can also be of assistance.

[3] Please see Appendix I for a sample Medical Grievance Procedure.

ARTICLE 10 MEDICAL SERVICES

1200. RESPONSIBILITY FOR HEALTH CARE SERVICES.

In Type I, Type II, and Type III facilities, the facility administrator shall have the responsibility to ensure provision of emergency and basic health care services to all prisoners.

Each facility shall have at least one physician available to treat physical disorders.

Security regulations applicable to facility personnel also apply to medical personnel.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

In every jail, from Temporary Holding through Community Release facilities, there should be a basic plan—written and accessible to staff—for the provision of emergency health care services. What should staff do if someone suddenly has a seizure or falls and is seriously injured? What is the fastest way to reach a doctor? What hospital is nearby and who transports? The plan will answer these basic questions and direct staff to the jail's approved emergency measures.

All Type I, II, and III facilities are expected to provide both emergency and basic health care to inmates and it is the facility administrator's responsibility to insure that a health care plan is developed. It is advisable for the administrator to work in conjunction with the local health department and local medical society in developing the plan and to determine the most efficient mode of providing care for the jail and jurisdiction.

Ways to Provide Care

The administrator may determine that all care will be arranged by transporting inmates to doctors' offices or hospitals, that only emergency care will be provided by transporting and basic care will be handled in the facility, that all care will be handled in the facility, or that only emergency care will be done in-house and all else will require transport to medical services. The facility administrator, in conjunction with the funding authority, may decide to hire medical personnel to work in the jail as employees of the department. He or she may decide to contract with the local hospital, a private doctor, a medical group, a health maintenance organization, or a medical center. The decision may be to develop a written program or agreement with the county Health Department or Health Officer to provide jail health care. A regional agreement may be worked out among several small counties to provide "roving" doctors and support personnel. The options are numerous, and combinations of options are also possible. It is imperative, however, that whatever arrangement is decided upon be set down in writing and there be a contract, program or inter-agency agreement developed. Having such a document leads to clarity of responsibility and serves as support for contentions which may be raised in a court of law.

Health Authority

Regardless of the service delivery mode chosen, there should be one individual responsible for overseeing, planning, coordinating, developing, and/or implementing health care delivery to the jail or jails, in conjunction with the facility administrator(s). The county Health Officer, a nurse, a facility physician, a private physician, or some other health professional can be named HEALTH AUTHORITY.[4] There will be a written agreement between the facility's funding source and that individual spelling out the areas of responsibility of the health authority in the jail or jails. If the health authority is not a physician, there will also be a 'responsible physician' available to the facility to make those decisions which the law permits only a physician to make.

"Physician Available" Defined

While Section 1200 says that each facility shall have at least one physician available to treat physical disorders, it does not mean that the physician must be on the premises at all times. "Available" shall be understood as accessable and may mean that the doctor is located at a hospital to which the facility transports, or down the street, or an hour away but able to get to the jail upon request. Each health authority will, in the medical procedures manual, define the parameters of health care consistent with availability of resources in the local community,[5] so that "availability" of health care in the jail will be comparable to "availability" in the community.

Relationship of Custody and Medical Personnel

"The provision of care, although delegated to medical people, is a joint effort and can be achieved only with mutual trust and cooperation. . . . The responsible physician arranges for the availability of medical services; the official responsible for the facility provides the administrative support that ensures accessibility of medical services to the inmates."[6] Cooperation between medical and custodial staff is essential to the smooth operation of the jail and to optimum provision of service. While medical staff shall have sole authority for medical treatment, they will perform only those procedures which are necessary to the health and welfare of the inmate during the period of confinement.

Security regulations shall apply to medical personnel as to anyone else in the facility. Custody staff will cooperate with medical staff in any and all ways requested and deemed appropriate, and medical staff will do likewise with the requests and requirements of custody.[7] The medical policy and procedure manual may address the issue of conflicts between custody and medical staff; policy and procedure should be developed to resolve disagreements.

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[4] "Health Authority" is synonymous with health administrator, medical authority, medical administrator, and medical director; the terms are used interchangeably to mean the person in charge of health care services in a facility or system.

[5] "Local community" means the area or environs, county or city in which the jail is located, not the inmate community as it is sometimes interpreted.

[6] American Medical Association, *Standards for the Accreditation of Health Care and Health Services in Jails,* Section 1002.

[7] All medical personnel are subject to review by regulatory bodies, licensing boards, and professional associations. See Appendix 2 for a comprehensive listing of these. In cases of dispute, these agencies are available to both medical and custodial staffs.

1201. HEALTH CARE SERVICES—TYPE IV FACILITIES.

In Type IV facilities, where routine medical services are provided by access into the community, there shall be a written plan for the treatment, transfer, or referral of emergencies. Type IV facilities are excluded from all the following provisions of this article.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Type IV are Community Release Program facilities, and it is intended that inmates of these facilities receive services in the community rather than have them duplicated in-house. Medical care is one of the services which inmates can obtain in the community, from private or public sources.

The requirement for Type IV facilities is that they have a written plan for the "treatment, transfer, or referral of emergencies." Such a plan would describe the elements necessary to enable staff to move quickly and appropriately in a medical emergency and might include: the location of the nearest hospital, the names and telephone numbers of doctors who could advise staff, department policy about emergency transportation, instructions relative to notifying inmates' families or employers, etc. Staff must be aware of and familiar with the plan, and it should be updated from time to time as circumstances change. Local health officers, Red Cross directors, physicians, and/or medical professional associations may be of assistance to the facility administrator in developing the plan and should be contacted for input.

In addition to emergency care, most Type IV facilities will provide some elements of routine care such as pill call and/or convalescence from short term illnesses. These too shall be set out in the plan even though they are not technically emergency care. The point is for the plan to reflect the policies and practices of the facility in medical matters.[8]

If a Type IV facility provides *all* medical care in-house and *does not release* inmates to get care in the community, it is patterning itself after a Type III facility as regards medical services, and thus must meet all medical standards in Article 10 of the Minimum Standards. The exclusion of Type IV facilities from medical standards except the health plan applies only where all or most medical care is achieved by access into the community.

1202. MEDICAL SERVICE AUDITS.

The responsible physician or county health officer shall develop a plan for regularly scheduled audits and correction of identified deficiencies of the medical services delivered.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Medical delivery systems in jails must have a way to monitor their effectiveness and to assure consistent quality of services. There shall be a written plan for quality assurance through medical process audits. Such audits are intended to identify important and/or potential problems in the provision of medical care; mechanisms for assuring accountability of health care staffs for the care they provide, and strategies for eliminating, reducing or correcting identified deficiencies. On-going audits are good clinical and management tools, and at the least there should be one comprehensive audit annually.

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[8] Please see Guidelines for Community Release Program Facilities for further discussion.

Medical personnel will know how to do process audits and should be expected to perform them or ask the medical society to perform them as required by the Minimum Jail Standards and by medical quality review standards for their professions. Facility administrators will cooperate in the development of the plan for audits.

In jails as in other settings in which medical audits are performed, a variety of sources may be used to identify health care delivery problems; however, the main source will probably be the medical record. Other possible means of generating audit information include:

a. studying outbreaks of illnesses such as diarrhea, flu, etc. (morbidity review)
b. studying deaths in custody [9] (mortality review)
c. individual case review
d. review of particular medications, i.e., antibiotics, psychotropics, etc.
e. monitoring activities of clinical staff, i.e., review of use of restraints, seclusion, hazardous procedures, etc.
f. review of similar diagnoses, i.e., all diabetics
g. liability claims review
h. data obtained from staff interview and observation of inmate medical services.

Once an actual or potential problem is identified, it should be assessed in terms of criteria acceptable to the clinical staff involved. When applied to actual practice, changes should result in improved medical care and clinical performance. Persons responsible for implementation of actions designed to eliminate or reduce problems should be identified. Some of the kinds of actions which might be taken to eliminate or reduce the significant problems identified include but are not limited to:

education/training programs
new or revised policies and/or procedures
staffing changes
adjustments in staff assignments.

The purpose of the audit is to insure optimum service delivery. The timely correction of identified deficiencies will help the jail to continue providing the level of care it intends. Documented efforts to correct problems will be valuable if the jail is ever involved in litigation relating to medical care.

Inspections

In addition to the audits performed regularly within the facility, there are also inspections pursuant to Penal Code Section 6031.[10] Local health departments inspect for compliance with medical and sanitation standards, Articles 10–14 of the Minimum Standards.[11]

If your local health department is the provider of health care to your jail or detention system, it may be advisable to have the medical authority attempt to find alternative methods of inspection. One possibility may be to arrange with

[9] See pages 29–30, these guidelines, about deaths in custody.
[10] Minimum Standards, Article 2, Section 1014.
[11] Health and Safety Code Section 459 mandates health department inspection at least annually and health inspectors use Board of Corrections' Standards as their criteria.

the health officer of another county for inspection of your health care delivery. Perhaps this could be accomplished by an inter-county agreement involving an exchange of services between health departments. Such an arrangement will remove the conflict of interest generated by a health department's having to inspect and evaluate its own operation. The California Conference of Local Health Officers may be a resource in helping a county develop such an arrangement.

1203. HEALTH CARE STAFF QUALIFICATIONS.

State and/or local licensure and/or certification requirements and restrictions apply to health care personnel working in the facility the same as to those working in the community; copies of licensing and/or certification credentials shall be on file in the facility.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Since one goal of jail medical care is to be consistent with standards of care in the community, it follows that the qualifications of health care providers in jails should be the same as those of providers in the community. The same licensure and/or certification requirements must pertain, and the facility administrator and/or health authority must be certain that medical personnel working in the facility:

1. have valid California licenses or are certified to provide care;
2. are working within the scope of practice described by their particular license or certificate; and
3. are keeping their licenses and/or certificates current.

There should be a written procedure whereby the health authority verifies the validity of licenses and certificates. (The standard requires that copies be kept on file in the facility; however, it is illegal to copy medical licenses so please, until the standard can be changed, disregard that requirement and keep on file instead the administrator's verification of validity.)

Those medical and/or allied health personnel which California licenses through the Department of Consumer Affairs include but are not limited to:

physicians
surgeons
dentists
dental technicians
dental hygienists
registered nurses
certified nurse midwives
vocational nurses
physicians' assistants
medical assistants
psychiatric technicians
clinical psychologists
psychology assistants

There are categories called 'nurse practitioner' and public health nurse which are not specifically licensed[12] but the members of which are registered nurses; health authorities can request copies of educational certificates, including course content, to verify scope of practice. Additionally there is a State Department of Health certificate for emergency medical technicians, also known as paramedics.[13]

If there is an x-ray unit within the correctional facility, persons taking the x-rays

[12] but are certified by accredited nursing programs.
[13] See Appendix 2 for a full list of licensed/certified personnel.

should be certified to do so, and people who operate the x-ray equipment should wear film badges which are monitored. The x-ray equipment should be registered with the state, and there must be a certified x-ray supervisor (MD) for the x-ray equipment. All x-rays should be read by a radiologist.

Some paramedical or allied health personnel categories are not licensed or certified, and employers shall take every care to guarantee that members of such categories do not practice medicine or perform duties for which they are not legally qualified. The liability to the jail and its administrators which could arise from using unqualified or unlicensed personnel or allowing staff to work beyond the scope of their licenses greatly exceeds any cost savings which might be generated.

The State Department of Consumer Affairs is able to assist administrators in determining scope of practice for the various licensure and certification categories, as well as being able to tell you what categories are and are not licensed and which groups can practice under protocols and/or standing orders from a responsible physician.[14] The Department's legal staff can provide assistance in clarifying the complex and sometimes baffling issues surrounding appropriate use of allied health personnel. You can contact the Department of Consumer Affairs at 1020 N Street, Sacramento, 95814, 916-445-1591.

1204. HEALTH CARE STAFF PROCEDURE.

Medical care performed by personnel other than a physician is performed pursuant to written protocol or order.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Whenever the responsible physician determines that a clinical function or service can be safely delegated to health care staff other than a physician, it must be performed pursuant to a written protocol or medical order. Protocols or orders are written by the responsible physician to non-physician medical care providers for the definitive treatment of identified minor, self-limiting conditions and for on site treatment of emergency conditions.

Director orders are those from a physician to qualified medical personnel, allied health personnel or medically trained corrections staff that instruct them to carry out a specific treatment, test or medical procedure on a given patient. *Protocol* refers to the rule and/or procedure to be followed in the performance of a clinical function. Whenever the facility physician determines that a clinical function can safely be delegated to staff other than a physician, it will be performed pursuant to a protocol which shall:

a. be in writing, dated and signed by the physician in charge. Where there is a medical administrator and/or a nursing administrator, these persons should also sign the protocol;
b. specify and outline the procedure to be performed;
c. establish the required training for personnel initiating the protocol;
d. establish the method for evaluating continued competence of persons authorized to perform function(s);

[14] See or ask Consumer Affairs to supply you with copies of the various scope of practice legislations such as the Nurse Practice Act, the Licensed Vocational Nurse Practice Act, etc.

e. state the limitations on conditions/settings in which protocols may be performed;
f. be reviewed and updated at least annually.

Because most jails will not have a physician on duty in the facility 24 hours a day, seven days a week, protocols and direct orders will be a crucial part of medical service delivery. Every effort should be made to insure that practice and procedure are consistent with accepted medical professional standards and that scope of practice is adequately considered.

1205. MEDICAL RECORDS.

(a) The health administrator/physician or facility administrator shall maintain individual, complete dated health records which shall include, but not be limited to:
(1) pre-screening/history;
(2) medical evaluation report;
(3) complaints of illness or injury;
(4) names of personnel who treat, prescribe, and/or issue medication; and,
(5) location where treated.

(b) The physician-patient confidentiality privilege applies to the medical/psychiatric record. Access to the medical/psychiatric record is controlled by the responsible physician or the medical administrator.

The responsible physician shall insure the confidentiality of each prisoner's medical record file and such file shall be maintained separately from and in no way be part of the prisoner's other jail records. The responsible physician or medical staff designated by him/her shall communicate information obtained in the course of medical screening and care to jail authorities when necessary for the protection of the welfare of the prisoner, of other prisoners, management of the jail, or maintenance of jail security and order.

(c) Written authorization by the inmate is necessary for transfer of medical/psychiatric record information unless otherwise provided by law or administrative regulations having the force and effect of law.

(d) Prisoners shall not be used for medical recordkeeping.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

An important part of a facility's health care delivery system is medical record keeping. The necessity of keeping complete, accurate, dated medical/psychiatric records cannot be overstated; the clarity and completeness of medical records will not only enhance efficient service delivery, but will also provide documentation in the event of litigation or inmate complaints relative to medical care. Log books and individual medical/psychiatric records shall be kept in an organized format and may be patterned after those used by the county or local hospital, especially if personnel from the hospital are going to use those records on a regular basis.

It is recommended that medical information be kept for every inmate who is assigned to a housing area. An individual medical record shall be opened for

each inmate who has positive medical findings revealed by the pre-screening or who has contact with the medical service for anything beyond minor, one-time matters. [15] The medical record shall contain all information relative to the inmate —the pre-screening; a medical evaluation report when an evaluation or physical has taken place, sick call, prescription medications, and all significant or repetitive contacts with medical services.

Even when inmates receive medical care at an outside provider's location, the facility should maintain records. You will want to record the inmate's complaint, the means and manner by which, and the location at which that complaint was treated. The doctor or hospital treating an inmate outside the jail will open a record and send a summary sheet back to the jail. The facility will either file that summary sheet, use it to open a medical record in-house, or note the diagnosis and treatment in a medical log.

There must be a record that prescription doses of medications have been administered, by whom, where, and if not why not. This information shall become part of the individual's medical record. The facility administrator and the health authority shall develop a policy regarding how information shall be shared between medical and custody staffs, particularly about medications. In many instances, failure or refusal of an inmate to take prescription medication will result in aberrant behavior and the medical/psychiatric staff's alerting custody to that possibility in advance may well prevent an incident from occurring.

All medical/psychiatric records are under the control of the health authority and shall be kept separate from other detention records. Inactive medical records must be kept for seven (7) years and medical records for juveniles must be kept for seven years after the juvenile reaches age 18. The health authority shall develop written policies defining who has access to medical records and under what conditions, such as those described above, information necessary for the protection of the welfare of prisoners, staff or the facility will be shared with non-medical personnel. Given cooperation between medical, mental health and custodial staff, the sharing of information will be carried out with due regard for both patient confidentiality and facility safety and security. At no time will inmates be used for medical records keeping nor will inmates have access to other inmates' records.

Medical Information Summary Form

It would be beneficial if all facilities in the state were to implement a medical information summary form for inmates being transferred from one facility to another or one system to another who are taking prescription medications, who have pending medical appointments or who have important medical conditions. Such a summary, arriving with the new inmate, will alert the receiving facility to any emergency or urgent medical needs of transferred inmates, thereby saving time and money, eliminating repetition of procedures and improving continuity of care. A proposed standard summary form is attached as Appendix 3.

[15] The pre-screening form may be kept in the inmate's booking jacket if there are no positive medical findings and a medical record is not being opened for that individual. If later the inmate has contact with medical service and a record is opened, the pre-screening form is then placed in the medical record.

1206. MEDICAL PROCEDURES MANUAL.

Every facility health administrator/physician shall, in cooperation with the facility administrator, set forth in writing policy and procedures which include but are not limited to:

(a) summoning and application of proper medical aid;
(b) contact and consultation with private physicians;
(c) emergency and non-emergency medical and dental services, including transportation;
(d) provision for medically required dental and medical prostheses and eyeglasses;
(e) notification of next of kin or legal guardian in case of serious illness;
(f) provision for care of pregnant women;
(g) screening, referral and care of mentally ill and retarded inmates;
(h) implementation of special medical programs;
(i) pharmaceuticals and a protocol for over-the-counter (non-prescription) medication; and
(j) use of non-physician personnel.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Facilities must have a medical policy and procedures manual which will most likely be separate from the general facility manual and which should be developed by the health authority and/or responsible physician working in cooperation with the facility administrator. The facility administrator is not expected to set policy regarding actual medical care delivery, but rather to insure that the policies of the health care system reflect and complement the general policies and procedures of the facility.

As with all policies, medical policies define both the actual delivery of service and the level of legal responsibility a facilty has; thus, every care must be taken to be realistic and explicit about what your policies are as exemplified by your practices. In other words, be sure your policies say what you do and that you do what your policies say. To have policies in your medical manual which are not followed is to invite legal liability.

Your manual should include policy and procedures for each aspect of medical service in your particular jail. The key to writing policies and procedures is that you identify how you perform a certain procedure and that the medical authority can support and justify that. Policy and procedures should be reviewed and updated at least annually by the health authority and the facility administrator, and it is advisable for each of these individuals to sign and date each policy and procedure each time it is reviewed and/or revised to assure that they are current and to document the review process.

Putting policies and procedures into written form is a valuable process and clarifies a good deal of what is and can be expected of jail health care systems. There should be policy and procedure not only for those areas set out in Section 1206, but also for those described in the other medical standards. For instance, you should have a policy on performing medical audits, their frequency, who will perform them and who is responsible for correcting identified deficiencies

(Section 1202). You will have procedures regarding the use of medical protocols (1204), use of the safety cell (1055), vermin control (1212), and so forth.[16]

By way of an example of one of the policies you will need to develop, consider the following on informed consent, taken from the American Medical Association's sample Medical Policy and Procedures Manual[17]:

> Despite incarceration, jail inmates retain the legal right to accept or refuse medical examinations and medical treatment.
>
> In the interest of protecting everyone involved, the policy of the XX County Jail is that all prisoners receiving medical examinations or medical treatment will sign the appropriate informed consent form.
>
> Additionally, inmates refusing medical treatment will sign the appropriate form.
>
> In the case of minors, consent of the parent, guardian, or legal custodian applies.[18]

As another example, facilities will have to develop policy regarding contact and consultation with private physicians. Are they allowed in your facility? If they are not, are inmates taken out to see private doctors? Is a court order required? Do you provide transport or must the inmate arrange his/her own? If you neither permit private doctors in nor take inmates out, state why and be able to justify your position.

Communicable Disease

For a number of reasons, jail populations tend to be more disease prone than the population at large, and among persons confined may be carriers of contagious disease. These commonly include tuberculosis, veneral disease, infectious hepatitis, and others. Such diseases endanger the health of other prisoners and the facility staff, thus all persons exhibiting symptoms of or suspected to be carrying these or other diseases must be examined by a physician as soon as possible. Once a positive determination has been made, the carrier must immediately be quarantined, segregated, and placed under medical care.[19]

Because you don't want contagious diseases spread through your facility, you will want to take every care to insure that people are carefully screened before they are housed or allowed to mingle with the general population. This identification is part of the purpose of the pre-screening called for in Section 1207, which is administered at booking (or prebooking in some systems) in order to give you an initial indication as to who might be carrying a disease who should be referred immediately to medical service and housed separately from the rest of the population.

Additionally, custody staff will be on the look out for and will refer any inmate who, after the time of booking and pre-screening, appears to be ill or to have

[16] Additionally you may have policies and procedures on matters not covered in standards, related to standards or important for to your facility only. Such issues as methadone maintenance, use of inmate food service workers, insuring currency of licenses of medical, personnel, etc., should be included in your manual if they are pertinent to your facility.

[17] This manual and others are available through the American Medical Association Corrections Program, 535 Dearborn Ave., Chicago, Illinois 60610. Several California jurisdictions and the Board of Corrections can provide samples of medical manuals; however other facilities' procedures may not work for you and you will want to modify or create policies and procedures to truly fit your practices and needs.

[18] For further discussion of informed consent, please see pages 25–26, Section 1214.

[19] See Section 1051 regarding segregation of these inmates and Sections 1207 and 1208 regarding prescreening.

the symptoms of any contagious disease. In all cases of suspected communicable disease, the medical advice of a physician should be obtained. Certain cases must be reported promptly and fully to the State Department of Health, pursuant to Title 17, Section 2500, of the California Administrative Code.

The medical manual should include procedures not only for the identification and treatment of communicable disease but also for review of inmates' conditions so that people who have recovered sufficiently can be returned to general housing when medical segregation or separation is no longer necessary. Procedures should also reflect that, when inmates are found to have communicable diseases, stringent sanitary conditions are imposed so that infected inmates observe careful personal hygiene habits and other people, inmates and staff, who come in contact with these infected inmates take care to wash their hands after contact. Clothing, bedding and linen of inmates with contagious diseases should be carefully separated from other institutional laundry and stored in sealed plastic bags until they are washed; laundry personnel should also observe careful personal hygiene when handling these items.[20]

If it ever occurs that disease in or near the jail endangers the health of inmates and staff, as certified by the responsible physician, a county judge may order the temporary removal of inmates to another place of confinement. Such a move is authorized by Section 4012 of the Penal Code.

Pregnancy and Related Issues

All facilities which house female inmates will have policy and procedures relating to the special medical needs of females. There will be policy defining inmates' access to gynecological/obstetric services, whether inmates are taken out of the facility or these specialists come into the facility. There shall be proper obstetric and gynecological equipment in the examination room of women's jails and other facilities where women are treated.[21] There shall be policy regarding the continuation of female inmates, in particular those who are to be confined for a relatively short time, on their medically prescribed oral contraceptives. These require a regular dosage to be effective and disruption of dosage during confinement can create problems after release. There shall be a procedure to provide the family planning information required by PC 4023.5 for "each and every female confined in any local detention facility." This information and other health and hygiene maintenance assistance are some of the services women's medical self-help groups and clinics can provide female inmates.

The availability of pregnancy testing, pursuant to PC 4023.6, should be discussed in the policy manual, and there must be a procedure for the pre-natal care of pregnant women, including special diets where such are necessary. The American Medical Association sample policy on this issue states:

> Any inmate being diagnosed as pregnant prior to or during incarceration, will be given comprehensive counseling and assistance. An individual treatment plan with respect for her desires in planning for her unborn child, will be developed and implemented including either abortion, adoption service,

[20] See pg. 40 of these guidelines (re: Section 1262) for a discussion of facility laundries, and see Sections 1262 and 1271 re: clothing and bedding exchange.

[21] See Section 1121(c) for physical plant requirements. Also see Penal Code Section 4028 and take special notice that "the rights provided for females by this section shall be posted in at least one conspicuous place to which all female prisoners have access."

or keeping the child.[22]

Appropriate resources, located by the health authority, should be identified for abortion and/or adoption services and the policy relative to abortion should include:

1) information on locations where abortions are performed,
2) evaluation of inmate's ability to pay for desired pregnancy termination,
3) sources of assistance for indigent inmates, and
4) a mechanism for transportation to and from the abortion clinic or hospital.

The availability of Medi-Cal funding for inmates may increase the likelihood that women in jail are not sentenced to have a baby they neither want nor can appropriately care for.

The mental health service as well as custody staff should be aware of the understandable concerns of inmate mothers who are separated by jail confinement from their families. The psychological problems and anxieties associated with worrying about children at home can be severe and some counseling and/or support service by volunteers or social service agencies may be required in addition to regular mental health services.

1207. PRE-SCREENING.

According to procedures established by the responsible physician and the facility administrator, a pre-screen is performed on all inmates prior to housing in a living area. The pre-screening shall be performed by a medically licensed person or trained non-medical staff per the written order of the physician responsible for health care at the facility.

There shall be a written plan to provide medical care for any inmate who appears at pre-screening to be in need of medical treatment or who requests medical treatment.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

A pre-screening medical checklist (receiving history) shall be administered to each inmate during the intake process, before the inmate is placed in any living area. The pre-screening medical checklist should be administered by a medically licensed person, such as a physician, registered nurse, certified physician's assistant, nurse practitioner, or licensed vocational nurse. Facilities lacking medically licensed personnel may use non-medical staff per the written order of the physician responsible for the health care of the facility; however, these personnel must be trained in the use of the screening form by a qualified physician, registered nurse, nurse practitioner or certified physician's assistant. The training should familiarize personnel with the screening form, the observations the screener is required to make, and other information deemed important for lay personnel to be aware of.

There should be a written plan, approved by the facility physician, for follow-up of positive responses to the pre-screening history. The plan should insure that a significant positive response is cause for the inmate to be referred to the medical service and a medical record to be opened for the inmate.[23]

[22] AMA sample Medical Policy and Procedures Manual, Section 3.23—156.
[23] See pages 8–10 for discussion of medical records.

Every effort shall be made to insure privacy for pre-screening. The pre-screen check list should be administered with auditory privacy, preferably in a private location.

The pre-screen should contain at a minimum the following questions and observations to be recorded on a form approved by the health authority:

QUESTION:

1. Are you currently under the care of a doctor for medical or psychiatric reasons?
2. Are you taking pills or other medications? If yes, what medications.
3. Do you have any illness or injury such as diabetes, heart disease, seizures (epilepsy), high blood pressure, tuberculosis, hepatitis, syphillis, gonorrhea, or other contagious disease?
4. Do you regularly use drugs such as alcohol, heroin, methadone, uppers or downers?
5. Have you ever attempted suicide? Are you thinking about suicide now?
6. Women: Are you pregnant or have you delivered a baby in the last 6 weeks?

OBSERVATIONS:

1. Does the prisoner appear to be sick or injured, suggesting the need for immediate medical attention?
2. Does the prisoner show any bizarre behavior suggesting the need for immediate medical/psychological evaluation, such as the risk of suicide or assault on the staff or other prisoners?
3. Does the prisoner appear to be so under the influence of drugs or alcohol to require immediate attention? Is the prisoner awake, alert, and responsive to questions?
4. Does the prisoner appear to be infested with lice or other vermin?

The person administering the pre-screen checklist shall record all responses on the approved form and follow the written plan for referring prisoners with significant positive responses for immediate medical evaluation.[24]

When a juvenile is brought into the jail, information should be obtained as to whether the minor is emancipated or living with parents or guardian or in a foster home. This information should be in the medical chart or easily accessible to the medical staff in the event that consents are needed. It may prove worthwhile to call parents, guardian or foster parents for additional medical information, as many times the minor may not be aware of his/her medical condition, doctor or medication currently being taken. Inquiries into the immunization status of the minor should be made. Also, particular attention should be paid to signs of trauma, and all institutional staff are reminded of their responsibility for reporting suspected abuse.

While the facility may or may not perform health appraisals (physical examinations) on all inmates,[25] written policy should define that a health appraisal is completed, within seven (7) days after arrival at the facility, for each juvenile.

[24] Please see appendix #4 for a potentially useful chart of visual observations to accompany the pre-screen check list.
[25] The AMA standards require that adults have a health appraisal within 14 days; Title 15 does not carry that requirement.

The health appraisal should include the following:

1. review of earlier receiving screening;—the pre-screen;
2. collection of additional data to complete medical, dental, psychiatric and immunization histories;
3. laboratory/diagnostic test results to detect communicable disease including venereal disease and tuberculosis;
4. recording of height, weight, pulse, blood pressure and temperature;
5. other tests and examinations as appropriate;
6. medical examination with comments about mental and dental status;
7. review of results of the medical examination, tests and identification of problems by a physician or his/her designee; and
8. initiation of therapy when appropriate.

While adults and emancipated minors may give consent for routine examinations and tests,[26] consents for minors must be obtained from the parents, guardian or legal custodian before any treatment except emergency treatment can be given. Many times it is extremely difficult to obtain a consent from the parent. It is essential to begin routine health care by a health appraisal, routine sick call, etc. So the physician or health authority at the facility may find it beneficial to contact the juvenile court judge of the county and request that he/she issue a generalized consent, in lieu of a consent of parent, guardian or legal custodian, to the physician authorizing that those minors in jail who are wards of the court may have a routine health appraisal, appropriate studies to detect communicable disease and immunizations where appropriate. The judge of the superior court may be contacted for those minors not wards and deemed unfit for juvenile court jurisdiction.

1208. PRE-SCREENING FOR MENTAL DISORDERS

Any inmate who appears to be in need of psychiatric attention or who is suspected of suffering any type of mental disorder shall be brought to the attention of an appropriate medical professional.

Jails with an average daily population of 51 or more shall have a plan for identifying, screening, treatment and/or referral of the mentally disordered inmate which is developed in consultation with the local mental health director or his designee.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The primary purpose of this section is to ensure the proper and timely identification of persons with mental disorders. Of paramount importance is the identification of those individuals with problems needing immediate attention, particularly those with the potential for suicide.

An initial assessment of the inmate's mental health status shall be included as part of the medical pre-screening called for in Section 1207, and, therefore, will be done prior to housing in a living unit. Ideally, this assessment will be effected by mental health staff; where this is not feasible, the specific training of the personnel doing intake screening, must include instruction as to the process they are to follow in mental health cases.

The process should be developed by the local mental health director or

[26] For a discussion of informed consent, see pages 25–26.

his/her designee and should include at least the following:

1. specification of what cases constitute an emergency;
2. the names and phone numbers of mental health professionals who can be called on a 24 hour basis for consultation;
3. specific procedures for the referral of non-urgent cases to the mental health staff working in the jail or to the staff of the local mental health clinic; and
4. specific procedures for the immediate transfer to a local hospital for urgent cases.

The health authority, the mental health professional responsible for developing the mental health portion of the pre-screening, and the facility administrator should cooperate to develop procedures for utilizing the mental health portion of the pre-screen, staff observation and/or a medical professional opinion where that is immediately available to make necessary special housing arrangements.[27]

Mentally Disordered Persons (Sections 1052, 1053, and 1055)

Those inmates who are perceived to be either gravely mentally disordered or severely mentally retarded, such that they appear to be a danger to themselves or others shall be housed in special safety housing, i.e. the safety cell described in Article 9, Section 1114. The decision to place individuals in administrative segregation for their own protection or the protection of others will be influenced by positive findings at the time of pre-screening and/or by observations of arresting and booking personnel. The most reliable determiner, however, will be the diagnosis or opinion of a qualified physician or mental health professional. Referral to such a professional will be part of the follow-up to the mental health portion of the pre-screening. Nonetheless, there will be times when severely disturbed individuals will be brought into the jail when there are no medical or mental health professionals on site. In those instances, custody staff will have to make the immediate decision and the facility manager or watch commander will have to approve it. A physician's opinion on retention in the safety cell must be secured within 24 hours or at the next daily sick call, whichever is earliest, and the inmate must be medically cleared for continued retention every 24 hours thereafter. In addition to and separate from this medical clearance, custodial personnel, the watch commander and/or the facility manager shall review the continued retention of the individual in safety housing every 8 hours at a minimum.

The safety cell is used only for those individuals who pose a threat to themselves or others due to mental disability or disorder; it is not to be used for discipline. The intent is to provide safe and humane quarters for such persons, protecting them and others from harm, and to this end, intermittent visual supervision shall be provided at least every one-half hour. This supervision should be documented.

[27] Please see Sections 1052, 1053 and 1055 regarding classification and special housing.

1209. TRANSFER TO TREATMENT FACILITY.

A mentally disordered inmate who appears to be a danger to himself or others, or to be gravely disabled, shall be transferred to a treatment facility designated by the county and approved by the State Department of Health Services for diagnosis and treatment of such apparent mental disorder pursuant to Penal Code 4011.6 and/or Welfare and Institutions Code 5150 unless appropriate facilities and personnel, as determined by the local mental health director, are present in the jail for this purpose. Inmates found unable to be cared for adequately within any jail shall be transferred to a designated treatment facility as soon as possible.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

A local detention facility is not normally equipped or staffed to confine people who are severely mentally disordered. Jails are not generally therapeutic environments, and therefore Section 4011.6 of the Penal Code allows for the transfer to a designated treatment facility of any detainee or prisoner who fits the clinical criteria set forth in Section 5150 of the Welfare and Institutions Code.

While Section 4011.6 allows any jail commander or judge of the county to effect such a transfer, it is ideally done after evaluation by or consultation with mental health staff designated by the county mental health director. Particularly given the increasing shortage of available treatment facilities, jail personnel should not expect transfers to treatment to be easily accomplished, regardless of how necessary they may be. A mental health evaluation should occur and staff should be fully cognizant of the jail's population, conditions, regulations, and resources in order that they may make the most reasonable judgements as to who should be transferred out of the jail for treatment.

There is often considerable controversy as to who should be kept in jail and who should be transferred to a treatment facility. There are some clearly disturbed and problematic persons who do not seem appropriately kept in either jail or an acute care hospital. Resolution will depend on the communication and coordination among health, judicial and custody staffs, and also, in large part, be determined by what other available facilities exist in the county, and on the condition and legal status of the individual being considered.

The facility administrator and/or health authority should document disposition of all requests for transfer to mental health facilities. The importance of documentation and maintenance of records pertaining to all aspects of the handling of mentally disordered persons cannot be overemphasized.

1210. INDIVIDUALIZED TREATMENT PLAN.

For each inmate treated by a mental health service, in a jail, the service shall develop a written treatment plan which shall be shared with staff responsible for ongoing care of the inmate and which shall include referral to continuing mental health treatment after release.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Both custody and health staffs will have confidential and distinct records which will play a part in determining the appropriate treatment for any inmate. A mental health treatment plan developed for an individual being treated in the jail will often include topics within the purview of the custody staff, such as the classification and cell assignment for that inmate.[28] Without violating the confidentiality of the clinical record, it is still both feasible and necessary for mental health staff to share the basic reasoning and conclusion of their recommendations. The essence of this process is the trust and communication between the custody and health staffs. Important information must be transmitted and shared among medical, mental health and custody personnel for optimum functioning of the health system and the total facility.

In many instances, the clinician treating a jail patient will recommend continuing mental health care after the patient's release from custody. This referral should be clearly documented in the record and fully discussed with the patient. Whenever possible, it is helpful to make the referral to a community mental health clinician who is at least familiar with the jail and with judicial proceedings, though this is not essential. It is also helpful if the two clinicians discuss the course of treatment personally, which can be done fully within the parameters protecting patient confidentiality.

1211. SICK CALL.

There shall be a written plan implementing daily sick call conducted for all inmates or provision made that any inmate requesting medical attention be given such attention.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

There shall be written policy and procedure stating the method or methods used to accomplish sick call. The policy will be part of the medical procedures manual and will have as its guiding principle that any inmate requesting or needing medical attention shall receive such attention, as soon as possible.

A daily sick call should be established at a time and place convenient to the facility to identify, examine and/or care for inmate illnesses and injuries. In facilities which do not have medical personnel on site, the plan for sick call may be that custody staff collects inmate complaints each day and refers them to appropriate medical care providers. Custodial staff may conduct sick call for minor problems as defined by the responsible physician [29] and contact a doctor or other medical professional as needed for more serious matters. Custodial staff may take inmates to medical services or arrange for a medical professional to come into the facility.

The area used for sick call, the medical examination area, shall be clean, well lit, well ventilated, appropriately equipped and supplied, and large enough to perform medical functions.[30] There should be adequate security personnel in medical areas. There shall be sufficient time for the medical examination of each inmate who has requested sick call, and every effort should be made to honor the inmate's privacy during examination and treatment.

Penal Code Section 4011 details the legal procedure for the removal of a seriously ill or injured inmate to a hospital for extended treatment. It should be emphasized that Section 4011 preserves the right of the inmate to decline health

[28] See Section 1052 and the preceding discussion of it at pages 17–18.
[29] See pages 7–8 regarding protocols and physician orders.
[30] See Section 1121 (c) and (d) and page 13 regarding equipment where females are in custody.

services and to provide his/her own medical care through a private physician at no expense to the facility. It is worthwhile to note that the 1980 legislature passed and the governor signed Senate Bill 148, extending Medi-Cal coverage in the first and last months of incarceration to those people in local detention facilities who would be eligible for such coverage if not confined. This may encourage more inmates to seek other than public health services during some of the period of incarceration.

1212. VERMIN CONTROL.

Each facility health administrator/physician shall develop a written plan for the prophylaxis, control and treatment of vermin-infested inmates. There shall be written, medical protocols, signed by the facility physician, if any prophylactic treatment is used for persons suspected of being infested or having contact with a vermin-infested inmate.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Vermin, such as mites or lice, usually come into detention facilities on inmates. If an infested inmate refuses treatment, the inmate should be isolated from others and the facility physician notified.

The written plan, including medical protocols, for the control of lice,[31] includes treatment of the inmate, the inmate's clothing and personal effects, and the living area. Treatment is recommended only when an infestation exists; it is not advisable to routinely treat all incoming prisoners, in as much as allergic reactions and other negative effects can occur from the treatment.

The area selected for delousing inmates should be separate from the rest of the jail and the surfaces in that area should be such as to facilitate cleaning and sanitizing. A shower shall be part of the delousing area.

"Pediculosis" is a condition in which a person is infested with one or more species of lice; the species occurring on people are body lice, head lice and pubic (or crab) lice.[32] Body lice and their eggs (or nits) are usually found in the seams of clothing. Some nits may be glued to the body hair. The application of pediculicides is directed toward killing these nits and such lice as may be on the body.

Head lice and their eggs are generally found on the head hairs. There is some uncertainty about the effectiveness of the available pediculicides to kill the eggs of head lice and a second treatment 7–10 days after the first is recommended. During the interim, before the second application, eggs of head lice could hatch and there is a possibility that lice could be transmitted to others; however, the risk is not great. Separate quarters for inmates undergoing treatment for head lice would further reduce the chances of transmission.

Pubic lice and their eggs are generally found on the hairs of the pubic area and adjacent hairy parts of the body. They can occur on almost any hairy part of the body including the hair under the arm, hair line of the head hairs, and eyelashes. Pubic lice and their eggs are generally susceptible to treatment by the available pediculicides. However, when the eyelashes are infested with pubic lice and their eggs, the treatment is best carried out by a physician.

[31] Treatment for mite infestation (scabies) must be referred to the responsible physician.
[32] See Appendix 5 for a full discussion of pediculosis.

Treatment of the Inmate

To be in strict conformity with existing laws, pediculicides for the control of lice must be labelled as being for the control of lice on humans. Do not be misled by labels which state that the materials are for the control of lice if the label fails to specify lice of humans. Such material may be for lice of dogs only.

Some currently available pediculicides for application on humans are:

1. Containing pyrethrins
   a. Rid lotion™
   b. Triple X lotion™
2. Containing tetrahydronaphthalene and copper oleate
   a. Cuprex lotion®
3. Containing isobornylthiocyanoacetate
   a. Barc lotion™

All of these may be purchased in pharmacies without prescription. Those containing pyrethrins usually have a cautionary note against their use on individuals who are sensitized to ragweed. Cuprex® and Barc™ may result in stinging sensations on individuals with breaks in the skin due to scratching, etc.

Kwell® shampoo and Kwell® lotion have sometimes been prescribed by physicians for the treatment of lice. There have been complaints of failure of these pediculicides to control head lice. Resistance to lindane, the active ingredient in Kwell® has been proven in head lice populations in some parts of the world and, though not proven here, may have occurred in the United States as well. If these materials are used, their effectiveness should be monitored.

It should be noted that directions for the use of pediculicides vary from one product to another and care should be taken to follow the specific directions for the product used. When an inmate is treated for lice and then transferred to another facility, information regarding the treatment should accompany the inmate.[33]

Treatment of Lice-Infested Clothing

If the infested inmate's clothing and other belongings are properly bagged, labeled and immediately removed from the facility, no disinfecting is required. Removal is the safest option and eliminates the possibility of the facility's being sued for clothing damage resulting from disinfecting. However, when the infested clothing and other belongings are retained by the facility, lice and their eggs may be killed by:

1. washing in water at 140°F for 20 minutes;
2. tumbling in a clothes dryer at 140°F for 20 minutes;
3. dry cleaning;
4. storing in plastic bags for 30 days; and/or
5. treating with an insecticide specifically labelled for this purpose, such as Li-Ban™, R&C Spray®, Silox, Dri-Cide, or non-toxic pesticide sprays, i.e., pyrethrins.

[33] The medical information summary form, discussed at page 10, would be one means of conveying this information.

These products are similar in effectiveness so it makes no difference which is used. However, Silox and Dri-Cide are packaged in one-half or one pound containers which *must* be kept covered after opening. These products should never be used on any inmate even though they are generally considered to be low in toxicity.

The general procedure for Silox and Dri-Cide—which can be obtained at hardware stores—is:

1. Place all materials, garments, etc. to be deloused in a polyethylene bag.
2. Add approximately one-half cup to one cup of the powder to the bag.
3. Thoroughly shake the powder into the clothing and apply thoroughly to all surfaces.
4. Allow the bag with the dusted clothing to stand at least four (4) hours.
5. Thoroughly shake the clothing to remove all pesticide dust before the garment or other item is returned to the inmate.

The directions for non-toxic sprays are found on the containers.

Treatment of the Living Area

Housing areas and equipment contaminated by lice should be disinfected with a non-toxic pesticide, i.e., pyrethrins. After disinfecting, all contaminated equipment and housing areas should be thoroughly cleaned. Floors or other surfaces may be cleaned of lice by using a vacuum cleaner with a disposable bag. The bag is then placed in a second bag, tightly closed and disposed of.

If vermin contamination is heavy, the services of a licensed pest control operator should be considered. Since new methods for dealing with vermin infestation are constantly being developed, it is recommended that you have your policies and procedures relative to vermin control reviewed annually by your local health department.

1213. DETOXIFICATION

The responsible facility physician shall develop written medical policies on detoxification which shall include a statement as to whether detoxification will be provided within the facility or require transfer to a licensed medical facility. The facility detoxification protocol shall include procedures and symptoms necessitating immediate transfer to a hospital or other medical facility.

Facilities without medically licensed personnel in attendance shall not retain inmates undergoing acute withdrawal reactions. Such facilities shall arrange for immediate transfer to an appropriate medical facility.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The health authority is responsible for detoxification protocols being prepared for the diagnosis and treatment of individual types of drug withdrawal reactions seen in the particular facility. Alcohol, opiate, amphetamines and barbituate withdrawals are the most frequently seen. Specific protocols for their diagnosis and treatment should be written and/or approved by the facility physician and carried out by a medically licensed person trained in their use.

Additionally, custody personnel should be trained to recognize inmates undergoing acute drug or alcohol withdrawal, and there must be a procedure to refer such people immediately to medical care. In each specific detoxification

protocol, the signs and symptoms of serious and life threatening reactions requiring hospitalization should be identified, for example:

1. Alcohol—delerium tremens with fever, tachycardia, tremor, hallucinations, and/or shock.
2. Barbituates—severe agitation, fever, seizures, and/or shock.
3. Amphetamines (including cocaine)—severe agitation, hypertension, fever, seizures, and/or shock.
4. PCP (Phencyclidine)—severe agitation, violent behavior, severe hypertension, fever, seizure, and/or shock.

Opiate withdrawal rarely requires hospitalization unless the inmate has other major medical problems.

Inmates who are mildly to moderately intoxicated on alcohol or other drugs (and occasionally it is impossible to tell the difference) should be placed in the detoxification cell or other designated area. [34] Mild to moderate intoxication means that the inmate is arousable, responds to simple commands, has no difficulty breathing, and does not appear acutely ill. Inmates in detoxification areas or cells should be re-evaluated every half hour or more frequently as necessary for signs of deterioration of their medical condition, e.g., they are less easily aroused, they show decreasing ability to follow simple commands, they have difficulty breathing, or they appear acutely ill. Monitoring of inmates in detox cells should be documented in the same manner as monitoring of inmates in safety cells. If the inmate's condition deteriorates, the written plan for immediate medical evaluation must be followed.

In as much as some drug and alcohol related illnesses are life threatening, care must be taken to distinguish these from the mild to moderate forms of intoxication previously described. The detoxification protocols should include a system for transferring patients to acute care hospitals when necessary.

1214. INFORMED CONSENT

Each facility health administrator/physician shall set forth a written plan for informed consent of inmates in a language understood by the inmate. Except for emergency treatment, all examinations, treatments and procedures affected by informed consent standards in the community are likewise observed for inmate care. In the case of minors, or conservatees, the informed consent of parent, guardian or legal custodian applies where required by law. Any competent prisoner may refuse in writing both emergency and non-emergency medical and psychiatric care. Use of over-the-counter medications shall be excluded from the requirements of this section.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The standards of informed consent to medical services in the community should also prevail in detention facilities. General consent to routine and necessary services may be made a part of the booking process, and each facility should define which examinations, treatments or procedures will require additional consent. The facility administrator and/or health authority should consult county counsel and the local medical association to pinpoint proper policy

[34] See Sections 1056 and 1113 of the Minimum Standards regarding the detoxification cell.

regarding informed consent and to create parameters for or a definition of "competence" on the part of inmates.[35]

"Language understood by the inmate" may be taken to mean some language other than English, i.e., Spanish, Chinese, etc., or English simplified and structured in such a way as to approach the inmate's mental ability. Complex medical terminology would not be a language understood by an undereducated inmate.

The emphasis of informed consent is on the provider's clear and careful explanation in a language and at a level which the user can comprehend and the user's willing and knowledgeable consent to what has been described. The inmate shall be required to complete and/or sign a form acknowledging his/her understanding of the procedure in question. The kinds of information to be included in obtaining informed consent are: the nature of the proposed treatment, the likely benefits, the risks and discomforts, alternative treatments available, and the understanding that the inmate may withdraw from the proposed treatment at any time.

Inmates have the right to refuse treatment, and, if there is a refusal, a signed refusal form should be kept in the inmate's medical record file. Signed informed consent forms must also be retained. Generally informed consent is not necessary for emergencies which require immediate medical intervention for the safety of the patient, emergencies involving patients who do not have the capacity to understand the information given, and public health matters such as communicable disease treatment when contagion cannot be controlled by isolation.

1215. DENTAL CARE

Emergency and medically required dental care is provided to each inmate, upon request, under the direction and supervision of a dentist, licensed in the state.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The two categories of dental care which should be made available to inmates are emergency and medically required dental care, the latter being defined as arising from a dental problem which interferes with the general health of the inmate or for which the inmate was referred by medical personnel. Dental care is not limited to extractions. When dental services are not provided in the facility, arrangements shall be made to transport inmates to the place where such services are to be delivered. If a facility has the capacity and the personnel to do more than this, there is certainly no prohibition against doing so. In some counties, there are volunteer dentists and dental hygienists who do some work in the jail and who might be willing to provide additional dental care to inmates. Of course, persons must be licensed to perform the service they provide.

The health authority, in coordination with the dentist or dentists who work in the jail, shall determine policies and procedure which spell out the level of dental service available to inmates and the steps to be taken in cases of dental emergencies. Procedures should be clear regarding appropriate temporary measures for facility staff to undertake until a dentist can be contacted.

[35] Please see Medical Policy and Procedures Manual, pg. 11, and Pre-Screening, pg. 16, for additional information about informed consent, and see Appendix 6 for a sample Informed Consent form, developed by San Francisco's Medical Center.

The local dental society may provide information about such measures and may be able to provide the facility with a list of dentists willing to see inmates on an emergency basis. In counties with few dentists and no dental society, the health authority can contact the California Dental Association in Los Angeles at (213) 776-4292 or (800) 262-1754, for advice regarding dental care for inmates.

In regard to juveniles in adult detention facilities, a dental screening should be performed at the time of the health appraisal, [36] and those juveniles in need should be referred to a dentist as soon as possible. In any event, dental hygiene services and dental examination should be provided within one month of admission to the facility. Dental treatment, not limited to extractions, should be performed when the health of the juvenile would otherwise be adversely affected as determined by the dentist or responsible physician. There should be access to the preventative benefits of fluorides in a form considered appropriate for the needs of the individual as determined by the dentist.

1216. ADMINISTERING AND STORING LEGALLY OBTAINED DRUGS.

Every facility administrator, in cooperation with the facility physician/health administrator, shall develop plans, establish procedures, and provide space and accessories for the secure storage, the controlled administration, and disposal of all legally obtained drugs. Such plans, procedures, space and accessories shall include, but not be limited to, the following:

(a) Securely lockable cabinets, closets, and refrigeration units.
(b) Means for the positive identification of the recipient of the prescribed medication, such as a hospital-type plastic identification wrist band or photograph.
(c) Procedures for administering legally obtained drugs only in the dose prescribed and at the time prescribed.
(d) Procedures for confirming the fact that the recipient has ingested the medication.
(e) Procedures for the administration of controlled substances and dangerous drugs in liquid or powdered form whenever possible.
(f) A procedure for recording the fact that the prescribed dose has or has not been administered, by whom, and if not, for what reason.
(g) A policy which prohibits the administration of drugs by inmates.
(h) A policy which limits the length of time medication may be administered without further medical evaluation.
(i) A policy which describes the length of time required for a physician's signature on verbal orders.

NOTE: Authority cited: Section 6030, Penal Code. Refererence: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The health authority shall develop policies and procedures in accord with Section 1216 regarding the administering, storing and disposing of legally obtained drugs. The State Pharmacy Board is available to consult with administra-

[36] See page 16 for reference to this health appraisal for minors.

tors in developing appropriate procedures for drug handling.[37]

The responsible physician/health authority is ultimately responsible for overseeing medications and monitoring records of medications dispensed. Recording must be thorough, including reasons why a prescribed medication was not administered, for example, "inmate was in court," "inmate slept through pill call," "inmate refused medication." The more detailed the documentation, the greater protection it affords the facility and dispensing personnel.

There must be a clear policy, consistently followed, regarding positive identification of recipients of medication. Hospital type arm bands and inmate photographs on medical records or i.d. cards are recommended; however, the best means of identification is dispensing staff's personal knowledge of inmates receiving medications whenever possible.

Over the counter medications, those readily available in the community without a prescription, do not fall under the restrictions of this standard. The facility should have a separate policy/protocol [38] regarding the use of over the counter medications including what kinds, how, when, and if they will be dispensed by medical or non-medical staff.

Procedures should be developed and carefully adhered to for the proper disposal of legally obtained drugs and supplies after their period of use. Dated medications should be routinely purged from stock after their period of use or expiration dates, and such equipment as used needles and syringes should be broken or otherwise rendered useless before being disposed of. There shall be a proper disposal procedure, approved by the responsible physician, assuring that needles and syringes are not able to be reused and that the disposal process is not hazardous.

All medical supplies should be kept in a secure area within the facility. Access to these supplies should be limited by proper key control to facility medical personnel. A close inventory should be kept of these supplies to insure that unauthorized use or removal will be promptly discovered.

1217. PSYCHOTROPIC MEDICATIONS

Psychotropic medications are dispensed only when clinically indicated and as one facet of a program of therapy. The administration of psychotropic medication is not allowed for disciplinary reasons.

There shall be a policy which limits the length of time psychotropic medications may be administered and a plan of monitoring and re-evaluating inmates receiving psychotropic medications.

Inmates who are found by a physician to be a danger to themselves or others by reason of mental disorders may be involuntarily given psychotropic medication approriate to the illness for a period of 72 hours after the need is identified. The medication shall be prescribed by the physician in written form in the inmate's record or by verbal order in dosage appropriate to the inmate's need. Verbal orders shall be entered in the inmate's record and signed by the physician within 72 hours. The responsible physician shall develop

[37] For jails in the southern part of the state the number is (213) 620-3860, and for those in the north, (415) 557-0546. You may also call the Executive Secretary of the Board at (916) 445-5014.

[38] See pages 1-8 for a discussion of protocols and direct orders.

a protocol for the supervision and monitoring of inmates involuntarily receiving psychotropic medication.

Psychotropic medication shall not be administered to an inmate after 72 hours unless the inmate has given his or her informed consent or is to be transferred within eight hours, pursuant to Section 4011.6 or 4011.8 of the Penal Code, to another treatment facility.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2, and 6031.4, Penal Code.

The proper use of psychotropic medications is subject to an array of laws and regulations covering such topics as informed consent, appropriateness and length of prescription and documentation. It is thus essential that the use of such medications be determined by a specific protocol, set and kept current by the local Mental Health Director or his/her designee.

The provision in this section for giving psychotropic medications on an involuntary basis is to be used only as a last resort, after every attempt has been made to transfer the patient to a designated treatment facility, and after an assessment has been made by a physician that a clear and present danger exists if the individual goes without medication. In such instances, the medical record should indicate:

1. a complete documentation of the imminent danger situation;
2. the record of supervision and monitoring according to the established protocol for such situations; and,
3. a specific record of the continuing effort to have the inmate/patient transferred as soon as possible to a designated treatment facility.

1218. PRISONER DEATHS.

There shall be a medical review of every death in custody. Autopsies shall be performed only by a licensed physician.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Pursuant to Health and Safety Code Section 7113, next of kin and appropriate agencies shall be notified when a death in custody occurs. Autopsies may be performed by a licensed physcian approved by the coroner, but are preferably performed by a medical examiner or forensic pathologist. The autopsy report shall be one element of a medical review after any death in custody.

The medical review is not the same as and is to be distinguished from the immediate review administrators, facility staff and in-house medical personnel do when a death in custody occurs. The immediate review is for the purpose of determining the most likely cause of death, the circumstances surrounding it, factors which may have contributed to it and what emergency procedures might need to be implemented. All relevant reports, findings or descriptions arising out of this analysis should be saved and made available to the medical review team which follows and to the annual health department inspectors.

The medical review is a more thorough assessment of the conditions surrounding an inmate's death. It may constitute a part of the regular audit required by Section 1202 or may be additional to it. Its purpose is to alert the medical delivery system to any weaknesses or failures on its part which may have led to the death or failed to prevent it. This is an additional quality control on the

jail medical service and should be performed after all autopsy and other reports have been received.

The medical review should be performed by a review team which minimally includes the facility administrator, the responsible physician and the charge nurse. It is encouraged that, in addition, an outside medical component such as a representative from the county medical association be included.

All circumstances surrounding the death should be evaluated from a medical perspective. Was the inmate seen prior to his/her death by medical personnel? What was the inmate's complaint? What was charted, if anything, on the medical record or in the custody log? What does the Coroner's Report indicate as to the cause of death? Were there any time delays in seeking medical assistance for the inmate? All information relative to the death shall be made available to the review team, including reports generated by medical or custodial staff during the initial analysis. Findings of the medical review should be reported in writing and deficiencies noted should be correced as soon as possible. Any plan for correction should be included in the audit file.

ARTICLE 11. FOOD

1240. FREQUENCY OF SERVING.

In Short Term, Type I, II, and III facilities, food shall be served three times in any 24-hour period. At least two of these meals shall include hot food. If more than 14 hours pass between these meals, supplemental food must be served.

A minimum of fifteen minutes shall be allowed for the actual consumption of each meal.

If the prisoner misses a regularly scheduled facility meal, he or she shall be provided with a sandwich and beverage in lieu of that meal.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Many Short Term and Type I facilities have been feeding two meals per day; all are now required to feed three. If more than fourteen (14) hours pass between meals, the sorts of supplemental food which might be considered are soup, a sandwich, a snack, fruit, or any other nutritious food which is convenient for the facility to have and make available to inmates.

The fifteen minutes for food consumption spoken of in this standard is a minimum. Allowing more time for meals may reduce prisoner and staff tensions surrounding meal times and may lead to a more relaxed facility.

Replacement meals must be provided when a prisoner misses a regularly scheduled meal due to circumstances of facility life, i.e., a work assignment, a transfer, late booking, a court appearance, a medical appointment, or the like. A sandwich and beverage (coffee, milk, water, juice, etc.) is the minimum replacement meal; administrators have the option of providing more or different replacements so long as the nutritional value of the replacement is adequate.

1241. MINIMUM DIET.

In Short Term and Type I facilities, the minimum diet in every 24-hour period shall consist of one-half the number of servings specified from each of the four food groups below; provided that any person being held for more than 48 hours, excluding weekends and holidays, is served the full number of servings specified below. In Type II and Type III facilities the minimum diet in every 24-hour period shall consist of the full number of servings specified from each of the four food groups below:

(a) Meat Group. This includes beef, veal, lamb, pork, poultry, fish, eggs, beans, peas, lentils, nuts, and peanut butter. The daily requirements shall be two servings selected from the combinations listed below:

3 oz. (without bone) lean, cooked meat, poultry or fish	= 1 serving
2 medium eggs	= 1 serving
1 cup cooked dry beans, peas or lentils	= 1 serving
4 tbsp. peanut butter	= 1 serving

(b) Milk Group. This shall include milk—fluid, evaporated, skim, dry, or buttermilk. Also cheese—cottage, cream, cheddar, etc., and ice cream or ice milk. The daily requirements shall be:

For youths 15–17 years, pregnant women and nursing mothers ..... = 32 fl. oz.
All others ..... = 16 fl. oz.
The equivalencies shall be:
1 inch cube cheddar-type cheese = 4 fl. oz. milk equivalent
⅔ oz. cheddar-type cheese ..... = 4 fl. oz. milk equivalent
½ cup cottage cheese ..... = 2⅔ oz. milk equivalent
½ cup ice cream ..... = 2⅔ oz. milk equivalent
½ cup ice milk ..... = 3⅔ oz. milk equivalent
1 oz. dry skim milk ..... = 8⅔ oz. milk equivalent
½ pint fluid milk (any kind) ..... = 8⅔ oz. milk equivalent
1 oz. evaporated milk ..... = 2¼ oz. milk equivalent

(c) Vegetable-Fruit Group. This shall include all vegetables and fruits, canned, frozen or fresh. The daily requirements shall be six servings at least one of which must be a "good" or "fair" source of Vitamin C as listed below:

½ cup vegetable or fruit ..... = 1 serving
1 medium apple, banana, orange, or potato ..... = 1 serving

Good Source Vitamin C	*Fair Source Vitamin C*
Orange—Orange Juice	Mustard Greens
Grapefruit—Grapefruit Juice	Potatoes (all kinds)
Broccoli	Spinach
Brussels Sprouts	Turnip Greens
Green Pepper	Tomato Juice
Raw Cabbage	Canned Tomatoes
Raw Tomatoes	

(d) Bread-Cereal Group. This shall include bread, rolls, pancakes, sweet rolls, ready-to-eat cereals, cooked cereals, cornmeal, and any source of food containing flour. The daily requirements shall be:

Females ..... = 8 servings
Males ..... = 12 servings
Equivalencies shall be:
1 slice bread ..... = 1 serving
1 oz. ready-to-eat cereal ..... = 1 serving
¾ cup cooked cereal ..... = 1 serving
¾ cup cornmeal, paste, etc. ..... = 1 serving
Any source of food containing .7 oz. of flour = 1 serving

Fats and sweets should be provided in amounts to assure calorie supply is at the required levels and spices should be used to improve the taste and eye appeal of food served.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Section 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The rationale for Short Term and Type I facilities being able to serve half-rations for those held less than 48 hours excluding weekends and holidays is and has traditionaly been that such facilities experience very fast turnover of inmates, and many of those inmates are unable to tolerate full meals. Many Short Term and Type I facilities feed by way of frozen meals prepared at the half-ration level. They may now add a sandwich and beverage or a third frozen meal to meet the three meal per day requirement, or can feed full rations if they so desire.

For inmates held in excess of 48 hours, excluding weekends and holidays, full rations shall be served, and, if Type IV facilities serve three meals a day to their inmates, they too are required to provide the full minimum diet.

Concern should be given to the weight problems some inmates experience. Whenever possible, high calorie foods should be an optional rather than an integral part of the diet. Special attention should be paid to the requirement that youths, pregnant women and nursing mothers get twice as much milk as required for others. While the minimum diet is high in the vegetable-fruit group and may be somewhat high in other areas as well—especially for a population which gets relatively little exercise—the intent is that a well balanced, healthful, nutritious diet be presented to inmates on a regular basis.

1242. MENUS.

Menus in Type II and Type III facilities shall be planned one month in advance of their use where kitchen facilities are a part of the detention facility. Such menus shall be planned to provide a variety of foods thus preventing repetitive meals.

If any meal served varies from the planned menu, the change shall be noted in writing on the menu.

Menus, as served, shall be evaluated by a public health nutritionist or a registered dietitian at least every six months.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

There is no requirement for Type I facilities to plan menus in advance; however, when the Type I houses sentenced people such as inmate workers, attention should be given to rotating their menu patterns. It would be useful for Type I facilities to plan menus in advance and keep copies of their menus for health inspections. It is assumed that sentenced prisoners assigned to Type I facilities will be fed in a manner consistent with that used in Type II and Type III facilities.

Menus in Type II and III facilities shall be planned one month in advance of their use. This insures that the purchasing agent for the facility or jurisdiction may make the necessary purchases beforehand and may make them in quantity to obtain bulk discounts. Moreover, the use of a 30 day planning cycle reduces the repetition in menus, facilitates the provision of all necessary nutritional values, and makes inmate dissatisfaction less likely.

Menus may be prepared by a nutritionist or dietician who is not directly connected to the jail and thus is not familiar with the particular institutional equipment and practices of that facility. Such a planner must be informed of preparation equipment and serving utensils and methods in order to plan menu items which can be feasibly prepared or served. The menu planner should consult with kitchen staff and serving personnel to insure that any item specified in the menu can be properly prepared and served as intended.

The menu planner should also be aware of the latest developments in the field of prepared and convenience foods. Often both time and money can be saved by selective buying of such items. Consideration may also be given to the new protein substitutes from various vegetable sources which can be used to bolster

protein content while holding down the cost of meals. The modern institutional menu should reflect both traditional items and convenience foods in a reasonable combination, with the choice being guided by cost per serving, preparation time, and acceptance by inmates.

For Type II and III facilities and Type IV's which routinely provide three meals a day, menus *as served* shall be saved until the next evaluation, i.e., for six months. Keeping copies of menus will prove useful for budget development, menu cycle planning, training new food service personnel and, of course, documentation in case of court action.

The evaluation of menus shall result in a written report which shall also be kept on file in the facility. The process by which the evaluation is performed shall be developed and initiated by the facility administrator; it is recommended that the semi-annual evaluation be accomplished by on-site visits from an independent consultant or someone from an outside agency such as a public health nutritionist, a hospital dietician, a contract dietician, etc. It is recommended that the evaluation include sampling a line meal.

In the event there is no readily available, appropriate person to do the semi-annual evaluations, and only as a last resort, the evaluation can be accomplished by mailing copies of menus to a nutritionist or dietician and receiving an evaluation report by mail in return.

In menu planning as in all other aspects of jail management, practice will follow the best policy; every effort will be made to insure that the menus which are evaluated are exactly the menus which were served. Deficiencies which evaluation may reveal will be corrected. The menu evaluation reports will be sent to the Board of Corrections with each county's annual health inspection report.

1243. FOOD MANAGER.

Except in Short Term, Type I, and Type IV facilities, there shall be employed or available in all detention facilities with an average daily population of 100 or more, a food manager who has the training and experience to:

(a) plan menus;
(b) provide a portion control system;
(c) supervise kitchen personnel;
(d) train inmate food service staff;
(e) prepare a yearly food budget;
(f) plan logistical support system for the food preparation function; and,
(g) provide a food cost accounting system.

In facilities of less than 100 average daily population and in Short Term, Type I, and Type IV facilities, there shall be a written food services plan.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

A food manager is required for facilities of 100 or more average daily population, excepting Short Term, Type I and Type IV's. Smaller facilities may also want to hire or consult a food manager, and it is possible for any facility or system to contract with an outside expert rather than have a food manager on staff of the department. The standard only requires the manager to be available to the facility.

The food manager must be given the necessary flexibility and resources to perform his/her assignments. The food manager should be directly responsible to the facility administrator and should have a clear line of authority over all other food service personnel. Logistical support is also critical to the food manager, so that purchasing agents and warehouse operators must be responsive to the food manager's concerns and needs.

There is at present no licensing requirement for food managers; however, the manager should be trained and experienced in the areas set out in Section 1243. The manager, although capable of supervising kitchen personnel, does not have to be the person who actually oversees their performance.

The food manager is responsible for developing the food service plan for a facility. The plan will describe in writing:

1. the sources of food;
2. the methods, equipment and supplies to be used for transporting and serving food at safe temperatures and of palatable quality;
3. The designation of staff for daily meal service;
4. the arrangements for disposal of unconsumed food in a safe and sanitary manner;
5. the food budget including actual food costs; and
6. inventories.

For smaller facilities and for Short Term, Type I and Type IV facilities a food manager is not required;[39] however, a food service plan shall be developed. This plan shall be written, updated as necessary, kept on file in the facility, and available for review. The food plan shall describe the actual feeding operation of the facility, speaking to as many elements of 1243 as apply to your particular facility.[40]

1244. FOOD HANDLERS.

There shall be a written procedure for medical screening of food handlers prior to working in a facility kitchen. The screening shall include a history of recent exposure to communicable diseases including negative tests for venereal disease, tuberculosis, hepatitis, and the absence of infected skin lesions.

All food handlers shall wear clean, washable outer garments, keep their hands clean, confine their hair, not smoke in the food preparation or food service areas, and use appropriate serving devices; i.e., tongs, gloves, ladles, etc.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

A medical screening program for food handlers prior to initial assignment in a facility food preparation or serving area is necessary to minimize exposure to diarrheal diseases and hepatitis for inmates and staff. A food handler is defined as any person who works with food or food preparing utensils in a facility kitchen or area where food is prepared and/or distributed to inmates and/or staff. Persons who distribute catered, individually packaged meals are exempt from this screening procedure.

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[39] Please see Community Release Program Guidelines for feeding options in Type IV facilities.
[40] A Type I's plan will include how it feeds inmate workers.

A written protocol for screening food handlers, approved by the responsible physician and administered by a staff person trained in its use, should include the following:

1. absence of exposure to and symptoms of food borne contagious diseases, especially hepatitis and diarrheal disease by history;
2. physical examination to exclude infected skin lesions and jaundice.

There is no reliable screening test currently available for detecting incubating hepatitis, however, a liver enzyme test could be done which will identify the early active cases as well as other possible liver disease. While early incubating cases of hepatitis will not be identified, the risk of hepatitis epidemics will be minimized.

Additional tests which could be administered, at the discretion of the facility physician, are:

3. a negative serological test for syphilis, and
4. absence of symptoms of active tuberculosis or a negative TB skin test.

These tests are "nice but not necessary" since syphilis and TB are not food borne illnesses. The standard is in error in that regard; however, you still may want to test for these diseases in order to be doubly safe.

The protocol should include a referral process for follow-up care of inmates with a positive finding on the food handler screen. No inmate will be assigned to work as a food handler until the medical screening is completed. There should be periodic reassessment of the health status of food service workers. While this protocol addresses inmate workers, it is recommended that non-inmate food service employees undergo this or similar screening prior to starting work as food handlers.

A basic food handling training program for kitchen staff could prove beneficial, covering the elements of proper food handling and personal hygiene; however, whether formal training is offered or not, food handlers shall be made aware of acceptable sanitary practices and shall assist in all efforts to minimize the chances of food contamination or the outbreak of food related illness.

Food handlers shall wear clean, washable outer clothing and appropriate covering to confine the hair. Proper serving utensils, such as tongs, scoops or ladles shall be used. Disposable plastic gloves are also useful for the serving or preparation of foods. Smoking or other use of tobacco in any form shall not be permitted in food service or preparation areas.

1245. KITCHEN FACILITIES, SANITATION, AND FOOD STORAGE.

Kitchen facilities, sanitation, and food preparation, service, and storage shall comply to standards set forth in Health and Safety Code, Division 22, Chapter 11, Article 2.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Food storage shall be of a capacity and quality to insure against food spoilage or contamination.[41] Careful attention shall be given to the proper refrigeration and freezer storage of meats and other readily perishable items. Leftovers, which

[41] The specific standards are set forth in Health and Safety Code, Section 28520 et seq., under Article 2, California Restaurant Act.

are to be used for subsequent meals, shall be placed in shallow, covered containers not over four inches in depth to assure rapid cooling. The refrigerators and freezers shall have an accurate, readily visible thermometer located in the warmest portion of the units.

The floor in all rooms in which food or beverage is stored or prepared, utensils are washed, or refuse or garbage is stored, and the floor of walk-in refrigerators, shall be of such construction and material as to be easily cleaned. They shall be smooth, in good repair and kept clean.

The food storeroom shall be clean, dry, well lighted and ventilated and pest free. Food supplies shall be stored in an orderly manner, at least six inches above the floor, and be protected from contamination by appropriately covered or sealed containers. Bulk food containers and lids should be labeled as to contents, and foods held for other than short periods should be dated on receipt to assure proper rotation of supplies.

Insecticides or other poisonous, odorous or toxic materials shall never be stored above or on the same shelf as foodstuffs. These materials should be kept in a separate room or cabinet provided for that purpose.

Kitchen waste materials should be kept in smooth, impervious, easily cleanable containers with tight-fitting lids, and be stored separately from any food storage. These waste materials shall be disposed of in a sanitary manner so as not to create a nuisance or a vermin problem.

Eating utensils and flatware of a quality which can be properly washed and sanitized shall be provided. Utensils shall be replaced when they become chipped, cracked, stained, or otherwise mutiliated. Utensil washing and sanitization shall be according to the standards in Health and Safety Code Sections 28554 through 28563, and storage of such utensils shall be according to Section 28564.

The type of eating utensils used has much to do with the attractiveness of the meal. The utensils must be appropriate to both the foods and beverages served and the dining location, i.e., the cell, dayroom, or dining room. Generally speaking, the material of choice is stainless steel for all eating utensils and flatware. While there is a higher initial cost, stainless steel is immune to rust, chipping, and breakage and is easy to clean and sanitize. Some high-impact plastics also meet institutional requirements for durability and cleanability.

Compartmented trays or pans should be used to keep various foods separated. Bowls should be used for soup, cereal and desserts. Cups or plastic glasses should be provided for beverages. The size of the utensil must be carefully determined in conjunction with the serving situation. Trays must not exceed the dimensions of available tables or food slots in barred cells. This also applies to cups which must be passed between cell bars or through serving slots. These openings should be sized and located to accommodate the pouring of such hot liquids as coffee, tea and cocoa by serving personnel.

Single-service disposable paper and plastic utensils and flatware may be used. Such single-service, disposable materials may be particularly useful for inmates who are ill with communicable diseases and inmates who are in administrative segregation and likely to abuse normal serviceware. Single-service items shall be used only once.

1246. FOOD SERVING.

Food shall be served only under the immediate supervision of a staff member.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

Comprehensive meal planning requires consideration of the actual serving of each item on the menu. There must be a feasible method of kitchen preparation, adequate serving and eating utensils, and above all, a practical method of service to the inmates in the desired quantity and quality. Each step of preparation and service must be worked out in detail to insure that the meals are wholesome and appealing.

It is very important that food be kept hot (140°F or above) or cold (45°F or below), as appropriate, until it reaches the inmate. If the kitchen is located some distance from the dining area, food should be transported in insulated, heated or cooled food carts or other containers. These may be loaded with pre-served trays or with bulk food containers and all necessary utensils and then taken directly to the dining area. Food transported on serving plates or containers should be covered and served as rapidly as possible to protect from contamination and to maintain safe temperatures.

Foods shall be served under the immediate supervision of a food service employee or a custodial officer, preferably with food service training. This will insure that fair and equal portions are given to each inmate in a sanitary manner.

Inmates should be required to finish their meals in the dining area and not be allowed to store food in their living quarters. Besides being unsanitary, such storage encourages pilfering, brings disciplinary problems, and invites vermin in the living quarters.

1247. SPECIAL DISCIPLINARY ISOLATION DIET.

A special disciplinary isolation diet which is nutritionally balanced may be served to an inmate. Such a diet shall be served twice in each 24 hour period and shall consist of one-half loaf of the meatloaf described in *Guidelines for the Establishment and Operation of Local Detention Facilities,* or other equally nutritious diet, along with two slices of whole wheat bread and at least one quart of drinking water if the cell does not have a water supply. Such a special diet shall not be continued for longer than 72 hours without the written approval of a physician. The use of special disciplinary isolation diet shall constitute an exception to the three-meal-a-day standard.

Should a facility administrator/manager wish to provide an alternate disciplinary diet, such a diet shall be submitted to the Board of Corrections for approval.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The Board of Corrections feels very strongly that food should not be withheld from an inmate as a disciplinary measure, nor should food be used as a factor in discipline except in the most extraordinary circumstances. If it becomes necessary, as a last resort and after careful consideration, to use a disciplinary isolation diet, such diet shall never consist of baby food. If anything other than the nutritionally balanced meatloaf described here is to be served as a special disciplinary isolation diet, the recipe shall be submitted to the Board of Corrections for prior review. When a proposed diet is submitted to the Board, staff will present it to a qualified nutritionist to evaluate.

The special diet meatloaf is prepared as follows:

Blend well together:

2 Oz. powdered milk
3½ Oz. raw grated potato
3½ Oz. carrots, chopped fine
1 Oz. tomato juice or puree
3½ Oz. cabbage, chopped fine
4 Oz. lean ground beef
2 Oz. lard or shortening
1 Oz. white or whole wheat flour
½ Oz. salt
1 tbsp. onion, chopped
1 egg
5 Oz. dry red beans, pre-cooked before baking
½ Oz. chili powder

Shape into a loaf and bake at 350–375° for 50–70 minutes. The meatloaf should be moist after baking, and some variation of the temperature and/or time may be necessary to achieve this moistness. The loaf is then sliced and half a loaf, preferably warm, is served at each meal with two slices of bread and a beverage.

This special diet shall not be maintained for more than 72 hours without the written approval of the responsible physician, nor should it be undertaken without the knowledge of both the physician and the facility administrator. It cannot be stressed enough that this diet is to be used only as a very limited management option.

1248. MEDICAL DIETS.

Provision shall be made to comply with any special medical diet prescribed for an inmate by the facility physician or other physician designated to provide medical care to inmates.

A copy of the special diet manual used shall be available in both the medical office and the food service office for reference and information.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The special diet manual outlines specific kinds of medical diets. Some examples of standard medical diets are: the diabetic, low salt, bland, high calorie/low calorie. These or any other prescribed medical diet will be initiated pursuant to a doctor's orders.

The responsible physician/health authority shall develop the facility's policy and procedures for medical diets, which shall include a means for documenting that inmates have gotten the diets prescribed. Small facilities and those which do not have full scale feeding programs shall seek the advice of whoever develops the food services plan or of the local hospital to determine how best to accommodate special medical diets.

1249. FOOD COST ACCOUNTING SYSTEM.

A food and cost accounting system shall be established which will reflect the average total cost per meal served.

NOTE: Authority cited: Section 459, Health and Safety Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

The food and cost accounting system should be able to provide detailed information as to the cost per meal served, including materials, labor and equipment costs. Such information is essential for sound food management.

In those jails where it is necessary to purchase meals for inmates from a private vendor, a contract should be carefully drawn to meet the standards and to provide for an equivalent food and cost accounting system. It should be possible to determine the cost per meal for contract meals as well as those prepared in house.

ARTICLE 12. INMATE CLOTHING AND PERSONAL HYGIENE

1260. STANDARD INSTITUTIONAL CLOTHING.

The standard issue of climatically suitable clothing to inmates held after arraignment in all but Short Term and Type IV facilities shall include, but not be limited to:

(a) clean socks and footwear;
(b) clean outergarments; and,
(c) clean undergarments;
(1) for males—shorts and undershirt, and
(2) for females—panties and bra.

The inmates' personal undergarments and footwear may be substituted for the institutional undergarments and footwear specified in this regulation.

Clothing shall be reasonably fitted, durable, easily laundered and repaired.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 459, Health and Safety Code.

At the discretion of the facility administrator, inmates may be allowed to wear their own clothing as long as such clothes are clean and appropriate. Clothing issue, if it is the facility's policy to issue clothing, shall occur at the time of booking, after arraignment, or when it become apparent that an inmate will remain in the facility for more than 48 hours excluding weekends and holidays.

Inmates' personal undergarments and footwear may be substituted for institutional issue; however, it may be preferable that the facility issue its own undergarments and footwear to reduce the danger of contraband and the chances of vermin infestation. If personal undergarments are permitted, inmates must be apprised of the facility's policy regarding the regular laundering of those garments.

Whether clothing is the inmate's own or standard issue, it should be easily recognizable so that inmates can be distinguished from staff and visitors and should not be demeaning or overly revealing. It should be in keeping with the norms of the community. Clothing may be of inexpensive but serviceable materials, easily washed and dried, and adequate for seasonal comfort, health and protection.

Sandals or tennis shoes are practical footwear; they are inexpensive and washable. Inmates who work at specialized jobs in or outside the facility should wear shoes or boots appropriate to the work they do, and whatever shoes or boots are issued to inmates should be cleaned at least by a thorough dusting with foot powder between uses.

1261. SPECIAL CLOTHING.

Provision shall be made to issue suitable additional clothing, essential for inmates to perform such special work assignments as food service, medical, farm, sanitation, mechanical, and other specified work.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 459, Health and Safety Code.

Special clothing, including shoes or boots, shall be suited to the type of work and climatic conditions at the work place. A written plan for providing special or safety clothing should be incorporated into the facility procedure manual.

There should also be a plan, in those facilities which do not regularly issue institutional clothing, to provide emergency clothing to those inmates who may be in need. Examples of circumstances which might necessitate issuing emergency clothing include an arrestee's coming into the facility in vermin infested clothing, destroyed or badly soiled clothing, or inappropriate clothing (such as a bathing suit, etc.). There are various service groups which may donate clothing to the jail for use as emergency issue.

1262. CLOTHING EXCHANGE.

There shall be a written plan for scheduled exchange of clean clothing. Unless work, climatic conditions, or illness necessitates more frequent exchange, outergarments, excepting footwear, shall be exchanged at least once each week. Undergarments and socks shall be exchanged twice each week.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 459, Health and Safety Code.

All clothing shall be issued in clean, freshly laundered condition, in good repair and free of vermin. Pants, shirts, skirts, etc. shall be exchanged at least once a week; undergarments and socks at least twice a week. More frequent exchanges of clothing may be necessary depending on work, climatic conditions or illness, and, where inmates are permitted to wear their own clothes, there shall be policy and procedures for laundering and/or repairing those clothes on a regular and as needed basis.

If there is a laundry in the facility, it should be designed to handle 20 pounds of wash per inmate per week. This will cover the weekly exchange of institutional clothing and linen plus such additional wash as work clothes, some personal clothing and kitchen linen. It may be more economical to use a private vendor or another nearby institutional laundry for these purposes; however, if the facility will provide its own laundry, space for the following must be allocated: soiled clothing storage, washer, extractor, dryer, clean laundry storage, and laundry supplies storage (soaps, bleaches, etc.). All of these basic elements are essential regardless of the size of the laundry. Dry cleaning equipment or a contract with a qualified private vendor may be necessary, to clean inmate personal clothing before it is stored and/or to clean blankets and other non-washable items.

1263. CLOTHING SUPPLY.

There shall be a quantity of clothing, bedding, and linen sufficient for actual and replacement needs of the inmate population.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 459, Health and Safety Code.

There should be a regular review of the inventory of clothing to determine that there is an adequate number of items in the proper range of sizes. There shall be a written procedure for the purchasing, handling, storage, transportation and processing of clothing, bedding and linen to assure that an appropriate, clean supply is on hand at all times. Actual and replacement needs must be considered; for example, handling or transportation delays might result from clothing and linen's being laundered at a remote facility, thus an inventory of four or five times the total inmate capacity may be necessary. (If the facility has its own laundry, three complete sets may well suffice.)

Adequate space shall be provided for the safe and sanitary storage of all clean clothing, bedding and linen. [42] Soiled clothing, bedding and linen shall be handled, sorted and stored separately from clean supply.

1264. PERSONAL CLOTHING STORAGE.

There shall be a written plan for the cleaning and/or disinfecting of all inmate personal clothing before storage and when necessary.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 459, Health and Safety Code.

All personal clothing shall be thoroughly cleaned and/or disinfected before storage. [43] A written plan shall include procedures similar to those found in guidelines for vermin control. [44] If inmates wear their clothing to court and then return them to the institution for re-storage, a decision should be made whether to clean that clothing each time or not. The "when necessary" in this standard is intended to give facilities latitude in this decision.

1265. ISSUE OF PERSONAL CARE ITEMS.

There shall be a written plan for the issue of personal hygiene items. All female inmates shall be issued sanitary napkins and/or tampons as needed. All inmates to be held over 24 hours who are unable to supply themselves with the following personal care items, because of either indigency or the absence of an inmate canteen, shall be issued:

(a) toothbrush,
(b) dentifrice,
(c) soap,
(d) comb, and
(e) shaving implements.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 459, Health and Safety Code.

Inmates shall be made aware that, pursuant to Section 1265, personal care items are available on an as-needed basis. The written plan for the issue of these items should include the process by which inmates are notified that these items are available, i.e., in a handout, by rules posted in the facility, as part of orienta-

[42] See Section 1121 (k) of the standards for space requirements.
[43] Personal clothing storage is included in the space requirement in 1121 (k).
[44] See pages 21–24.

tion, or in some other way.

The question may arise whether personal care items can appropriately be purchased by the inmate welfare fund. It may be advisable for facility administrators to request an opinion of county counsel before deciding whether or not to use inmate welfare funds in this way.

Provision should be made to have both sanitary napkins and tampons available so female inmates can continue to use whichever form of protection is more effective for them. [45]

1266. SHOWERING.

There shall be a written procedure for inmate showering/bathing. Inmates shall be permitted to shower/bathe upon assignment to a housing unit and at least every other day or more often if possible.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 459, Health and Safety Code.

Ideally, inmates should be able to shower daily, but they *must* be permitted to shower or bathe at least every other day. [46] Those whose jobs or work assignments cause them to require more frequent showers should be permitted to shower whenever necessary. It is understood that staffing limitations may sometimes make it difficult to get inmates to showers and back to their housing units, but procedures must be worked out in such a way that this essential hygiene function is carried out on a regular basis.

1267. HAIR CARE SERVICES.

(a) Hair care services shall be available.

(b) Inmates, except those who may not shave for reasons of identification in court, shall be allowed to shave daily and receive hair care services at least once a month.

(c) Equipment shall be sterilized, before use, by a method approved by the State Board of Barber Examiners to meet the requirements of Section 6586.5(h) of the Business and Professions Code.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 459, Health and Safety Code.

Unless there is a specific court order to the contrary, every class and type of prisoner should be allowed to shave every day if they so desire. Equipment shared among inmates shall be sterilized before each use. [47] Sterilizing chemicals, as all other cleaning and disinfecting agents, shall be stored in secure areas unavailable to inmates.

How hair care services are to be provided is at the discretion of the facility administrator. The standard purposely leaves open the options of inmates caring for their own and/or other inmates' hair, inmate barbers being assigned, and/or non-inmate personnel being used. The standard neither intends nor should be construed as meaning that professional hair care services must be available in every jail in California.

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[45] Pursuant to Penal Code Section 4023.5(a)(1).

[46] See Section 1120 (e) for design requirements relative to shower/bathing facilities.

[47] See Appendix 7 for disinfecting procedures and chemicals approved by the State Board of Barber Examiners and the State Board of Cosmetology to meet the requirements of Section 6586.5 (h) of the Business and Professions Code.

ARTICLE 13—BEDDING AND LINENS

1270. STANDARD BEDDING AND LINEN ISSUE.

The standard issue of clean, suitable bedding and linens, for each inmate entering a living area who is expected to remain overnight, shall include, but not be limited to:

(a) one serviceable mattress which meets the requirements of Section 1272 of these regulations;

(b) one mattress cover or one sheet;

(c) one towel; and,

(d) one freshly laundered or dry cleaned blanket or more depending upon climatic conditions.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code, and Section 459, Health and Safety Code.

The number of blankets a facility issues will vary with the geographical location, the season of the year, and the presence or absence of climate control equipment in the facility. A second sheet, pillow and pillow case may be issued in addition to the mattress cover or sheet required, at the discretion of the facility administrator, to maintain inmate morale.

Temporary Detention, and Short Term facilities shall supply bedding for at least those inmates held overnight or in excess of four hours between midnight and 6 a.m. [48]

If, during periods of emergency, it is necessary to sleep inmates on the floor, additional sanitary measures such as more frequent cleaning of the floors, mattresses and covers should be carried out. Mattresses should be moved during the day to prevent inmates from walking or eating on them.

1271. BEDDING AND LINEN EXCHANGE.

There shall be a written schedule for the exchange of freshly laundered and/or sanitized bedding and linen issued to each inmate housed. Washable items such as sheets, mattress covers, and towels shall be exchanged for clean replacement at least once each week. If a top sheet is not issued, blankets shall be laundered or dry cleaned at least once a month or more often if necessary. If a top sheet is issued, blankets shall be laundered or dry cleaned at least every three months.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code, and Section 459, Health and Safety Code.

The intent of Section 1271 is for each inmate being housed to receive clean, freshly laundered and/or sanitized bedding and linen and for that bedding and linen to be exchanged regularly. When a top sheet is used, there is less direct contact of inmate to blanket, and laundering or dry cleaning of blankets may occur every three months rather than every month. If illness or other circumstances cause blankets to need more frequent laundering or cleaning, blanket exchange will occur more frequently.

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[48] See Section 1110 (b) regarding Temporary Holding facilities.

1272. MATTRESSES.

Mattresses issued to inmates in all facilities shall be of the type constructed with an easily cleaned, non-absorbent ticking. Mattresses purchased for issue to inmates in facilities which are locked to prevent unimpeded access to the outdoors shall be certified by the manufacturer as meeting all requirements of the State Fire Marshal and the Bureau of Home Furnishings' test standard for penal mattresses.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code, and Section 459, Health and Safety Code.

Mattresses issued to inmates must be constructed with an easily cleaned, non-absorbent ticking or cover. Such a covering allows potential stains and soil to be wiped off with a damp cloth and do not require periodic sterilization as did the old-fashioned cotton ticking.

If mattresses are to be used in medium to maximum security facilities (Type I and Type II), it is necessary that they meet the test standard for penal mattresses established by the Bureau of Home Furnishings. This test considers a number of important issues such as the ease or difficulty with which the mattress can be made to burn, the smoke generation, and the percentage of weight loss. It is a test which was developed in early 1980 after a series of experiments, so don't expect that mattresses purchased before 1980 can pass the test. When you are purchasing mattresses, your contract should include a certification by the manufacturer that the mattress you receive has satisfactorily met the penal mattress test criteria established by the Bureau of Home Furnishings Technical Bulletin No. 121. Keep the letter of certification on file for review by the fire marshall during his annual inspection.

While it is recommended that all mattresses pass the penal mattress test criteria, the regulations do not require this for minimum security facilities (Type III and Type IV) because prisoners are free to leave the area of a fire. However, if there are locks on doors to prevent prisoner exit, the mattresses issued must be certified as passing the penal mattress test.

To determine the fire safety of existing mattresses, ask your vendor to describe the contents of the mattress and consult with your local fire authority. The mattress will be relatively safe if it is borate treated cotton, neoprene, or a polyurethane foam known as Hypol. Regular polyurethane, untreated cotton, fiber pad, and some other foams are not acceptable in secure facilities.

ARTICLE 14. FACILITY SANITATION AND SAFETY

1280. FACILITY SANITATION, SAFETY, AND MAINTENANCE.

The facility manager shall develop and implement a written plan for the maintenance of an acceptable level of cleanliness, repair and safety throughout the facility. Such a plan shall provide for a regular schedule of housekeeping tasks and inspections to identify and correct unsanitary or unsafe conditions or work practices which may be found.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code, and Section 459, Health and Safety Code.

Facility administrators/managers shall determine what is an "acceptable level of cleanliness" for their facilities given the constraints of time, staff, contracts with a maintenance agency, and/or marshalling and supervising inmate workers. The intent is not that each facility be spotlessly clean all the time; what is crucial is that the facility be maintained in as safe and healthful a manner as is possible.

A plan for an acceptable level of cleanliness, repair and safety should include:

1. a statement of policy about the environmental health and safety of the facility;
2. designation of the responsibilities and duties necessary to implement the plan;
3. schedules of functions, i.e., daily, weekly, monthly or seasonal cleaning, maintenance, pest-control and safety surveys;
4. lists of equipment, cleaning compounds, chemicals and related materials used in the facility and instructions on how to operate, dilute or apply the material in a safe manner; and
5. records of self-inspection procedures, forms and actions taken to correct deficiencies.

Additionally, consideration should be given to general job descriptions and/or limitations relating to personnel assigned to carrying out the plan and to training or expertise necessary for accident prevention and avoidance of hazards relating to the maintenance of the facility.

When inmate work crews are used, additional controls should be implemented to account for all equipment and cleaning materials. Specialized tasks such as changing air filters and cleaning ducts or facility pest control may be more appropriately handled by a maintenance department or by contract with private firms.

1281. FIRST AID KIT(S).

First aid kit(s) shall be available in all facilities. The responsible physician shall approve the contents, number, location and procedure for periodic inspection of the kit(s).

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code, and Section 459, Health and Safety Code.

The purpose of a first aid kit is to provide emergency medical supplies for the application of first aid pending the arrival of trained medical staff. The number and location of kits should be determined by the facility administrator working in conjunction with and subject to the approval of the responsible physician/health authority. A procedure for inventorying and restocking first aid kits should

be included in the facility's medical manual.

The kit itself should be durable, portable and designed to keep out dust. The contents should be selected in accordance with the known use and anticipated needs of the facility location involved. Consideration should be given to the estimated time of arrival of trained emergency medical personnel and to the possibility that emergency crews may not be available. The skill and training of staff likely to use the kit should also be taken into account.

In the usual detention setting, excluding kitchens or other work crew areas, emergencies which can be anticipated are: cardiorespiratory collapse or distress; fights and/or falls resulting in hemorrhage, sprains or broken bones; shock resulting from trauma, hemorrhage or fractures. The first aid kit should contain those supplies which will be needed in these usual and any other emergencies covered in the facility's written procedures on the application of first aid. For example, if a person is hemorrhaging and written instructions allow for the placement of a tourniquet under defined circumstances, then, in addition to compresses for direct pressure control, the kit would also contain a tourniquet.

For those detention settings which have no medical staff immediately available and do not have other risks on site such as burns, toxic fumes, etc., a typical first aid kit might contain:

1. many sterile compresses, several sizes, for direct pressure control of hemorrhages;
2. wound wipe packets;
3. gauze pad dressings and tape;
4. tourniquets, if indicated by written procedure;
5. rescue blanket;
6. splint (optional depending on availability of other medical staff and supplies as indicated by written procedure);
7. ammonia inhalants, for fainting episodes;
8. instant cold pack (optional depending on ETA of medical care and written procedures);
9. mouth to mouth resusitator, if staff is trained to insert;
10. triangular bandage;
11. flexible gauze bandage;
12. scissors; and
13. bandaids.

Where inmates are exposed to toxic materials, chemicals, heat, poisons or other potential problems such as those encountered in camps or remote work crew locations, first aid kits should also include supplies to manage those additional risks, for example:

snake bite kit;
insect sting kit;
rescue carrier;
oxygen supply and mask; and
neck and spine immobilizer.

1282. SELF-CONTAINED BREATHING APPARATUS.

The facility administrator, in consultation with the local fire authority or State Fire Marshal, shall determine that there are a sufficient number of self-contained breathing apparatus easily accessible for facility staff to enable the evacuation of prisoners in case of fire and smoke.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 6031, 6031.1, 6031.2 and 6031.4, Penal Code.

There are not a lot of items in living areas of detention facilities that provide highly combustible fire loading; however, it has often been demonstrated that adequate combustibles do exist to start fires capable of taking lives of both inmates and staff. Most often deaths occurring from fires in detention facilities have been the result of inhalation of highly toxic smoke provided by burning or smoldering cell padding or mattresses.

Self-contained breathing units allow fire fighters and/or trained staff to enter into areas that are smoke inundated and evacuate persons in danger. They also allow those wearing such gear to take action in extinguishing the fire. Self-contained breathing apparatus have not been in evidence in those jails where deaths have occurred and their availability should greatly reduce the potential for loss of life in detention facility fires.

The local fire authority inspects detention facilities annually to determine how many, if any, self-contained breathing units are required. Should the local fire authority prefer, the State Fire Marshal will conduct their annual inspections. In some instances, the fire inspector may determine no units are required at a facility as the serving fire department is immediately available and has the required number of units and persons skilled in their use.

Where the staff of a detention facility would use this gear in emergencies, it is extremely important that they receive regular training and drill in the proper use of the equipment. There should be a written plan for maintenance of the equipment including air replacement. When questions arise concerning this equipment and its use, they should be directed to the serving fire agency or the State Fire Marshal.

CONCLUSION.

California jails have come a long way since the Board of Corrections first developed standards for the secure housing, clothing and feeding of prisoners in local detention facilities. These health and sanitation standards and guidelines are yet another step in the unending progression of detention and corrections practice, reflecting current norms—the state of the art, so to speak—in detention health care and living conditions. They are intended to be a resource to administrators operating facilities in an enlightened, modern, forward looking atmosphere. They will provide support and guidance in avoiding litigation and prisoner unrest, and will assist in developing health care and sanitation service delivery consonant with humane incarceration and Constitutional requirements.

Questions regarding the standards or guidelines should be directed to the Board of Corrections. Staff stands ready to answer your questions and assist you in whatever ways they can.

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APPENDIX 1

CONFIDENTIAL

FOR OFFICE USE ONLY:

COMPLAINT #_____
DATE RECEIVED _____

GRIEVANCE FORM

NAME_____ JAIL #_____ TIER #_____ CELL #_____

COMPLAINT: (Include all people involved and when incident occurred)

PROBLEM: _____

Has this problem/complaint been brought to the attention of the following? If yes, whom by name, what was outcome?

TIER DEP./SGT.	YES	NO	RESPONSE:
HOSP./SOC. WKR./PRIS. SERV. WKR./OTHER	YES	NO	RESPONSE:

WHAT DO YOU WANT DONE ABOUT PROBLEM?:

HOW CAN THIS PROBLEM BE SOLVED?:

SIGNATURE: _____ DATE:_____

OMBUDSMAN:

INVESTIGATION (Interviews and evidence): _____

_____

_____

_____

_____

_____

_____ Date: _____

Initials: _____

RESOLUTION: _____

_____

_____

_____

_____

_____ Date: _____

Initials: _____

DO YOU WISH TO APPEAL THIS DECISION? YES_____ NO_____ (Check one)

Grievance Advisory Panel Undersheriff

STATE WHY YOU WISH TO APPEAL: _____

_____

_____

SIGNATURE: _____ DATE: _____

APPENDIX 2

VARIOUS HEALTH CATEGORIES

IN CALIFORNIA 1980

ACUPUNCTURIST
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825, (916) 920-6347

AMBULANCE ATTENDANT (EMT)
Licensed by counties. Rudy Blea is Coordinator of the Program, Public and Environmental Health, Department of Health Services, 714 P Street, Room 450, Sacramento, CA 95814 (916) 445-1102

ART THERAPIST
Registered. Contact American Art Therapy Association, P.O. Box 11604, Pittsburgh, PA 15228

AUDIOLOGIST
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6388

AUDIOMETRIST
Not licensed. Given a certificate good only in public schools by Dept. of Health Services, Maternal and Child Health Branch, 2151 Berkeley Way, Berkeley, CA 94704 (415) 540-2081

BEHAVIORAL SCIENCE EXAMINERS
Board of Behavioral Science Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-4933. Licensed marriage counselors, clinical social workers, educational psychologists

BIOANALYST
Licensed. Department of Health Services, Laboratory Field Services Section, 2151 Berkeley Way, Berkeley, CA 94704 (415) 540-2488

CHIROPRACTORS
Board of Chiropractic Examiners, 1021 O Street, Sacramento, CA 95814 (916) 445-3244

CLINICAL SOCIAL WORKERS
Licensed. Board of Behavioral Science Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-4933

CLINICS
Department of Health Services, 2422 Arden Way, Suite 35, Building B, Sacramento 95825 (916) 920-6851

COSMETOLOGIST
State Board of Cosmetology, 1020 N Street, Sacramento, CA 95814 (916) 445-7061

CYTOTECHNOLOGIST
Contact the American Cancer Society, California Division, 731 Market Street, San Francisco, CA 94104

D.E.A. CERTIFICATES
Contact Drug Enforcement Administration, U.S. Department of Justice, P.O.

Box 28082, Central Station, Washington, DC 20005 (202) 724-1013

DENTAL ASSISTANT
Certified, registered. For information, contact Committee on Dental Auxiliaries, Room A-147, 1021 O Street, Sacramento, CA 95814 (916) 445-8626

DENTIST
Board of Dental Examiners, 1021 O Street, Sacramento, CA 95814 (916) 445-6407

DENTAL HYGIENIST
Licensed, registered. Contact Committee on Dental Auxiliaries, 1021 O Street, Sacramento, CA 95814 (916) 445-8626

DENTAL LABORATORY TECHNICIAN
Not licensed or regulated. For further information contact Board of Dental Examiners, 1021 O Street, Sacramento, CA 95814 (916) 445-6407

DIETARY TECHNICIAN
Not licensed. Registration with the American Dietetic Association, 430 No. Michigan Avenue, Chicago, IL 60611

DIETICIAN AND NUTRITIONIST
Not licensed. Registration with American Dietetic Association, 430 No. Michigan Avenue, Chicago, IL 60611

EEG TECHNICIANS
Not licensed

EEG TECHNOLOGISTS
Not licensed

EDUCATIONAL PSYCHOLOGIST
Licensed. Board of Behavioral Science Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-4933

EMERGENCY MEDICAL TECHNICIAN (AMBULANCE)
Licensed by certain counties. For information, contact Rudy Blea, EMT Coordinator, Public & Environmental Health, Department of Health Services, 714 P Street, Room 450, Sacramento, CA 95814 (916) 445-1102

EMERGENCY MEDICAL TECHNICIAN II
Licensed by counties. For information, contact Jean Ann Harlow, Coordinator, OSHPD, Health Manpower Projects, Division of Health Professions Development, 455 Capitol Mall, Suite 120, Sacramento, CA 95814 (916) 322-5566

EXPANDED ROLE PHARMACISTS—MEDICATION
Department of Health Services, OSHPD, Jean Ann Harlow, Coordinator, Division of Health Professions Development, 455 Capitol Mall, Suite 120, Sacramento, CA 95814 (916) 322-5566

FAITH HEALERS
Not licensed

HEALTH ADMINISTRATIVE ASSISTANTS
Not licensed

HEALTH CENTERS
Department of Health Services, 2422 Arden Way, Suite 35, Building B,

Sacramento, CA 95825 (916) 920-6851

HEALTH EDUCATOR
Not licensed. For information, contact Society for Public Health Educators, Inc., 655 Sutter Street, San Francisco, CA 94102

HEALTH SERVICES
Information (916) 445-4171

HEARING AID DISPENSERS
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6388

HERBALISTS
Not licensed. For information, Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6347

HOME HEALTH AGENCIES
Department of Health Services, 2422 Arden Way, Suite 35, Building B, Sacramento, CA 95825 (916) 920-6851

HOME HEALTH AIDE
Department of Health Services, Rachel Valencia, 744 P Street, Room 440, Sacramento, CA 95814 (916) 445-3281

HOSPITALS
Department of Health Services, 2422 Arden Way, Suite 35, Building B, Sacramento, CA 95825 (916) 920-6851

HOSPITAL AND HEALTH SERVICES ADMINISTRATORS
For information, contact American College of Hospital Administrators, 840 North Lake Shore Drive, Chicago, IL 60611

HOSPITAL PHARMACY TECHNICIANS
Not licensed

HYPNOTISTS
Not licensed except for those involving marriage, family and child counselors, in which case, refer to Board of Behavioral Sciences, 1020 N Street, Sacramento, 95814 (916) 445-4933

INHALATION THERAPISTS
For information, contact American Association of Respiratory Therapy, 7411 Hines Place, Dallas, Texas 75235

LABORATORY ASSISTANTS
Not licensed. For information, contact Department of Health Services, Laboratory Field Services, 2151 Berkeley Way, Room 609, Berkeley, CA 94704 (415) 540-2488

LABORATORY TECHNICIANS
Not licensed. For information, contact Department of Health Services, Laboratory Field Services, 2151 Berkeley Way, Room 609, Berkeley, CA 94704 (415) 540-2488

LABORATORY TECHNOLOGISTS, CLINICAL
Department of Health Services, Laboratory Field Services, 2151 Berkeley Way, Berkeley, CA 94704 (415) 540-2488

LEARNING DISABILITY SPECIALIST
Not licensed

MARRIAGE, FAMILY AND CHILD COUNSELORS
Board of Behavorial Science Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-4933

MARRIAGE, FAMILY AND CHILD COUNSELOR INTERNS
Board of Behavorial Science Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-4933

MEDI-CAL
Contact Department of Health Services, 28th and Q Streets, Sacramento, CA (916) 440-7702

MEDICARE
Contact Social Security Administration, 1501 L Street, Sacramento, CA (916) 440-2431

MEDICAL ASSISTANTS
Not licensed. Contact Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6347

MEDICAL LABORATORY ASSISTANTS
Not licensed. For information, contact Department of Health Services, 2151 Berkeley Way, Berkeley, CA (415) 540-2488

MEDICAL RECORD ADMINISTRATOR
For information, contact American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois

MEDICAL SECRETARY
Not licensed

MEDICAL TECHNOLOGIST
Now called Clinical Laboratory Technologists. Contact Department of Health Services, Laboratory Field Services, 2151 Berkeley Way, Room 609, Berkeley, CA 94704 (415) 540-2488

MENTAL HEALTH ASSISTANTS
Now listed as Psychiatric Technicians

MENTAL HEALTH TRAINEE
Contact Board of Psychiatric Technician Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-2933

MENTAL HEALTH WORKER
Contact Board of Psychiatric Technician Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-2933

MENTAL RETARDATION SPECIALISTS
Not licensed

MIDWIVES
Board of Registered Nurses, 1020 N Street, Sacramento, CA 95814 (916) 445-8603

MOBILE INTENSIVE CARE PARAMEDIC (EMT)
Licensed by each county health officer. Contact Rudy Blea, Coordinator, Public and Environmental Health Division, Department of Health Services, 714 P Street, Room 450, Sacramento, CA 95814 (916) 920-6712

MULTISKILLED HEALTH WORKERS
Not licensed

NURSE—LVN
Board of Vocational Nurse and Psychiatric Technician Examiners, 1020 N Street, Room 406, Sacramento, CA 95814 (916) 445-0793

NURSE ANESTHETIST
Not licensed. For information, contact the American Association of Nurse Anesthetists, 111 East Wacker Drive, Chicago, IL 60601 (312) 644-3093

NURSE ASSISTANTS
Department of Health Services, Licensing and Certification Division, 2422 Arden Way, Suite 35, Building B, Sacramento, CA 95825 (916) 920-6851, or the district offices.

NURSE PRACTITIONERS
Board of Registered Nursing, 1020 N Street, Sacramento, CA 95814 (916) 445-8603

NURSE, R.N.
Board of Registered Nursing, 1020 N Street, Sacramento, CA 95814 (916) 445-8603

NURSE, VOCATIONAL
Board of Vocational Nurse and Psychiatric Technician Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-0793

OCCUPATIONAL THERAPISTS
Registered by American Occupational Therapy Association, 6000 Executive Boulevard, Suite 200, Rockville, Maryland 20852, or contact Occupational Therapy Association of California, 1225 8th Street, Sacramento, CA 95814 (916) 446-2404

OCCUPATIONAL THERAPIST ASSISTANT
Certified by the American Occupational Therapy Association, 6000 Executive Boulevard, Suite 200, Rockville, Maryland 20852, or contact Occupational Therapy Association of California, 1225 8th Street, Sacramento, CA 95814 (916) 446-2404

OPERATING ROOM TECHNICIANS
Contact Association of Operating Room Technicians, 1100 West Littleton, Suite 101, Littleton, Colorado 80210

OPHTHALMOLOGIST
These are licensed M.D.s, with ophthalmology as a specialty. Contact Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6411. American Board of Ophthalmology, 8870 Towanda Street, Philadelphia, PA 19118 (214) 242-1123

OPTICIAN, DISPENSING
Board of Medical Quality Assurance, 1430 Howe, Sacramento, CA 95825 (916) 920-6347

OPTOMETRIST
Board of Optometry, 1020 N Street, Sacramento, CA (916) 445-2095

OSTEOPATHS
Board of Osteopathic Examiners, 921 11th Street, Suite 1201, Sacramento, CA 95814 (916) 322-4306

PARAMEDIC (MOBILE INTENSIVE CARE)
Most are licensed by county health officers. For information, contact Rudy Blea, Coordinator for EMT program, Department of Health Services, 714 P Street, Room 450, Sacramento, CA 95814 (916) 445-1102

PHARMACIST
Board of Pharmacy, 1021 O Street, Room A-198, Sacramento, CA 95814 (916) 445-5014

PHARMACY TECHNICIANS
Not licensed. Contact Board of Pharmacy, 1021 O St., Room A-198, Sacramento, CA (916) 445-5014

PHYSICAL THERAPIST
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6373

PHYSICAL THERAPY ASSISTANT
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6373

PHYSICIAN
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6411

PHYSICIAN'S ASSISTANT
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6373

PLASTIC SURGEON
These are licensed M.D.s, with plastic surgery as a specialty. Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6411. Board of Plastic Surgeons, 4647 Pershing Avenue, St. Louis, MO 63108

PODIATRIST
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6347

PSYCHIATRIC AIDE
Not licensed

PSYCHIATRIC HOSPITALS
Department of Health Services, 2422 Arden Way, Suite 35, Building B, Sacramento, CA 95825 (916) 920-6851

PSYCHIATRIC TECHNICIAN
Board of Vocational Nurse and Psychiatric Technician Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-2933

PSYCHOANALYST (RESEARCH)
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6347

PSYCHOLOGIST
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6383

PSYCHOLOGY ASSISTANTS
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6383

PSYCHIATRIST
These are licensed M.D.s with psychiatry as a specialty. Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6411. American Board of Psychiatry and Neurology, 1603 Orrington Avenue, Suite 490, Evanston, IL 60201 (312) 864-0803

PSYCHOLOGIST, EDUCATIONAL
Board of Behavioral Science Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-4933

PUBLIC HEALTH NURSE
Department of Health Services, Office of County Health Services, Local Public Health Assistance, Department of Health Services, 714 P Street, Room 1325, Sacramento, CA 95814 (916) 445-1761

RADIATION THERAPY TECHNICIANS
Not licensed. Contact Radiologic Health Section, 555 Capitol Mall, Sacramento, CA 95814 (916) 322-2073

RADIOLOGIC SUPERVISOR or OPERATOR
Certified. Department of Health Services, Radiologic Health Section, 555 Capitol Mall, Sacramento, CA 95814 (916) 322-2073

RADIOLOGIC TECHNOLOGIST, THERAPEUTIC
Certified. Department of Health Services, Radiologic Health Section, 555 Capitol Mall, Sacramento, CA 95814 (916) 322-2073. Also, American Society of Radiologic Technics, 500 North Michigan Avenue, Chicago, IL 60611

RADIOLOGICAL TECHNICIANS
Certified. Department of Health Services, Radiologic Health Section, 555 Capitol Mall, Sacramento, CA 95814 (916) 322-2073

RADIOLOGY TECHNOLOGIST
Certified. Department of Health Services, Radiologic Health Section, 555 Capitol Mall, Sacramento, CA 95814 (916) 322-2073

RECREATION THERAPIST
Not licensed. Contact National Therapeutic Recreation Society, 1000 North Kent Street, Arlington, Virginia 22209, or California Board of Park and Recreation Personnel, 1416—9th Street, 14th Floor, Sacramento, CA 95814 (916) 445-6477

REGISTERED NURSES
Board of Registered Nursing, 1021 N Street, Sacramento, CA 95814 (916) 445-8603

REGISTERED TRAINED DENTAL ASSISTANT
Board of Dental Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-6407

REHABILITATION CENTER
Department of Social Services, 744 P Street, Sacramento, CA 95814 (916). 445-3284

REHABILITATION COUNSELOR
For information, contact National Rehabilitation Association, 1522 K Street, N.W., Washington, DC 20005

SANITARIAN
Registered. Local Environmental Health Program Section, 1220 S Street, Sacramento, CA 95814 (916) 322-2040

SANITARIAN TECHNICIANS
Not licensed. Local Environmental Health Program Section, 1220 S Street, Sacramento, CA 95814 (916) 322-2040

SOCIAL WORK AIDE
Not licensed

SOCIAL WORK ASSISTANT
Not licensed

SOCIAL WORKER, CLINICAL
Board of Behavioral Science Examiners, 1020 N Street, Room 558, Sacramento, CA 95814 (916) 445-4933

SOCIAL WORKER, REGISTERED
Board of Behavioral Science Examiners, 1020 N Street, Room 558, Sacramento, CA 95814 (916) 445-4933

SPEECH AND HEARING AIDS
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6388

SPEECH THERAPISTS (Pathologists)
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6388

SURGEONS
Board of Medical Quality Assurance, 1430 Howe Avenue, Sacramento, CA 95825 (916) 920-6411

SURGICAL TECHNICIANS
Not licensed

VISION CARE TECHNICIAN
Not licensed. (Cross reference, see Opticians, Optometrists)

VOCATIONAL NURSE AND PSYCHIATRIC TECHNICIANS
Board of Vocational Nurse and Psychiatric Examiners, 1020 N Street, Sacramento, CA 95814 (916) 445-0793

VOCATIONAL REHABILITATION COUNSELOR
Not licensed

WOMEN'S HEALTH CARE SPECIALISTS
Jean Harlow, Health Manpower Projects, Division of Health Professions Development, 455 Capitol Mall, Suite 120, Sacramento, CA 95814 (916) 322-5566

X-RAY TECHNICIAN
Department of Health Services, Radiologic Health Section, 555 Capitol Mall, Sacramento, CA 95814 (916) 322-2073

APPENDIX 3

INTERFACILITY MEDICAL INFORMATION SHEET

Sending Facility _____ Date _____

Address _____ Phone _____

Patient's Name _____ AKA _____

Date of Birth _____ SS # _____

Diagnosis _____

Pertinent History and Present Condition _____

_____

X-Ray and Laboratory Results _____
(include dates)

_____

Medications and Treatments _____

_____

Date and Time of Last Dose _____

_____

Pending Medical Appointments _____

_____

Signature _____
M.D./R.N.

APPENDIX 4

CONCERNS FOR TRAINING

OFFICER VISUAL OBSERVATION

	YES	NO
1. Is the inmate's consciousness level impaired? (Difficult to arouse, disorganized, confused, decreased breathing, increasing lethargy.)		
2. Does the inmate have obvious symptoms suggesting the need for emergency care? (Bleeding, difficulty breathing, cold clammy perspiration, muscular twitching, violent shaking, nausea and vomiting convulsions.)		
3. Does the inmate appear to be under the influence of alcohol? (Incoordination, speech disturbance, altered respirations, unsteadiness, desire to sleep, reddened eyes.)		
4. Does the inmate appear to be under the influence of any other drug? (Anxiety, reduced activity, decreased breathing, difficult to arouse, reddened eyes, incoordination, sleepiness.)		
5. Are there visible signs of alcohol/drug withdrawal? (Muscular twitching, tremors, convulsions, nausea and vomiting, profused sweating, hallucinations, delusions, restlessness, anxiety, continuous yawning, irritation of respiratory passages evidenced by runny nose and tearing, increased breathing.)		
6. Does the inmate's behavior suggest the risk of suicide? (Severe depression, sadness, withdrawal-silence, insomnia, mood variations, lethargy, history of previous suicide attempt.)		
7. Does the inmate's behavior suggest a mental disorder? (Disordered social behavior—violent or nonviolent, confusion and disorganization, hallucinations, profound depression, anxiety, irritability, compulsive repetition of small meaningless acts, suspiciousness, fear.)		
8. Do you suspect the inmate of having body or head lice? (Skin dry and shows signs of irritation, scratching behavior.)		
9. Is the inmate carrying medication or does the inmate report being on a medication that must be administered during any specific time?		

REMARKS:

APPENDIX 5

Prepared: Benjamin Keh, Senior Public Health Biologist
Vector Biology and Control Section
California State Department of Health Services
2151 Berkeley Way
Berkeley, California 94704
May 1980

Some Information About Pediculosis and Pediculcides Pertinent to the Operation of Detention Facilities

Pediculosis is a condition in which man is infested with one or more species of lice.[1] The species occurring on man are: *Pediculus humanus,* the body louse; *P. capitis,* the head louse; and *Pthirus pubis,* the pubic (or crab) louse. All three species occur in California. The head louse and pubic louse occur much more commonly than the body louse.

Infestation with lice usually result in pruritus. In addition, the body louse is a well-known vector of diseases. The ability of the head louse to transmit louse-borne diseases under natural conditions has not been clearly established. Pubic lice have not been implicated in the transmission of disease.

The body louse infests a very small segment of the population, especially individuals who wear the same clothing for a long period of time. Such individuals are ordinarily isolated from the general population but, when jailed, are brought into close contact with a broad diversity of people, some of whom may conceivably carry the etiologic agents of louse-borne diseases. These diseases (louse-borne typhus, louse-borne relapsing fever, and Wolhynian fever) are not known to occur in California at the present time. The last known case of louse-borne typhus in California was imported from Mexico in 1917. Nevertheless, the possibility of epidemics, seemingly remote at this time, warrant corrective measures when dealing with body lice infestations. Body lice tend to leave the body of a feverish individual. This is precisely the condition favorable to the spread of louse-borne diseases. Accordingly one may be justified in invoking Section 1012 of the Minimum Jail Standards and in carrying out prophylactic measures rather than in resorting to isolation.

To detect body lice, examine the inside seams of clothing for lice and their eggs. Many cases of body lice infestations would be found by examining the inside seams of the collar of the coat alone. Another favorite spot are the seams of the fork of trousers. Bite marks on the body tend to parallel those seams loaded with lice. Smears of brownish lice feces may be seen on the axillae (armpits) when these are wetted by perspiration.

Head louse infestations are detected by examining the head hair for eggs. To a lesser extent, the lice themselves may be seen especially on individuals who are heavily infested. Tiny brown specks, caused by lice feces, may be visible on the collar if it is light-colored and if the hair is long.

Pubic lice infestations are generally somewhat more difficult to detect. Pubic lice and their eggs are usually found on the pubic hair and on hair of the adjacent

[1] Strictly speaking, an infestation of pubic lice should be referred to as pthiriasis.

areas but, in heavy infestations, may occur over most of the hairy parts of the body. The feces of these lice will speck the underwear. Pruritus (or itching) often accompany pediculosis. This and inmate complaints may be helpful in uncovering cases of pediculosis. Cases of pediculosis when few lice are present and when individuals appear not to react to bites are more difficult to detect.

Li-Ban(TM) and R&C Spray,(R) also sold in pharmacies, are developed for use against human lice that may occur on fomites (mattresses, furniture, garments, etc.).

The regulations provide that economic poisons:

1. that are not registered in California may not be sold in this State.
2. that are unregistered may not be possessed or used.
3. must be used in accordance with label directions. This includes observing the restrictions on pests to be controlled, the surfaces or objects to be treated, and the manner of application.

If in doubt, contact the County Agricultural Commissioner for information.

Certain economic poisons have appeared on the market which are intended for the control of lice originating from animals, commonly from dogs, and are labeled simply for the control of lice (and possibly other arthropods). Such economic poisons cannot be legally used to control lice of humans unless these insects are specifically included. A review of the label information of several economic poisons currently on the market and sometimes used to control human lice on clothing etc. were found not to mention human lice on the label and thus are being used illegally.

One should be aware of the possibility that lice from humans can develop resistance to insecticides. If there are repeated failures to effectively control lice when one of these materials is used on inmates according to directions and if there are reasons to believe that re-infestations are not occurring, then one should switch to another pediculicide containing a different active ingredient.

There is some uncertainty regarding the effectiveness of any of the existing pediculicides to kill all the eggs of head lice. In fact there are specific experiments which showed that currently available pediculicides will only kill some eggs of head lice. Thus, it appears that manufacturers' claims that these pediculicides are ovicidal are open to question.

Using a pediculicide that is effective against the moving stages of head lice, we must repeat the treatment after 10 days. This allows the eggs that were not killed to hatch and the new lice to be killed in the course of the second treatment.

New information about pediculosis and pediculicides are becoming available all the time and periodic updating of procedures should be made.

APPENDIX 6

CONSENT TO OPERATION, ADMINISTRATION
OF ANESTHETIC AND THE RENDERING OF
OTHER SPECIAL MEDICAL PROCEDURES

San Francisco Medical Center

Date_____ Hour_____ Ward, Clinic_____ Service_____

Person who counseled patient and obtained consent_____

Does patient speak English? Yes____ No____ If not, give language and name of interpreter ____

_____

Children and Incapacitated Adults

A) When the patient is a minor the signature of a parent or sole legal guardian must be obtained.
Name and Relationship of Adult Giving Consent _____

_____

If above person(s) not available, give reason: _____

B) When the patient is unconscious, unable to sign, or unable to understand the need for the procedure(s) the signature of next of kin, guardian, or responsible adult must be obtained.
Responsible adult or guardian and relationship:_____
Reason why patient unable to sign: _____

_____

1. Consent to Operation or Rendering of Other Medical Services

I authorize and direct _____ M.D., and/or associates _____

_____ to perform the following procedure upon me (my child/etc.) _____

(name)

Medical terminology (written by surgeon) _____

_____

Lay terminology (written by patient _____

_____

and/or to do any other therapeutic procedure that he, their judgment may decide to be advisable for my well-being. No warranty or guarantee has been made as to the result or cure. The possible alternative methods of treatment have been explained to me and understanding these alternatives, I consent to the procedure listed above. The nature of the procedure and its follow-up care, its complications, and possible and results have been explained to me. I hereby authorize and direct the above-named physician and/or his associates or assistants to provide such additional services for me as he or they may deem reasonable and necessary including, but not limited to, the performance of services involving pathology and radiology and I hereby consent thereto.

2. Consent to Administration of Anesthetic

I hereby authorize and direct members of the medical staff of the San Francisco General Hospital to administer and maintain general, regional, local anesthesia or the like deemed nature of this anesthetic, the possibility that an alternative may have to be used, and the possibility of complications have been explained to me. With full understanding, I hereby consent thereto:

Person Obtaining Consent

Print _____ X Print _____
Sign _____ X Sign _____
(I consent to the above)

Witness

Print _____ _____
(State Relationship)

Name of person(s) who explained anesthesia to patient: _____

3. **Emergency Case.** In emergencies when it is not possible to obtain the above required signatures, the following must be completed:

I hereby certify that this patient requires an immediate surgical operation or special medical procedure and that delay will be life or limb threatening.

Physician Certifying Emergency _____

Senior Physician in Attendance _____

N.B. It is the duty of the physician performing the procedure to have this form signed and attached to history.

APPENDIX 7

Listed below are the disinfectant chemicals which have been approved by the State Board of Barber Examiners to meet the requirements of Section 6586.5(h) of the California Barber Law.

GROUP NO. 1

Amway Disinfectant	Chlorazene	Steri-clor
Bacilli Kill	Chloro-zol	Sterozol
Besticide	Micro-Jet	

The strength of the solutions in Group No. 1 can be determined by dipping the solution paper prepared with starch potassium iodide. If the solution is up to the required strength, the paper will turn a dark blue. The manufacturers of the chemicals in this group have agreed to furnish the barber supply houses with test papers to be supplied to the barbers free of charge when they purchase the chemicals.

GROUP NO. 2

Amicide	Herpicide Disinfectant Tabs	Roccal
Barbicide	Mar-V-Cide	Timsen

The strength of the solutions of Group No. 2 can be tested by Stone Marshall Test Paper—A. When this paper is dipped in the solution, the paper will turn green if the solution is of the required strength. Or these solutions can be tested by Hyamine Testabs. In using these tabs, note the color chart on the box containing the Testabs.

GROUP NO. 3

Herpicide Sterilizing Tabs	Micro-Merc	Shaklee's SGC
Merax	Ra-Caps	

The strength of the solutions in Group No. 3 can be determined by testing with Red Litmus Paper. When dipped in the solution, the papers will turn blue if the solution is of the required strength. Red Litmus Paper may be purchased at your drug store.

GROUP NO. 4

Hexol "A" Oleum Pinus Solubilis

The strength of the solutions in Group No. 4 cannot be determined by the chemical reaction, but if mixed according to the directions furnished by the manufacturers and changed each week, it will meet the requirements of the law.

GROUP NO. 5

Anti Spor
Danco Germicidal Oil for Sterilizing Clippers
Phenosterzine "Clipper Dip" for Sterilizing Clippers

Appropriate testing materials for Group No. 5 solutions will be furnished by manufacturers of the product.

GROUP NO. 6

Clippercide Spray (for sterilizing clipper blades only)

Approval of Clippercide Spray is for the purpose of disinfecting clipper blades only. No field test available. The Board will take samples of the solution and submit them to the State Laboratory for testing.

The Board of Cosmetology hereby amends regulations in Chapter 9, Article 7, of Title 16 of the California Administrative Code as follows:

(10) Amend Section 979 to read:

979. DISINFECTING INSTRUMENTS AND EQUIPMENT

Combs, brushes, rollers, clips, and other hair accessories which have been used on a patron, or soiled in any manner, shall be placed in a properly labeled receptacle provided for the purpose; such instruments and accessories shall not be employed on another patron until they have been properly cleaned and disinfected:

(a) Combs, brushes, etc. shall be cleaned with soap (or detergent) and water to remove all foreign matter which might harbor bacteria.

(b) Combs, brushes, hair accessories, tweezers, razors, scissors, and other non-electric instruments shall be disinfected by immersion for at least two (2) minutes in a solution containing at least one thousand (1,000) parts per million (1,000,000) of a quaternary ammonium compound, or a solution containing at least five hundred (500) parts per million (1,000,000) of calcium hypochlorite.

NOTE: Authority cited: Section 7311 of the Business and Professional Code. Reference cited: Sections 7310, 7311.

(11) Amend Section 980 to read:

980. DISINFECTING ELECTRICAL INSTRUMENTS

Clippers, vibrators, and other electrical instruments which touch a patron's skin, hair, or clothing, shall be disinfected prior to each use. Any method generally accepted by health authorities or recommended by the manufacturer will be acceptable.

NOTE: Authority cited: Section 7311 of the Business and Professions Code. Reference cited: Sections 7310, 7311.

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