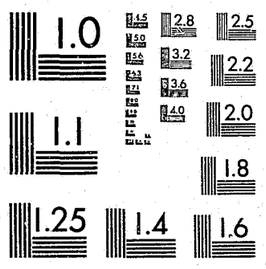

TRAINING PACKAGE FOR FEDERAL AND STATE JAIL INSPECTORS TO REVIEW HEALTH CARE SERVICES

MANUAL FOR INSTRUCTORS

TRAINING PACKAGE
FOR
FEDERAL AND STATE JAIL INSPECTORS
TO REVIEW HEALTH CARE SERVICES

MANUAL FOR INSTRUCTORS

NATIONAL INSTITUTE OF CORRECTIONS

Bureau of Prisons, U.S. Department of Justice

TRAINING PACKAGE DEVELOPED BY
THE
AMERICAN MEDICAL ASSOCIATION

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Under Grant CI-2 from the National Institute of Corrections, Bureau of Prisons, U.S. Department of Justice. Points of view or opinions stated are those of the author and do not necessarily represent the official positions or policies of the U.S. Department of Justice.

- MARCH 1982 -

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INSTRUCTOR'S MANUAL

To All Instructors

In September 1980, the Department of Correctional Activities of the American Medical Association (AMA) was awarded a grant by the National Institute of Corrections to develop "A Training Package for Federal and State Jail Inspectors." The initial purpose of this 21-hour course is to provide both federal and state jail inspectors with the knowledge and skills necessary to enable them to measure the extent of a jail's compliance with the AMA Standards for Health Services in Jails in an acceptable and competent manner. The ultimate goal of this training package is to increase the effectiveness of federal and state jail inspectors' review of jail health care programs and their ability to assist local jail officials to improve such programs by identifying community resources which may be of assistance and providing other technical assistance when possible; thereby, promoting better and more cost effective health services for inmates.

This manual has been prepared for and can be used as a guide to instructors in planning for and teaching any or all units within the course. There is a great amount of information in the manual, but it is not a cookbook. It is assumed that you, the instructor, will bring to your teaching assignment your own knowledge and expertise in particular areas, and that you will use this to supplement the source material in the manual.

Specific information about using the manual and conducting the course is provided below.

A. THE INSTRUCTOR'S MANUAL

This manual is divided into five sections, corresponding to the five units of the course. For each unit, there is a specific lesson plan. Lesson plans contain the following information:

- Name of unit
- Time allotted for the unit
- Objectives of the unit
- Format for instruction
- Audio-visual aids (if any)
- Suggested procedure for instruction
- Specific content information to be covered

Objectives

Specific instructional objectives are listed in the lesson plan for each unit. These make clear what the trainee should expect to learn during the presentation of that particular unit. For the most part, the objectives are presented more as learning goals rather than specific performance objectives, because it is not within the scope

of this course to test performance.

It is important to specify objectives (learning goals) to trainees at the beginning of each session. Unless trainees know what they are expected to learn, the session will be without focus.

Content

The content information is in the form of an outline. The content outlines are quite detailed and thorough. This is to ensure that all the essential information which you should cover is clearly delineated.

In preparing to teach any particular unit, you should first carefully go over the lesson plan, including the content outline for that unit. Familiarize yourself with the information. Do further research if necessary. Then prepare your own teaching notes based on the material in the manual and other resources. Feel free to add illustrations, anecdotes, further related items of information, and so on. Wide left-hand margins have been set to enable you to make your own notes.

Procedures

In order for instruction to "come alive" it is necessary to encourage trainees to participate in classroom discussion and activities. Thus, it is very important for every instructor who teaches this course to do as much as possible to vitalize instruction, so that trainees can take an active part. Although there are no formulas for accomplishing this, the following guidelines and devices are useful:

Group Discussion

Make clear that you care about the group's feelings and that you

are concerned with developing a relationship of mutual respect. Encourage trainees to ask questions and offer ideas.

Try to sense the group atmosphere and be willing to discuss group reactions to particular issues or ideas.

To stimulate discussion, it is often helpful to ask for a reaction from trainees: "How does this fit into your view of your job?" "How would you address this situation?" etc.

Periodically, attempt to link the thoughts and feelings of group members as you summarize and clarify elements of the discussion.

Try to avert the discussion's taking negative and unproductive turns. As an example, inspectors may often like to tell "war stories" about inmates they have known or jails they have inspected. Many such stories will only be marginally related to the issue at hand, interesting as they may be. Do not allow discussions to become bogged down with such "war stories."

Be alert to detect feelings and attitudes which are implied.

If necessary, try to help trainees verbalize their thoughts if they seem to be having trouble doing so.

B. TRAINEE'S MANUAL

Each trainee in the course should receive a trainee's manual. Like the instructor's manual, the trainee's manual is divided into five sections corresponding to the five units of the course.

The trainee's manual has two purposes, namely to provide trainees with:

1. Pre-organized hand-out materials which will be useful learning aids during the course itself; and
2. Materials for future reference.

It is not expected that trainees will take many notes during the course. The trainee's manual is intended to serve the purpose of class notes. The trainee's manual contains virtually all of the same information as the instructor's manual.

C. CLASSROOM ARRANGEMENTS AND BREAKS

The physical setting of the classroom has a definite effect on the efficiency of any teaching session. The following conditions should be met:

Temperature

Ideal classroom temperature is between 68 and 72 degrees Fahrenheit. Trainees do not learn well in a classroom that is too hot or too cold.

Ventilation

The classroom should be well-ventilated. If smoking is permitted, it should be adequately ventilated so that non-smokers are not made ill or uncomfortable. Be sure that ashtrays are available for smokers.

Illumination

Lights in the classroom should be sufficiently bright so that trainees can see without eyestrain. There should be enough light falling on desks or tables to enable trainees to read their manuals and take notes with ease.

Acoustics

The classroom should have good acoustics so that trainees can hear well. The classroom should not be an "echo chamber." Before getting into the teaching session itself, be sure that all trainees can hear well.

Seating

Seating possibilities will, of course, depend on what is available. The traditional schoolroom style arrangement is not always likely to stimulate instructor-trainee interaction. Any informal arrangement in which the instructor is seated with the group and participants are able to see one another's faces would be preferable. Two possibilities include:

1. Conference Table - several small tables are joined to form a large table similar to those used in board and executive sessions.
2. "U" Arrangements - when trainees are seated at individual desks and tables are unavailable, the desks can be arranged in a "U" shape.

Breaks

Be sure to allow trainees adequate break periods. Usually a five to ten minute stretch break every hour is a good idea, with one longer break in the morning and one in the afternoon.

UNIT I

INSTRUCTOR'S MANUAL

UNIT I

INTRODUCTION TO THE COURSE:

ORIENTATION AND MOTIVATION

NOTE: This Unit was taken from Unit I of a previous AMA Manual, Training of Jailers In Receiving Screening and Health Education (1978).

UNIT TITLE: Introduction to the Course: Orientation & Motivation

TIME: 90 minutes

OBJECTIVES: Upon completion of this unit, each trainee will be aware of:

1. The importance of this course which deals with the inspection of a jail's health care delivery system.

2. How a course like this can contribute to the professional growth of the jail inspector.

3. How a good health care program in the jail can contribute to the jail's efficiency.

4. The basic areas of content which will be covered in each of the remaining units of this course.

FORMAT: Showing of film, followed by a lecture and discussion.

AUDIO-VISUAL AIDS: Film: "Out of Sight, Out of Mind."

PROCEDURE:

1. Show the film, "Out of Sight, Out of Mind." Follow with a short discussion of the film. Indicate to trainees that the issues brought forth in the film will be discussed in more depth in this unit, as well as in the other units of this course.

2. Explain the basic objectives for this unit, as specified above.

3. Present the lecture, based on the CONTENT OUTLINE which follows: Remember, this is basically an introductory unit, and therefore the information is fairly general. You are simply trying to orient and motivate trainees.

4. Allow time for trainee questions and discussion throughout the lecture and at the end of the session. Encourage trainees to ask questions freely. However, if questions relate to subjects which will apparently be covered in later units, defer them until then.

CONTENT OUTLINE:

I. JAILS: THE "NEGLECTED CHILD" OF THE CRIMINAL JUSTICE SYSTEM

Note: Some of the ideas and concepts discussed here were brought out in the film, "Out of Sight, Out of Mind." Refer to the film in the discussion and try to relate the ideas below to the film.

A. On any given day, more than 158,000 people are confined in America's 3493 jails. [1] This number has increased year by year.

1. They have little to do; their daily routines are boring, empty and meaningless.

2. For the most part, these people are either awaiting judicial processing or serving short terms ("warehoused").

B. Historically, few citizens have noticed or cared about the jail and the people in it; but jails are important, because what happens in the jail can have a good deal of impact on society.

1. Practically all inmates of the state and federal prisons were at some time confined in city or county jails, awaiting disposition and/or sentenced there for less serious offenses.

a. The way in which people are treated in jail may influence their attitude in such a way that they later commit further, more serious crimes which again land them in prison.

b. Possibly, had they been treated differently while in jail, they might not have ended up in prison.

2. The jail can serve as a referral source for people with a variety of common medical and social problems, including:

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[1] LEAA, Sourcebook of Criminal Justice Statistics-1979 (Washington, D.C.: U.S. Government Printing Office, 1980), pp. 628-629.

a. Drug and alcohol abuse;

b. Mental illness or deficiency; and

c. Infectious diseases, including venereal disease and tuberculosis.

C. Because jails have historically been so neglected, they have suffered a number of common problems, including:

1. Overcrowding;

2. Understaffing;

3. Old, decrepit facilities;

4. Lack of programs and resultant idleness; and

5. General apathy and negative attitudes on the part of the community.

D. Times are changing, however, and more people are recognizing that the jail is important, that the jail experience does have impact on people - for better or worse - and that attention must be paid to improvements in the delivery of services in the nation's jails.

E. One of the areas in which this realization is coming to the forefront is medical and health care. For one thing, information about medical and health care conditions in jails is now more available.

F. In 1972, the AMA conducted a national survey[2] which pointed out the disgracefulness of the health services gap between jail and community. On the basis of responses to the survey questionnaire from about 1200 facilities, the AMA found that:

1. As far as the provision of medical care to inmate populations was concerned:

[2] American Medical Association, Medical Care in U.S. Jails - A 1972 Survey (Chicago, Illinois: Division of Medical Practice, February 1973). This initial survey was designed to identify the problem areas in jail medical and health care.

a. Almost two-thirds of the responding jails had only first aid capability;

b. Seventeen percent had no in-house medical facilities;

c. Only 17 percent of the responding jails had facilities for alcoholics;

d. Only 13% had facilities for the mentally ill; and

e. Less than 10% had facilities for drug addicts.[3]

2. The predominant pattern for medical care was "emergency care only" ("wait until they drop").

3. Concerning the availability of medical personnel, respondents indicated that medical personnel in jails were available on an extremely limited basis:

a. In 440 (38%) of the responding jails physicians were available on a regularly scheduled basis;

b. In 586 (51%) of the responding jails physicians were available on an on-call basis;

c. In 360 jails (31%), no physicians were available to provide medical care to inmates;

d. Only 215 jails (18.6%) claimed availability of nurses; and

e. Only 176 jails (15%) claimed availability of psychologists.[4]

G. In 1977, the results of another survey were published. This survey was conducted by an independent contractor who was evaluating the effectiveness of the AMA's program. Thirty jails in six states participated and the results showed a gross inadequacy of health care and medical services for inmates.[5] This survey also revealed some depressing statistics:

[3] Ibid, p. ii.

[4] Ibid.

[5] B. Jaye Anno, Analysis of Inmate/Patient Profile Data (Washington, D.C., Blackstone Associates, June 1977), p. 107.

1. Of 641 inmates examined in these jails:

   a. Over 12% had abnormal tuberculosis test results (compared with 7% of the general population[6]).

   b. Almost 6% had positive test results for syphillis (compared with 1.5% of the general population, based on pre-marital serological tests[7]).

   c. About 30% showed symptoms of liver malfunctions and possible hepatitis.

In summary, various studies have shown a great disparity between jail epidemiological statistics and those for the general population. Recently published reports have documented a continued high rate of tuberculin skin test positivity and venereal test positivity among persons incarcerated in jails[8].

H. The 1977 study[9] also revealed the following:

1. Of 502 inmates interviewed:

   a. Only 20% reported having a physical examination on admission to a jail;

[6] Center for Disease Control, "Tuberculosis - United States, 1979: Surveillance Summary," Morbidity and Mortality Weekly Report 29 (June 27, 1980), pp. 305-307.

[7] Yahudi M. Felman, M.D., "Repeal of Mandated Premarital Tests for Syphillis: A Survey of State Health Officers," American Journal of Public Health 71 (February 1981), pp. 155-159.

[8] See: American Thoracic Society "Screening for Pulmonary Tuberculosis in Institutions," American Review of Respiratory Disease 115 (May 1977), pp. 901-906; Lambert King, M.D. and George Geiss, M.D., "Tuberculosis Transmission in a Large Urban Jail," Journal of the American Medical Association 237 (February 21, 1977), pp. 791-792; William W. Stead, M.D., "Undetected Tuberculosis in Prison: Source of Infection for Community at Large," JAMA 240 (December 1, 1978), pp. 2544-2547; William E. Morton, M.D., et. al., "Effects of Socioeconomic Status on Incidence of Three Sexually Transmitted Diseases," Sexually Transmitted Disease 6 (July-September 1979), pp. 206-210; Public Health Service, "Sexually Transmitted Disease (STD)," U.S. Department of Health and Human Services, 1979.

[9] Anno, op. cit., p. 108.

   b. Almost 26% reported that they were unable to obtain needed medical care because it was not available or because access to such services was denied by correctional or medical staff (mostly the former);

   c. About 60% said that the health care in the jail was not as good as what they were use to in the community; and

   d. Almost 40% of the inmates felt that their health status had declined since being incarcerated.

2. The major significance of the data was not the discovery that inmates have health problems. Their lack of regular prior care and their extensive use of alcohol and drugs (as indicated in the survey) rendered the above statement "an expected finding." [10]

3. What was important was not the incidence of particular diseases and problems per se, but rather, that for the most part, these conditions were not previously known to the jails and, hence, inmates were not being treated,[11] despite the strong possibility of contagion both during their time in jail and following release.

I. Clearly, then, there is a need for improved medical and health care in jails. In addition to infectious diseases (cited in the above statistics), mental illness and drug and alcohol problems are common in jails. Historically, little has been done with such problems in the jail setting. Much can and should be done, however, and this course will help you (the jail inspector) to do your part in that endeavor.

[10] Ibid.

[11] Ibid.

II. RATIONALE FOR THIS COURSE (i.e., reasons why jail inspectors should learn about the need for the provision of adequate health care in jails)

A. Professional Growth

1. As a professional, you (the jail inspector) have a great deal of responsibility.

2. Your duties involve inspecting such routine areas of jail operation as:

   a. Administration
   b. Fiscal Management
   c. Training and Staff Development
   d. Records
   e. Physical Plant
   f. Safety and Sanitation
   g. Inmate Clothing and Hygienic Living Conditions
   h. Food Services
   i. Medical and Health Care Services
   j. Security and Control
   k. Prisoner Rights
   l. Inmate Rules and Discipline
   m. Mail and Visiting
   n. Reception, Orientation, Release and Property Control
   o. Classification, and
   p. Inmate Services and Programs.

3. Your own knowledge, attitudes and behavior - particularly, the way that you feel about your job and the way you act on the job - will have an impact on the jails you inspect.

4. In terms of health care, a professional attitude is very important.

   a. If staff sense that you do have a positive attitude about the inmates' welfare, that you are concerned about the adequacy of health care provided in the jail and its implications for the public health of the community at large, they will be influenced by your thinking and attitudes.

   b. Being a professional also means that you know what to do.

      (1) This course will provide you with the knowledge and specific skills related to inspecting a jail's health care delivery system.

      (2) Learning these skills and applying them to your work should increase your capacity to function as a professional jail inspector.

   c. In short, knowledge, skills and the right attitude will all increase your status as a professional, and will enable you to do your job as a professional should.

B. Job Efficiency

1. In all aspects of inspecting a jail, knowing what you are doing and systematizing your efforts make for much greater job efficiency. This is certainly true in regard to the health care delivery system in the jail.

2. This course will stress the need for clear-cut procedures in inspecting a jail's health care delivery system.

3. This course will deal with specific skills necessary to determine whether or not a jail's health care delivery system is adequate.

III. PURPOSE OF THIS COURSE

A. The overall purpose of this course is to upgrade the health and medical care in the nation's jails. This is important both to improve the health status of inmates as well as to reduce the likelihood that sheriffs, jail administrators and the cities, counties, states and federal agencies who operate and/or use these jails will be the targets of expensive litigation. Facilities which do not provide adequate health care for their charges are vulnerable to judgements requiring payment of thousands and, in some cases,

hundreds of thousands of dollars as a result of their neglect.12/

IV: OBJECTIVES

The objectives of the course or the means by which the above purpose will be achieved are to provide the trainee with:

A. An understanding of the AMA's Standards for Health Services in Jails;

B. Knowledge of the meaning, interpretation, and rationale for each standard;

C. Skill in applying the Standards as a measuring device to determine compliance at any given jail; and

D. Ability to provide individual jails with information regarding how to correct various deficiencies identified in their existing health care system.

V. OVERVIEW

Here is an overview of what you will learn in each of the remaining four units of this course:

A. UNIT II: LEGAL ISSUES - THE GROWING REQUIREMENTS OF REGULATIONS, STANDARDS AND COURT ORDERS

You will learn:

1. About the requirements of different sets of standards;

2. Of court decisions affecting jail health care;

3. What the constitutional right to health care and "deliberate indifference" mean and how they are applied; and

12 For example, see Tucker v. Hutto, E.D.Va., 1979 (File #: civil action 78-0161-R). This case involved an individual suing an institution for malpractice and a Constitutional tort ("deliberate indifference to his medical and psychiatric needs..."). The "deliberate indifference" resulted in this individual being paralyzed. The individual sued the state, and this case was settled out of court for an amount of more than $500,000.

4. About different practices concerning jail health care which are affected by court decisions.

B. UNIT III: REVIEW OF THE AMA STANDARDS FOR HEALTH SERVICES IN JAILS

1. You will learn the purpose of the AMA Standards in general as well as the purpose of specific standards.

2. Your knowledge of the meaning and interpretation of the AMA Standards will be increased.

C. UNIT IV: HOW TO SURVEY JAIL HEALTH CARE SYSTEMS AND MEASURE COMPLIANCE

You will learn:

1. Where the AMA Standards fit into the USMS audit format.

2. How to measure a jail's level of compliance with each standard.

3. How to verify compliance from different data sources (i.e., how to resolve conflicting information).

4. How to use a sample audit form of the United States Marshals Service (USMS).

5. The end results of systematic inspection.

D. UNIT V: HOW TO PROVIDE TECHNICAL ASSISTANCE TO JAILS AND ADVISE PERSONNEL REGARDING THE EFFECTIVE UTILIZATION OF EXISTING COMMUNITY RESOURCES

You will learn about the following resources which can help to upgrade jail health care delivery systems and make them more cost effective:

1. AMA monographs;

2. Other publications and training manuals; and

3. Referral sources in the community (e.g., health agencies which have demonstrated that they can and will provide services if asked).

INSTRUCTOR'S MANUAL

UNIT II

LEGAL ISSUES:
THE GROWING DEMANDS
OF REGULATIONS, STANDARDS AND COURT ORDERS

UNIT TITLE: Legal Issues: The Growing Demands of Regulations, Standards and Court Orders

TIME; 2½ Hours

OBJECTIVES; Upon completion of this unit each trainee will be aware of:

1. Inmates' constitutional right to care.
2. Legal obligations to the pre-trial detainee.
3. Legal considerations relating to the use of allied health personnel in jails.
4. Legal considerations relating to inmates' medical records and jail inmates' right to refuse medical care.
5. The developing need for jail health care standards.

FORMAT: Lecture and discussion

AUDIO-VISUAL AIDS: None

PROCEDURE: 1. Explain the basic objectives for this unit, as specified above.

2. Present the lecture, based on the CONTENT OUTLINE which follows.

3. Allow time for trainee questions and discussion throughout the lecture and at the end of the session. Encourage trainees to ask questions freely. However, if questions relate to subjects which will apparently be covered in later units, defer them until then.

CONTENT OUTLINE: I. INMATES' CONSTITUTIONAL RIGHT TO CARE

A. Have Prisoners Forfeited Their Legal Rights? Generally, prisoners have enforceable legal rights. All but eight states no longer suspend the civil rights of prisoners, and two of the eight limit the forfeiture of civil rights to life termers. Two others, by court decisions, no longer bar the right, leaving only Alaska, Idaho, Oklahoma and West Virginia suspending the rights of the prisoner (less than a life term) to sue under federal civil rights statutes.1/

B. Constitutional Right is Basic. Regardless of statutory right, the prisoner retains certain basic constitutional rights. The Eighth Amendment to the U.S. Constitution provides "Excessive bail shall not be required nor excessive fines imposed, nor cruel and unusual punishment inflicted." The Amendment has been made applicable to the states through the Fourteenth Amendment. In Estelle v. Gamble (429 U.S. 97, 1976) the Supreme Court, in discussing incarceration without adequate medical care, stated "We have held repugnant to the Eighth Amendment punishments which are incompatible with the evolving standards of decency that mark the progress of a maturing society... or which involve the unnecessary and wanton inflicting of pain."

C. Is Medical Care a Constitutional Right? In general, courts have ruled that the inmate has the right to adequate medical care. The case which signaled the beginnings of the reversal of a "hands off" doctrine with respect to prisoners' rights to medical care was Newman v. Alabama (349 F. Supp. 285, M.D. Ala., 1972) which found the whole state correctional system in violation of the Constitution by failing to provide inmates with adequate and sufficient medical care.2/ The principle was refined in the landmark case Estelle v. Gamble (Supra.) where the Court said "(The) principles behind the guarantee against cruel and unusual punishment establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison

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[1]William Paul Isele, "Constitutional Issues of the Prisoner's Right to Health Care" Chicago: American Medical Association (1980), pp. 2-4.

[2]B. Jaye Anno, Health Care in Jails: An Evaluation of a Reform. University of Maryland, College Park, Maryland (Dec., 1981)

authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met."

D. What is "Adequate Medical Care?" The courts have used the term "adequate" to describe the minimal obligations on the part of the incarcerating authority. At other times, the term "reasonable" is used. For care to be reasonable, it must be adequate under the totality of circumstances. In Mills v. Olivier (366 F. Supp. 77, E.D.Va.1973) the Court said that every prisoner complaint may not require immediate diagnosis and care, but that "under the totality of the circumstances, adequate medical treatment (needs to) be administered when and where there is reason to believe it is needed."

E. The Standard of "Deliberate Indifference." In assessing whether the medical care being provided is "reasonable" or "adequate," courts have sometimes used a standard of "deliberate indifference" (Estelle v. Gamble, supra). In the Estelle case, the Court clearly indicated that the standard would be violated whether the "indifference" was on the part of doctors in their response to the prisoners' medical needs, or by the denial of access to care by security personnel, or in the intentional interference of the care once a course of treatment had been prescribed. In effect, however, the Court narrowed the "deliberate indifference" standard as including only the wanton infliction of unnecessary pain and not circumstances involving inadvertent failure to provide medical care.3/

Generally, the court will not find deliberate indifference or violation of the Eighth Amendment if it can reasonably determine that the act (or failure to act) complained of is only a difference in medical opinion or judgement.

F. Inadequate Health Care. Inadequate or unreasonable health care may have a threefold definition, represented by these three instances:

1. If the lack of care is such as to "shock the conscience of the Court", i.e., "deliberate indifference" to the prisoner's condition; or

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3Vicki C. Thompson. "The Difficulty in Defining Constitutional Standards for State Prisoners' Claims of Inadequate Medical Treatment." 17 Duquesne Law Review: 690.

2. If the treatment of the prisoner is "grossly negligent" or constitutes "barbarous acts"; or

3. If a deprivation of care would, in the judgement of a physician exercising ordinary skill and care, seriously endanger the prisoner's well being, the courts will consider such treatment inadequate and therefore enough to constitute a violation of the prisoner's constitutional rights.

Nearly all of the Federal Courts have accepted one or more of these tests.

G. Negligence or Medical Malpractice will not Ordinarily Give Rise to a Constitutional Right.

1. Regarding the competence of physicians employed to render care to prisons and jails, the courts have not allowed prisoners to bring civil rights actions when there is merely a disagreement between the prisoner and the physician over what treatment is needed. (See Coppinger v. Townsend, 378 F.2d 392, C.A.10, 1968).

   In the Coppinger case, the Court made clear that what constitutes "adequate" medical care is a medical determination, with which the courts indicate their desire not to interfere. Essentially, injury to the prisoner resulting from a simple negligence ("malpractice") is not a violation of Eighth Amendment guarantees.

2. When some medical care has been provided to a prisoner, such that he/she cannot claim total neglect of medical needs, the prisoner must show previous intentional acts to support his/her claim that the right to medical care has been denied.

   It has been clearly stated that prison officials and medical officers have wide discretion in treating prisoners. To state the issue succinctly, the Federal Civil Rights Act was designed to protect constitutionally guaranteed rights, not to provide a Federal forum for trial of actions for alleged medical malpractice. (Mayfield v. Craven, 299 F. Supp. 1111, E.D.Cal, 1969 at 1113)

H. The Relation of the Degree of Care to the Size of the Institution. It is recognized that large state penitentiaries are more likely to have in-house infirmaries than are local jails. Yet, the rights of those confined in local jails pending trial must not be given

any less attention than those convicted and confined; in fact, "distinctions, if any are conceivable, should be the other way." (Rozecki v. Gaughan, 459 F.2d 6 C.A.1, 1972).

I. Cost as a Factor. Many courts have taken the position that cost should not be a factor in determining what "adequate" health care for prisoners is. In the language of Newman v. Alabama (503 F.2d 1320, C.A.5, 1975 at 1333):

> It is without some trepidation that we uphold the findings of a constitutional violation. Officials in the Alabama Penal System are shackled by anachronistic equipment, inadequate staffing, and parsimonious funding, factors which render Sisyphean their task of insuring that adequate medical care is available to inmates.
>
> By the same token, however, we cannot be impervious to the precarious position of inmates who, though depending solely on a prison for medical attention, find their pleas for attention unheeded. Deep-seated inmate frustrations can be exacerbated by a perceived callous indifference to their medical plight. The incidence of frustration thwarts the purported goal of rehabilitation.

J. Some Cases. Here are some Court decisions which find that the correctional institution may be held liable for failure to provide adequate or reasonable medical care to its inmates:

1. Hughes v. Noble (295 F.2d 495, 1961). A pre-trial detainee had been in an auto accident. Despite repeated requests, medical attention was denied for 13 hours. On release, he went to a physician who diagnosed two dislocated and one fractured vertebrae. Dismissal of the complaint by a Federal District Court was ruled improper by a Court of Appeals.

2. Martinez v. Mancusi (443 F.2d 921, 1970). A prisoner was made to walk and stand shortly after surgery, in disregard of the doctor's orders. Medications prescribed by the surgeon were withheld. Dismissal of the complaint by a Federal District Court was ruled improper by a Court of Appeals.

3. Porter v. County of Cook (335 N.E.2d 561). A county jail inmate had been declared paranoiac by a psychiatrist and ordered to the hospital for his own protection. Jail personnel ignored the order. The inmate was severely burned when he set fire to his mattress to drive away "voices." The Court upheld a $117,500 verdict against the county.

4. Raty v. Solano County (35476 Solano Co., Ca. 1976). An inebriated inmate sustained injury to his right eye while in jail. He contended that jail personnel were responsible for failure to safeguard his health and for failure to recognize his need for medical care. The inmate was awarded $12,500.

5. Sanlin v. Pearsall (427 F.Supp. 494, 1976). A jailer sprayed an inmate with mace. He knew that the mace had penetrated the inmate's eyes, yet failed to ascertain the inmate's obvious need for medical attention. The jury's verdict in the jailer's favor was against the weight of the evidence. The jury verdict was set aside and a new trial ordered against the jailer; however, his superiors were not held liable for his actions.

6. Shea v. City of Spokane (Wa. App. 562 2d 264). A jailer refused to give a prisoner his medications and refused to let the prisoner call his physician. The city was held liable to the inmate for $275,000.

7. In Runnels v. Rosendale (449 F.2d 733, 1974), the inmate alleged denial of drugs for pain after an operation for hemmorhoids (without consent of inmate). The Court of Appeals ruled that the withholding of the painkillers constituted a deliberate infliction of pain.

8. In Westlake v. Lewis (537 F. 2d 857, 1976), the plaintiff said that he had an ulcer and needed a special diet and medication. His request was ignored, and when he began to vomit blood, he was given antacids. The Sixth Circuit Court said that when a prisoner alleges he has been allowed to suffer pain when relief is readily available, he has stated a cause of action.

9. In Talbert v. Eyman (434 F.2d 625, 1970), the institution's doctors were skeptical of medication being taken by a prisoner, but told him he could have it if he paid for it. However, the medication was returned for security reasons when sent by

his wife and again when sent directly by the drugist. The Court said the failure to provide or allow the prisoner the medication was arbitrary and capricious.

10. In Sawyer v. Sigler (320 F. Supp. 690, 1970), the prison rule required all medication to be taken in crushed or liquid form. The prisoner, suffering from emphysema, needed medication three times a day, but became nauseated if he took it in crushed form. The doctor prescribed the whole form administration of the drug, but was overruled for security reasons. The Court said that in the absence of showing that the prisoner had a tendency to abuse drugs, requiring him to take the medicine in the crushed form constituted cruel and unusual punishment.

On the other hand, here are examples of situations where the Court found that the gist of the complaint did not show "deliberate indifference" or "criminal" or "capricious" behavior which "shocks the conscience," but instead alleged only a difference of medical opinion or negligence and as such did not create a constitutional question:

11. In Courtney v. Adams (529 F.2d 1056, 1976), the inmate asked that an operation date for removal of a growth next to his heart be advanced because the growth was enlarging. The request was denied. The Court said the complaint alleged only a disagreement as to medical treatment.

12. In Fore v. Godwin (407 F. Supp. 1145, 1976), the Court looked at the medical records and concluded that a prisoner cannot be the ultimate judge of what medical treatment is necessary or proper and Courts must place their confidence in the reports of reputable physicians.

13. In Hampton v. Holmesburg Prison Officials (546 F. 2d 1077, 1976), a federal pre-trial detainee alleged denial of medical care. He had suffered injuries to his face, head and hand and two days later asked for medical care and submitted sick call slips the next day. Five days later he saw the prison nurse and seven days later the prison doctor. The Court found no constitutional grounds for his complaint since there was no indication of any deliberate or intentional prevention of his receiving medical attention.

14. In McCracken v. Jones (562 F 2d 22, 1977), a jury verdict in favor of the plaintiff was reversed on appeal. The inmate argued that his injured back had been examined by the prison doctor who prescribed exercise, which advice he refused to follow. His own doctor later performed surgery. The Court said that the defendants were entitled to rely on the diagnosis they received from the state medical authorities who had examined the plaintiff.

But again, more recently, in Bucks v. Teasdale (492 F Supp. 650, 1980) (citing also Todaro v. Ward, 565 F. 2d 48, 1977), the Court spoke of its own imposed admonition to avoid interference in prison management saying that the admonition "give(s) way in the face of clearly demonstrated constitutional violations. The constitutional rights of inmates are to be 'scrupulously observed.' Further, the policy of deference to prison officials has been held to be accorded lesser weight in the area of medical treatment, given that the concerns of prison security are of somewhat lesser magnitude."

K. Conclusions. A prisoner does not lose all of his civil rights during incarceration. She/he retains a constitutional right to adequate medical care by way of the Eighth Amendment which prohibits cruel and unusual punishment. What constitutes "adequate medical care" is constantly being refined by the courts. In general, a court will look to the totality of circumstances and will find a constitutional violation if there is "deliberate indifference" or conduct which "shocks the conscience" or "extreme gross negligence" or "barbarous acts" and if the action (or failure to act) has resulted or will likely result in seriously endangering the inmate's well-being. On the other hand, the courts will not invoke the constitutional question if what it finds are contentions of negligence or malpractice or there is simply a difference in medical opinion or judgement.

II. LEGAL OBLIGATIONS TO THE PRE-TRIAL DETAINEE

A. When speaking of the pre-trial detainee, it is important to remember one of the basic principles of our system of justice, namely that a person is considered innocent until proven guilty in a court of law. This is the due

process clause of the Constitution. Generally, then, the detainee who is being held but has not been convicted, should not be punished because of the condition and restriction of the facility. Yet, since the need for discipline and order are no less necessary where a detainee is involved, the interests of the government are essentially the same.4/ See, however, Brenneman v. Madigan (343 F.Supp. 128, N.D.Cal, 1972) where the Court held that the constitutional authority for the state to distinguish between criminal defendants by freeing those who supply bail pending trial and confining those who do not, furnishes no justification for treating pre-trial detainees as convicted prisoners.

B. With regard to health care, authorities must be made particularly sensitive to the health and well-being of pre-trial detainees, even more so than to that of convicted prisoners. Courts that have dealt with the subjection of detainees to unsanitary conditions or denial of medical attention have recognized that both the convicted inmate and the detainee must be afforded certain rights, and have indicated that "distinctions, if any are conceivable" would have to be made in favor of pre-trial detainees.5/

1. If a pre-trial detainee is incarcerated in worse circumstances than the convict who is being "punished," it is difficult to say that the detainee is not also being punished.

   It is clear that the conditions for pre-trial detainees must not only be equal to, but superior to, those permitted for prisoners serving sentences for crimes they have committed against society.6/

2. According to Isele,7/ the case of Jones v. Wittenberg (323 F.Supp. 93, N.D. Ohio, 1971, aff'd sub nom. Jones v. Metzger, 456 F.2d 854, C.A.6, 1972) discussed the rights of both convicted prisoners

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[4]William Paul Isele. "Health Care In Jails: Legal Obligations to the Pre-Trial Detainee." Chicago: American Medical Association (1980), pp. 1-3.

[5]Ibid.

[6]See Inmates v. Eisenstadt, 360 F.Supp. 676 (D.Mass., 1973); also Hamilton v. Love, 328 F.Supp. 1182 (E.D.Ark., 1971) at 1191.

[7]Isele, op.cit., p.2.

and detainees to proper health care. Examining the 'medieval' conditions of an Ohio County jail, the trial Court made these observations:

> When the total picture of confinement...is examined, what appears is confinement in cramped and overcrowded quarters, lightless, airless, damp and filthy with leaking water and human wastes, slow starvation, deprivation of most human contacts..., no exercise or recreation, little if any medical attention, no attempt at rehabilitation...If the constitutional provision against cruel and unusual punishment has any meaning, the evidence in this case shows it has been violated... Obviously, if confinement in this jail is cruel and unusual punishment forbidden to be employed against those who are in jail to be punished, it is hard to think of any reason why it should be permitted for those who are only in jail awaiting trial, and are, according to our law, presumed to be innocent of any wrongdoing...The Constitution does not authorize the treatment of a pre-trial detainee as a convict.

C. Distinguishing between prohibited punitive measures and permissible regulatory restraints:

1. In Bell v. Wolfish (441 U.S. 520, 1979), the Supreme Court reversed the lower court's decision in finding as unconstitutional the treatment of detainees at the Metropolitan Correctional Center in New York City. The Court, in effect, established a test which requires, absent a showing of intent to punish, a showing that the condition or restriction of confinement is not reasonably related to government objectives but appears excessive.

2. Again, in Bell v. Wolfish, the Court noted that an arbitrary or purposeless restriction would justify interference by Federal Courts, but that the legitimate interests in maintaining security and order, as well as additional interest in ensuring the detainee's presence at trial, are among the justifications for the restraint imposed and will ordinarily not constitute punishment.8/

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[8]Judith Ann Mackarey. "A Review of Prisoners' Rights Under the First, Fifth and Eighth Amendments". 18 Duquesne Law Review: 683.

D. In summary, the rights of detainees are first construed under the Fourteenth Amendment which provides for due process. Since the detainee has not been convicted, he/she should not be punished. On the other hand, the legitimate interests of government in maintaining order and security are also noted by the courts. In effect, a test of reasonableness under the totality of circumstances is applied, taking into consideration: the nature and severity of the incarceration act complained of; the likelihood of its (incarceration) very limited duration; the needs of the government to maintain order in the institution; and the fact that the complainant is innocent until adjudged otherwise.

III. THE USE OF ALLIED HEALTH PERSONNEL IN JAILS: LEGAL CONSIDERATIONS

A. Who Delivers Care

1. As we have seen in prior sections, constitutional challenges to the medical care being given to inmates are most often based on a charge that the neglect of the facility's administration was so great as to constitute deliberate indifference or wanton disregard of their medical needs. In those situations the courts have looked to the withholding of treatment, the inaccessibility of medical attention, and the failure to provide medical care once prescribed, as the basic ingredients of an unconstitutional act.

2. Now we turn to a question of the adequacy of care - not from a standpoint of sufficiency in quantity, but rather from the standpoint of the sufficiency of the quality as measured by the adequacy of those delivering the care. In other words, are the people being employed to provide the medical and health services licensed or certified (if license or certifications are generally required), trained and experienced?

B. The terms "allied", "paramedical", "paraprofessional" and "licensed" have all been used when who delivers the health care is discussed.

1. According to the American Medical Association, provision of medical and related health services is by physicians, selected independently licensed practitioners (such as the podiatrist, clinical psychologist, nurse, optometrist), medical allied persons with occupational baccalaureate degrees, and medical

allied occupationists without such degrees.9/ The latter two are combined in "Allied Health."

2. The terms "paramedical" and "paraprofessional" tend to be less used. Instead, more emphasis is placed on the qualifications of the individual as measured by licensing or certification.

3. Allied health personnel are either "licensed" or "certified" by the state. Certification is the more common rule and generally intones the concept that the individual is working under the direction of the licensed professional. In some cases, "working under the direction" is not sufficient but immediate supervision is required.

4. In the prison or jail the primary responsible health care people are the doctor and dentist, with the licensed registered nurse and the clinical psychologist as the selected licensed practitioners. But the bulk of the day-to-day care is delivered by allied health professionals or in many instances by unlicensed and non-certified individuals with on-the-job training.

C. The adequacy of medical and health services provided inmates is sometimes challenged on the basis of the number of "medical" people employed and their quality.10/

1. Generally speaking, a court will find the staffing of a prison medical department inadequate when it has been shown that the lack of staff, or of sufficiently qualified staff, means that prisoners will inevitably suffer because of delay or denial of necessary medical care.11/

2. Only in severe cases is the court likely to be specific in its order with respect to how many nurses or physicians need be added to the staff. More often the court will simply find the numbers inadequate. Or, more recently, order officials to comply with standards developed by nationally recognized bodies such as the American Medical Association.

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9 American Medical Association. "Board of Trustees Report F to AMA House of Delegates," Chicago, June, 1972.

10 The question of unqualified staff and the results flowing therefrom have been held to be within the purview of judicial review. See Laaman v. Helgemoe (437 F. Supp. 312, 1977) and Palmigiano v. Garrahy (443 F.Supp. 956, 1977).

11 Ellen J. Winner, "An introduction to the constitutional law of prison medical care," Journal of Prison Health, Spring/Summer, 1981: pp. 67-84.

3. Aside from numbers, the question of quality is addressed by looking at the training of the prison medical staff. Generally, the courts will not go beyond the license or certificate of the individual staff, but will accept their qualifications based on their having met the state standards for such licensing or certification. However, if the licensed or certified individuals go beyond their training or the scope of the state prescribed authority, a constitutional violation may be found. In Owens v. Sudridge (311 F. Supp. 667, 1977) the Court observed that the non-medical personnel were competently carrying out the orders of a physician when administering medications and working under his supervision. It found no constitutional violation. And in Burks v. Teasdale (492 F. Supp. 650, 1980), the Court said, "While the record indicates that there are varying levels of qualification within the (paraprofessional) staff, taken as a whole, this Court is unable to conclude that there is a systematic deficiency posing a risk of magnitude to demonstrate a deliberate indifference to the serious medical needs of the prison population.

D. The Use of "Untrained" Personnel

1. Most facilities suffer from a shortage of qualified medical personnel. To bolster their staff, the trained personnel are augmented by non-licensed/certified people who are used for a variety of tasks in the health arena.

2. While recognizing the difficulties facing the prison administration in meeting the demand for health services, the courts will generally strike down a system which clearly shows heavy reliance on such untrained or unqualified people.

3. The problem becomes more acute if inmates are used in the health care delivery system. The practice is still fairly common, although standards which have been developed in recent years disallow the use of inmate workers. The AMA's Standards for Health Services in Jails (September, 1981) under Standard 122 provides that inmates may not be used for these duties:

"a. Performing direct patient care services;

b. Scheduling health care appointments;

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

d. Handling or having access to surgical instruments, syringes, needles, medications or health records; and

3 Operating medical equipment for which they are not trained."

E. In summary, courts recognize and accept the use of allied health personnel in prison and jails. The extent and latitude of their authority to provide medical services is to be generally consistent with the right afforded to such personnel in the free world. Where there is violation of such authority or where the adequacy or competency of such staff is demonstrated, the courts will find a constitutional violation.

IV. MEDICAL RECORDS AND THE RIGHT TO REFUSE MEDICAL CARE

A. Inmates' Medical Records

1. Confidentiality: medical care records are generally afforded the greatest degree of confidentiality. In the free world, the privilege of confidentiality between a doctor and a patient is broken by the courts only in very special cases and under unique circumstances. That right of confidentiality also extends to the inmate and his/her medical records, but not always to the same degree:

a. The needs of the community or the prison/jail administration, if clear enough, can outweigh the privilege of confidentiality.

b. The prison/jail doctor has the same (and must observe the same) stricture of confidentiality, subject to the reasonable needs of the administration. Where such needs exist, the administration/corrections officers have a similar responsibility to keep the matters contained in the inmates' records confidential.

c. In almost every state and in the District of Columbia, this right of confidentiality has been specifically enumerated in enacted statutes.

d. Medical records and information are of a confidential nature. Certain considerations such as the welfare of the patient, the welfare of the community, or the dictates of the law, can outweigh the need of confidentiality. Nevertheless, unauthorized disclosing of a person's medical record is legally actionable"12/

2. The need to keep good records: not only do the courts hold that medical records in whatever form are confidential, but they also look with critical disfavor on jail and prison administrations which fail to keep adequate inmate medical records.

a. A poor record, or absent record, can be the cause of grievous harm to the inmate patient.

b. In Burks v. Teasdale (492 F.Supp. 650, 1980), the court rejected the contention that there is an insignificant relationship between proper medical records and adequate medical care. Noting that under a training program physicians rotated through the hospital, the court said that inattention to proper charting increased the possibility of a disaster, and the prison's failure to remedy the situation demonstrates "a sufficient deliberate indifference."

B. The Right to Refuse Medical Care: Generally, any adult person who is mentally competent has the right to refuse medical treatment. In life-threatening situations, and under special circumstances, the courts may intervene to impose medical treatment on an unwilling patient.

1. The same right to refuse medical treatment is available to the inmate; however,

2. That right needs to be tempered by the state's right to protect its citizens and the facility's right to protect the remaining inmate population. An obvious example would be the prison authority's right to medically treat an inmate who has a contagious disease.

3. In emergency situations the consent to treatment may be implied under the circumstances.

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12 William P. Isele, "Health Care in Jails: Inmates' Medical Records" Chicago: American Medical Association (September, 1981), p. 13.

C. In summary, the confidentiality of prisoners' medical records shall be maintained, recognizing, however, the special needs of the community and the law. Similarly, the need for adequate medical records in incarcerating institutions is recognized by the court. A showing of clear inadequacy of medical records can lead to a conclusion that the prisoner may be subjected to unnecessary hazard and even life-threatening situations. Such determination will be violation of the Eighth Amendment and considered as cruel and unusual punishment. As to the right of an inmate to refuse medical treatment, the prisoner generally has the same right as that of any competent adult. However, treatment may not be refused where there is an overriding government interest, as when it is necessary to protect other inmates against contracting contagious diseases.

V. THE DEVELOPING NEED FOR STANDARDS

A. Movements to reform correctional systems have taken various paths. One has been the development of standards.

B. In order to improve or rectify a condition, a base or guideline or standard needs to be first established or recognized. The word "standard" can mean a goal or a model or an example. In this light it is something at or near the top of excellence. Or, "standard" can mean "sound and useable but not of top quality" (Webster). In either case, the word "standard" refers to something set up on an authoritative basis by which quantity or value may be measured.

C. Historically, the use of "standards" accelerated its way into the correctional health care lexicon in the early 70's through work by the National Advisory Commission on Criminal Justice Standards and Goals (1973) and soon after, in activity of the National Sheriffs' Association (1974). In addition, the American Correctional Association (ACA) began the process of revising its Manual of Correctional Standards (1966) which included health as one of the topics to be addressed.13/

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13 B. Jaye Anno, Health Care in Jails: An Evaluation of a Reform, University of Maryland, College Park, Maryland (1981), p. 47, unpublished doctoral dissertation.

At the same time, the authoritative use of standards at the local and state levels was at best, spotty. Some states enacted jail inspection legislation which included some mention of health care standards.14/

However, by mid-1970, a major perceived need in improving health care in the correctional systems and especially in jails, was the lack of adequate standards by which to measure either the quality or quantity of health care, or to establish acceptable minimums, or to be used as goals or models. The General Accounting Office (GAO) of the federal government in a 1976 report pointed out that efforts to improve health care conditions in 22 jails which had received funding for that purpose were hampered by the fact that "There are no nationally acknowledged standards to be applied in determining whether physical conditions are adequate and whether sufficient services are available in local jails."15/

D. The American Medical Association's "Standards": It was in this climate of a perceived need for jail health care standards that the American Medical Association's program to improve health care in the nation's jails began. The program focuses on accreditation of jails which meet the AMA-developed Standards for Health Services in Jails.

A first task of the AMA program, funded principally by LEAA, was to develop standards which "reflect the viewpoint of organized medicine regarding its definition of adequate medical care and health services for correctional institutions."16/ To accomplish this goal, the AMA called upon its own Advisory Committee's special task forces set up to address special issues (such as psychiatric services) and hundreds of sheriffs, facility administrators and health care providers in jails across the country. All these groups and individuals participated in a five-year effort to develop, modify, test, revise and finally publish the current AMA Standards for Health Services in Jails.

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[14] American Bar Association, Survey and Handbook on State Standards and Inspection Legislation for Jails and Juvenile Detention Facilities, third edition, Washington, D.C.: (August, 1974).

[15] General Accounting Office, Conditions in Local Jails Remain Inadequate Despite Federal Funding for Improvements, Washington, D.C.: (April 5, 1976), p. i, as noted in Anno, footnote 1/, supra, at p. 49.

[16] American Medical Association, Standards for Health Services in Jails, Chicago: (September, 1981), p.i of the Preface.

E. How Severe or Exacting Should Standards Be? An early question facing the AMA's Advisory Committee was how stringent to make the standards. Should they be minimal, general and easily met? Or should they be tough and set a mark of excellence? Or somewhere in between?

1. Some of the difficulties of the early 1970 attempts to develop standards for corrections could already be seen. Most were too general, using loose terms such as "reasonable," "appropriate," "adequate" and "acceptable." They were also often found to be indefinite even when the accompanying terms appeared to have recognized meanings. So "physical examinations" and "screening" and "available emergency care" still left to the sheriff or administrator such substantial leeway as to sometimes defeat the purpose of the standards.

2. The AMA approach was to consider the standards as minimal, but with an underlying philosophy that the health care provided in institutions should be equivalent to that available in the community and subject to the same regulations. The goal was to make the standards tough enough to be meaningful and clear proof of the adequacy of the health care provided in the facility, yet not so stringent as to be simply idealistic and attainable only by a very few. The standards were not to"turn off" too many jails which, with encouragement, could improve their health care for inmates, but which would have no foreseeable chance of ever meeting a very strict code.

F. The AMA standards have been revised with changes that reflect the previous years' experience with earlier editions. The current edition, published in September 1981, contains standards covering sections on Administrative Matters, Personnel, Care and Treatment, Pharmaceuticals, Health Records and Medical-Legal Issues.

G. In addition to the Standards for Health Services in Jails (revised September, 1981), various other organizations and agencies have developed jail health care standards or included one or more of such standards in a larger publication. These include:

1. The Manual of Standards for Adult Local Detention Facilities (Second Edition), developed by the American Correctional Association (ACA) for The Commission on Accreditation for Corrections (health care standards for the most part adopted from the AMA standards);

2. Standards for Health Services in Correctional Institutions (1976), developed by The American Public Health Association (APHA);

3. The Manual on Jail Administration (1974) and Jail Officers' Training Manual (1980), developed by the National Sheriffs' Association (NSA).

4. The Report on Corrections, released by The National Advisory Commission on Criminal Justice Standards and Goals in 1973;

5. Federal Standards for Prisons and Jails (1980), developed by The U.S. Department of Justice (health care standards for the most part adopted from AMA standards); and

6. A number of states have incorporated AMA standards in the standards they have developed.

H. In summary: In the early 70's, organizations and agencies interested in improving the health care of inmates, began the development of standards by which to measure such medical and health care and thereby seek its improvement. The American Medical Association-developed standards have been used and cited by authorities, courts and legislative bodies. An important consideration in the development and use of standards has been the need for them as a measure of sufficiency - with recognition of the general, widespread inadequacy of health care in many institutions.

NOTE: In the Course Unit which follows, we will examine each of the 56 standards contained in the AMA Standards for Health Services in Jails (revised September, 1981).

INSTRUCTOR'S MANUAL

UNIT III

REVIEW OF THE AMERICAN MEDICAL ASSOCIATION'S

STANDARDS FOR HEALTH SERVICES IN JAILS

UNIT III - REVIEW OF THE AMERICAN MEDICAL ASSOCIATION'S STANDARDS FOR HEALTH SERVICES IN JAILS (September 1981)

Time: 12 hours

Objectives: Upon completion of this unit, each trainee will have an understanding of:

1. The following aspects of the AMA Standards:
   a. Definitions of terms
   b. Administrative standards
   c. Personnel standards
   d. Care and Treatment standards
   e. Pharmaceutical standards
   f. Health Records standards
   g. Medical Legal standards
2. Those standards which may be "not applicable" and under what circumstances.
3. Alternative approaches to meeting the standards (i.e., not meeting the "letter" of the standard but meeting the "spirit" of it).
4. How to verify compliance including:
   a. Who to interview
   b. How to resolve conflicting information
   c. How to measure the level of compliance with both types of standards:
      (1) Essential and
      (2) Important

Format: Lecture, Discussion and "Situational" Exercises

Procedure: 1. Explain the basic objectives for this unit, as specified above.

2. Present the lecture, based on the Content Outline which follows.

3. Allow time for trainee questions and discussion throughout the lecture and at the end of the session. Encourage trainees to ask questions freely.

4. After each major segment of the Standards has been covered, try a few "Situational" Exercises with the class to test their grasp of the materials. Sample situations and an "Answer Sheet" are provided in Appendix A.

5. Be sure that the class is aware that this unit reviews all of the AMA standards. Depending upon the amount of time an inspector has to spend at each jail, it may not be possible to apply each standard at each jail. In some instances, only those standards designated as "essentials" will be applied, while in others, both "essential" and "important" standards can be reviewed. Nevertheless, it is important for the trainees to understand the meaning of each standard, in case a full review at a given jail is to be performed.

NOTE: The layout of this unit is different from that in the Student's Manual. The Student's Manual contains a published copy of the AMA STANDARDS. In the Instructor's Manual, "Content Outline: I. INTRODUCTION TO The AMA STANDARDS FOR HEALTH SERVICES IN JAILS", corresponds to the "Preface" of the published STANDARDS and section "II. IN DEPTH REVIEW OF STANDARDS", corresponds to the standards themselves. The only exception is that the subsection "To Verify Compliance" (of each standard) is added as a separate section of Unit III in the Student's Manual.

CONTENT OUTLINE: I. INTRODUCTION TO THE AMA STANDARDS FOR HEALTH SERVICES IN JAILS

A. INTRODUCTION

1. The standards are the result of over five years of deliberations by the AMA's Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions and its successor, the Advisory Group on Accreditation; several state medical society project advisory committees; three special national task forces and AMA staff.

2. Equally important, several hundred sheriffs, facility administrators and health care providers in jails across the country contributed substantially to the standards.

3. The previous editions of Standards have been approved by the National Sheriffs' Association, the American Correctional Association, the Commission on Accreditation for Corrections and the AMA House of Delegates.

4. In addition, several state jail inspection/regulatory bodies have adopted the basic standards and various court decisions have incorporated aspects of the AMA's Standards document.

5. Many jails have been or are under legal action for failure to provide adequate health care.

   (a) A number of court decisions involving pretrial detainees have stressed that detainees must be accorded all of the rights of a citizen and deprived only of such liberty as necessary to ensure their presence at trial.1/

   (b) Additionally, the courts have stated that sentenced individuals should not be denied adequate medical care on the grounds that such deprivation constitutes "cruel and unusual punishment" prohibited by the Eighth Amendment to the Constitution of the United States.2/

1/ e.g., Jones v. Wittenberg, 323 F. Supp. 93 (N.D. Ohio, 1971); Brenneman v. Madigan, 343 F. Supp. 128 (N.D. Cal., 1972); Dillard v. Pritchess, 399 F. Supp. 1225 (C.D. Cal., 1975).

2/ e.g., Newman v. Alabama, 503 F.2d 1320 (C.A. 5, 1975); Holt v. Sarver, 300 F. Supp. 825 (E.D. Ark., 1969); Ramsey v. Ciccone, 310 F. Supp. 600 (W.D. Mo., 1970): and Schmidt v. Wingo, 499 F.2d 70 (C.A. 6, 1974).

6. The AMA's Standards reflects the viewpoint of organized medicine regarding its definition of adequate medical care and health services for correctional institutions.

   (a) They are considered minimal.

   (b) The basic philosophy underlying these standards is that the health care provided in institutions should be equivalent to that available in the community and subject to the same regulations.

7. Standards are acknowledged criteria for qualitative and/or quantitative measurement of health care delivery systems.

   (a) The AMA's Standards forms the basis of a program to accredit jail health care systems.

   (b) As of October 1981, there were 111 facilities which were AMA-accredited under earlier editions of the Standards. (See Appendix B for a list of all facilities, including their average daily populations, ever accredited by the AMA.)

   (c) Experience has shown that the same AMA Standards have been met by jails which range from the smallest local facilities to the largest metropolitan jails.3/

8. As demonstrated in the AMA's Jail Program, implementation of these standards can result in:

   (a) increased efficiency of health care delivery;

   (b) greater cost effectiveness; and

   (c) better overall health protection for inmates, staff and the community.4/

B. CONTENTS

1. These standards address the following aspects of medical, psychiatric and dental care and overall health services:

   (a) Administrative Matters

   (b) Personnel Matters

3/ The smallest facility accredited to date had an average daily population (ADP) of 1, whereas the largest had an ADP of 3,100.

4/ See references under "AMA Jail Program" in the Bibliography.

   (c) Care and Treatment

   (d) Pharmaceuticals

   (e) Health Records

   (f) Medical Legal Issues

2. Experience dictates that a safe, sanitary and humane environment which meets sanitation, safety and health codes is a prerequisite for a good health care program.

   Since environmental issues are addressed in detail in other national standards, they are not included in the AMA Standards as a special section.

3. The health care of women inmates is also not addressed in a special section.

   (a) For the most part, the basic health care needs of incarcerated individuals will be the same regardless of sex.

      (1) Where differences exist on the basis of sex, the special needs of women are identified within the standards themselves.

      (2) The AMA's Standards are meant to apply equally to male and female inmates.

   (b) A facility cannot meet compliance if the required services are available only to one sex and not the other.

4. The medical program must function as part of the overall institutional program.

   (a) The implementation of standards calls for close cooperation between the medical staff, other health professionals, correctional personnel and the facility's administration.

   (b) Facility administrators and clinicians will find the standards helpful in providing services to inmates.

   (c) The standards also provide information useful to administrators in program planning and budgeting.

   (d) The Standards document will also assist clinicians to establish priorities, determine services, allocate resources and train staff.

5. This edition of the AMA's Jail Standards includes detailed chemical dependency and psychiatric standards.

(a) These additions are extremely important as national criminal justice service agencies universally report that a major problem they must address is the detention of mentally ill and chemically dependent people in jails.

(b) The AMA's National Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions, its successor, the AMA Advisory Group on Accreditation and the AMA's Ad Hoc Task Force on Psychiatric Standards for Jails and Prisons strongly support the policy adopted by some law enforcement administrators stating that their officers will not place charges against suspected mentally ill persons for the sole purpose of detention.

Admission to appropriate health care facilities and/or the provision of services in the community in lieu of jail detention should be sought for such persons.

(c) However, it is also recognized that a number of serious offenders jailed for cause may be mentally ill and that psychiatric problems can develop during incarceration.

Thus, the recommended approach for health professionals is to develop appropriate medical services for the seriously mentally ill both in and out of correctional facilities.

(d) The standards contained herein represent an outline of a program necessary to properly detect, treat and refer psychiatric patients in correctional facilities.

Psychiatric services are part of the medical program with the treatment of psychiatric illness being the goal.

6. Implementation of these standards assumes a multidisciplinary model of health care delivery.

With respect to psychiatric services, the primary responsibility remains with the physician.

Other health care staff (such as nurses, social workers and psychologists) can provide psychiatric services under a physician's supervision.

7. The standards place responsibility on medical staff to consult with non-medical colleagues in the management of inmates with behavior problems.

Medical staff are called upon to provide advocacy services for the alcoholic, the drug abuser and the mentally retarded individual.

Standards helps to promote the proper diagnosis and referral of those inmates to services appropriate to their needs.

8. Reliance on community resources for manpower and facilities is the only way that most correctional facilities can provide special services such as detoxification and psychiatric care.

(a) Correctional facilities function best as part of the human services system of the surrounding community.

(b) The emphasis of the standards is to bring medical resources into the facility for routine care and transfer out inmates with extraordinary needs.

9. Studies show that the most frequent cause of death in jails is suicide - frequently alcohol and/or drug related - followed by withdrawal from alcohol and drugs independent of medical supervision.5/

These standards address not only the need for adequate professional screening, referral and treatment of inmates with psychiatric and chemical dependency problems, but also the need for training correctional staff in these areas, which can impact heavily on the effectiveness of the health care delivery system.

10. Finally, various health providers report that a number of inmates on sick call come there because of social problems which have not been addressed.

5/ See e.g., Page Hudson, M.D., "Jail and Prison Deaths: A Five Year Statewide Survey of 223 Deaths in Police Custody - North Carolina, 1972-1976," Proceedings: 2nd National Conference on Medical Care and Health Services in Correctional Institutions (Chicago:AMA,1978); pp. 63-66.

(a) Some jails employ social workers/counselors to handle these problems.

(b) Others use volunteers who are properly screened, oriented/trained and supervised.

(c) Please refer to the AMA's monograph, "The Use of Volunteers in Jails", for guidance concerning the development of such a program. (See Appendix C - "Publications List.")

C. LAYOUT OF THIS UNIT

1. There are fifty-six standards included in this unit.

(a) They are arranged numerically within specific topic areas (e.g., Administrative, Personnel, etc.), with the title of each preceding the standard.

(b) Essential standards are listed first in each topic area, followed by the Important standards.

(1) For accreditation, all applicable essential standards must be met.

(2) In addition, 70% of the applicable important standards must be achieved for one year accreditation and 85% for two years.

2. Following each standard is a Discussion. The Discussion elaborates on the conceptual basis of the standard and in some instances, identifies alternative approaches to compliance.

(a) In addition, definitions of key terms will be found in the Discussion section.

(b) The first time a key term appears, it is underlined in the standard itself and if not defined in the standard, it is defined in the Discussion.

(c) Further, a GLOSSARY of terms is provided in the Appendix to the Standards (Section II, G of this unit) and key words are listed alphabetically in the INDEX.

3. After each standard and its Discussion, also included in this manual are:

(a) Any "Special Notes" (e.g., if the standard can be non-applicable and under what circumstances); and

(b) Suggestions on how to verify a facility's compliance with the standard.

II. IN DEPTH REVIEW OF THE STANDARDS

A. Administrative Standards: Various aspects of management of the health care delivery system in a jail, including processes and resources, are addressed. The method of formalizing the health care system is outlined. However, the standards do not dictate organizational structure.

1. Essential Standards

a. *Standard 101 - Responsible Health Authority*

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

(1) Discussion

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

(b) The health authority's responsibility includes arranging for all levels of health care and assuring quality and accessibility of all health services provided to inmates. It may be necessary for the facility to enter into written agreements with outside providers and facilities in order to meet all levels of care.

(c) A responsible physician is required in all instances; he or she makes the final medical judgments. In most situations the responsible physician will be the health authority. In many instances the responsible physician also provides primary care.

(d) The health administrator is a person who by education (e.g., RN, MPH, MHA* and related disciplines) is capable of assuming responsibilities for arranging for all levels of health care and assuring quality and accessibility of all services provided to inmates.

(2) Special Note

(a) Regarding the use of allied health personnel, please refer to the AMA monograph on "The Use of Allied Health Personnel in Jails." Also, new health care providers may find helpful information in the AMA monograph "Orienting Health Providers to the Jail Culture." (See Appendix C -"Publications List.")

(3) To verify compliance, do the following:

(a) Ask the person identified as the Health Authority if he/she has been delegated the responsibility for the jail's health care services.

(b) If the Health Authority is not a physician, ask him/her if final medical judgments rest with a single designated physician.

(c) If the Responsible Physician is someone other than the Health Authority, ask if he/she has been designated to make final medical judgments.

b. Standard l02 - Medical Autonomy

Matters of medical (including psychiatric) and dental judgment are the sole province of the responsible physician and dentist respectively; however, security regulations applicable to facility personnel also apply to health personnel.

* RN=Registered Nurse; MHA=Master of Health Administration; MPH=Master of Public Health.

(1) Discussion

(a) The provision of health care is a joint effort of administrators and health care providers and can be achieved only through mutual trust and cooperation.

(1) The Health Authority arranges for the availability of health care services.

(2) The official responsible for the facility provides the administrative support for accessibility of health services to inmates.

(b) Health personnel have been called upon to provide non-medical services to inmates:

(1) "talking to troublemakers;"

(2) providing special housing for homosexuals or scapegoats in the infirmary;

(3) medicating unruly inmates;

(4) conducting body-cavity searches for contraband; and

(5) taking blood alcohol samples for the possible purpose of prosecution.

These are examples of inappropriate uses of medical personnel.

(c) Regarding body-cavity searches, the AMA House of Delegates established policy on this matter in July, 1980. In summary, it declared that:

(1) Searches of body orifices conducted for security reasons should generally be performed by correctional personnel with special training.

(2) Where laws or agency regulations require body cavity searches to be conducted by medical personnel, they should be performed by health care personnel other than those providing care to inmates.

(3) Where searches of body orifices to discover contraband are conducted by non-medical personnel, the following principles should be observed:

(a) The persons conducting these searches should receive training from a physician or other qualified health care provider regarding how to probe body cavities so that neither injuries to the tissue nor infections from unsanitary conditions results;

(b) Searches of body orifices should not be performed with the use of instruments; and

(c) The search should be conducted in privacy by a person of the same sex as the inmate.

(2) To verify compliance, do the following:

(a) Ask the responsible physician and dentist if they make final judgments regarding medical and dental matters.

(b) Ask health providers if the responsible physician has sole province in making medical judgments regarding inmates' health needs.

(c) Ask the responsible physician and health providers if security regulations applicable to facility personnel also apply to health personnel.

c. *Standard 103 - Administrative Meetings and Reports*

Health services (including psychiatric) are discussed at least quarterly at documented administrative meetings between the health authority and the official legally responsible for the facility or their designees.

There is, minimally, an annual statistical report outlining the types of health care rendered and their frequency.

(1) Discussion

(a) Administrative meetings held at least quarterly are essential for successful programs in any field.

(1) Problems are identified and solutions sought.

(2) Health care staff should also be encouraged to attend other facility staff meetings to promote a good working relationship among all staff.

(b) Regular staff meetings which involve the health authority and the person legally responsible for the facility and include discussion of health care services, meet compliance if documented.

(c) If administrative and regular staff meetings are held, but neither is documented, the health authority needs to submit a quarterly report to the facility which includes:

(1) the effectiveness of the health care system;

(2) description of any health environmental factors which need improvements;

(3) changes effected since the last reporting period; and

(4) if necessary, recommendations for corrective actions.

(d) Health environment factors which are of the greatest concern are those in which there are life-threatening situations (e.g., a high incidence of suicides and/or physical assaults) or severe overcrowding which affects inmates' physical and mental health.

(e) The annual statistical report should indicate the number of inmates receiving health services by category of care

as well as other pertinent information (e.g., operative procedures, referrals to specialists, ambulance services, etc.). See Appendix D for sample statistical forms.

Reports done more frequently than quarterly or annually satisfy compliance.

(2) To verify compliance, do the following:

(a) Ask the health authority and the person legally responsible for the facility if they discuss health services at least quarterly at documented meetings.

(b) Review the documentation of previous administrative meetings.

(c) Review a copy of a quarterly report on the health care delivery system and health environment as well as the statistical summary.

d. *Standard l04 - Policies and Procedures*

There is a manual of written policies and defined procedures approved by the health authority which includes the following:

Liaison Staff (l06)
Peer Review (l07)
Public Advisory Committee (l08)
Decision Making - Special Problem Patients (l09)
Special Handling: Patients With Acute Illnesses (l10)
Monitoring of Services/Internal Quality Assurance (lll)
Access to Diagnostic Services (l13)
Notification of Next of Kin (l14)
Postmortem Examination (l15)
Disaster Plan (l16)
Basic Training of Correctional Officers/ Jailers (l20)
Medication Administration Training (l21)
Inmate Workers (l22)
Food Service Workers - Health and Hygiene Requirements (l23)
Utilization of Volunteers (l24)
Emergency Services (l25)
Receiving Screening (l26)
Detoxification (l27)

Access to Treatment (l28)
Daily Triaging of Complaints (l29)
Sick Call (l30)
Health Appraisal (l31)
Skilled Nursing/Infirmary Care (l33)
Use of Restraints (l36)
Special Medical Program (l37)
Standing Orders (l38)
Continuity of Care (l39)
Health Evaluation - Inmates in Segregation (l40)
Health Promotion and Disease Prevention (l41)
Chemically Dependent Inmates (l42)
Pregnant Inmates (l43)
Dental Care (l44)
Delousing (l45)
Exercising (l46)
Personal Hygiene (l47)
Prostheses (l48)
Food Service (l49)
Management of Pharmaceuticals (l50)
Health Record Format and Contents (l51)
Confidentiality of Health Record (l52)
Transfer of Health Record and Information (l53)
Records Retention (l54)

Each policy, procedure and program in the health care delivery system is reviewed at least annually and revised as necessary under the direction of the health authority. Each document bears the date of the most recent review or revision and signature of the reviewer.

(1) Discussion

(a) The facility should keep one manual containing all written policies and procedures.

(b) The facility need not develop policies and procedures for the following standards <u>when</u> the processes, programs and/or services do not exist.

(1) *Standard l06 - Liaison Staff;*
(2) *Standard l08 - Public Advisory Committee;*
(3) *Standard l24 - Utilization of Volunteers;*
(4) *Standard l33 - Skilled Nursing/ Infirmary Care;*
(5) *Standard l38 - Standing Orders; and*
(6) *Standard l43 - Pregnant Inmates.*

Note, however, that these are the only standards where a policy statement may not be requested.

(c) It is not expected that each policy and procedure in the original manual be signed by the health authority.

(1) Instead, a declaration paragraph should be contained at the beginning or end of the manual outlining the fact that the entire manual has been reviewed and approved, followed by the proper signature.

(2) When individual changes are made in the manual, they would need to be initialed by the health authority.

(d) Periodic review of policies, procedures and programs is considered good management practice.

(1) This process allows the various changes made during the year to be formally incorporated into the agency manual instead of accumulating a series of scattered documents.

(2) More importantly, the process of annual review facilitates decision-making regarding previously discussed but unresolved matters.

(2) To verify compliance, do the following:

(a) Examine the facility policy and procedure manual, making sure that it includes all applicable written policies and procedures as demanded by this standard.

(b) Ask the health authority if he/she has approved the manual and if a regular, yearly review of it is made by him/her.

2. Important Standards

a. *Standard 105 - Support Services*

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

(1) Discussion

(a) The type of space and equipment for the examination/treatment room will depend upon the level of health care provided in the facility and the capabilities and desires of health providers.

(b) In all facilities, space should be provided where the inmate can be examined and treated in private.

(c) Basic items generally include:

(1) Thermometers;
(2) Blood pressure cuff;
(3) Stethoscope;
(4) Ophthalmoscope;
(5) Otoscope;
(6) Percussion hammer;
(7) Scale;
(8) Examining table;
(9) Goose neck light;
(10) Wash basin;
(11) Transportation equipment (e.g., wheelchairs and litter);
(12) Drug and medications books such as the Physician's Desk Reference or AMA Drug Evaluations; and
(13) Medical dictionary

(d) If female inmates receive medical services in the facility, appropriate equipment should be available for pelvic examinations.

(e) If psychiatric services are provided in the jail, the following basic items should be provided:

(1) Private interviewing space:

(2) Desk;

(3) Two chairs; and

(4) Lockable file

(2) To verify compliance, do the following:

Ask the health authority if he/she has determined that the health care staff, space, equipment, supplies and materials are adequate for the facility's health care delivery system.

b. *Standard 106 - Liaison Staff*

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

(1) Discussion

(a) Invaluable service can be rendered by a health trained corrections officer or a social worker who may, full or part time, review receiving screening forms for follow-up attention, facilitate sick call by having inmates and records available for the health provider, and help to carry out physician orders regarding such matters as diets, housing and work assignments.

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

(c) Health trained staff may include correctional officers and other personnel without health care licenses who are trained in limited aspects of health care as determined by the responsible physician.

(2) Special Note

(a) If the facility has full-time (e.g., 37.5 - 40 hours per week) qualified health personnel, then this standard will not be applicable.

(3) To verify compliance, do the following:

(a) Ask the responsible physician and the person legally responsible for the facility if the jail has any full time qualified health personnel and if not, if there is a health trained staff member who coordinates the health care delivery system in the facility.

c. *Standard 107 - Peer Review*

Written policy defines the medical peer review program utilized by the facility.

(1) Discussion

(a) Quality assurance programs (peer review) are methods of insuring the quality of medical care.

(b) Funding sources sometimes mandate quality assurance review as a condition for funding medical care.

(c) The American Medical Association's Resolution 121 (A-76) on quality assurance passed by the AMA House of Delegates (1976) reads: "RESOLVED, That the American Medical Association endorse the principle that correctional facilities provide adequate medical care to their inmates which is subject to physician peer review in each community."

(1) A sample policy might be:

"If complaints regarding health care of jail inmates exist, they will be referred to the county medical or specialty society for follow-up the same as complaints are handled regarding health care provided to residents in the community."

(d) Formal, periodic peer review by an outside agency, while not required by the standard, is implemented by some jails on the basis that it helps to advance the effectiveness of the jail health care delivery system.

(e) Some county medical societies, upon request from the sheriff or jail administrator, send in a volunteer team of various specialists to review the jail's health care system and make recommendations regarding needed changes.

(2) To verify compliance, do the following:

Ask the responsible physician and the health authority if they utilize a physician peer review program for services provided to inmates by physicians.

d. *Standard 108 - Public Advisory Committee*

If the facility has a public advisory committee, the committee has health care services as one of its charges. One of the committee members is a physician.

(1) Discussion

(a) Correctional facilities are public trusts but are often removed from public awareness.

(1) Advisory committees fill an important need in bringing the best talent in the community to help in problem-solving.

(2) The role of the advisory committee is to review the facility's program and advise those responsible.

Such a monitoring process helps the staff identify problems, solutions and resources.

(b) The committee may be an excellent resource for support or facilitation of medical peer review processes which are carried out by the medical society or other peer review agencies.

(c) The composition of the committee should be representative of the community and the size and character of the correctional facility.

The advisory committee should represent the local medical and legal professions and may include key lay community representatives.

(d) While grand juries and public health department inspection teams play an important role in advising jails in some communities, their operations do not satisfy compliance, mainly because they are more official than "public" bodies.

(2) Special Notes

(a) If the facility does not have a public advisory committee, this standard will not be applicable.

(b) Please refer to the AMA monographs "The Role of State and Local Medical Society Jail Advisory Committees" and "Organizing and Staffing Citizen Advisory Committees to Upgrade Jail Medical Programs." (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

Ask the official legally responsible for the facility if the jail has a public advisory committee and if it does, whether or not a physician is a member.

e. *Standard 109 - Decision Making -- Special Problem Patients*

Written policy requires consultation between the facility administrator and the responsible physician or their designees prior to the following actions being taken regarding patients who are diagnosed as having significant medical or psychiatric illnesses:

Housing assignments;
Program assignments;
Disciplinary measures; and
Admissions to and transfers from institutions.

(1) Discussion

(a) Maximum cooperation between custody personnel and health care providers is essential so that both groups are made aware of movements and decisions regarding special problem patients.

(1) Medical or psychiatric problems may complicate work assignments or disciplinary management.

(2) Medications may have to be adjusted for safety at the work assignment or prior to transfer.

(b) Significant aspects of medical or psychiatric illness may include:

(1) Suitability for travel based on medical evaluation;

(2) Preparation of a summary or a copy of pertinent health record information (please refer to Standard 153 for guidelines);

(3) Medication or other therapy required enroute:

(4) Instruction to transporting personnel regarding medication or other special treatment.

(2) Special Note

Refer to the AMA monographs on "The Recognition of Jail Inmates With Mental Illness: Their Special Problems and Need for Care" and "Management of Common Medical Problems in Correctional Institutions." (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

(a) Ask the health authority and the person legally responsible for the facility:

(1) if they consult in regard to patients who are diagnosed as having significant medical or psychiatric illnesses with respect to the items listed in Standard 109, and

(2) if medical care aspects are considered in the routine transfer of inmates to other facilities.

(b) Ask health providers if there are written policies and procedures which govern the routine transfer of inmates to other facilities.

f. *Standard 110 - Special Handling: Patients With Acute Illnesses*

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

(1) Discussion

(a) Psychiatric and other acute medical problems identified either at receiving screening or after admission must be followed up by medical staff.

(1) The urgency of the problems determines the responses.

(2) Suicidal and psychotic patients are emergencies and should be held for only the minimum time necessary, but no longer than 12 hours before emergency care is rendered.

(b) Inmates awaiting emergency evaluation should be housed in a specially designated area with constant supervision by trained staff.

(c) All sources of assistance for mentally and acutely ill inmates should be identified in advance of need and referrals should be made in all such cases.

(d) All too often seriously ill inmates have been maintained in correctional facilities in unhealthy and anti-therapeutic environments.

(e) The following conditions should be met if treatment is to be provided in the facility.

(1) Safe, sanitary, humane environment as required by sanitation, safety and health codes of the jurisdiction.

(2) Adequate staffing/security to help inhibit suicide and assault (i.e., staff within sight or sound of all inmates); and

(3) Trained personnel available to provide treatment and close observation.

(2) To verify compliance, do the following:

(a) Ask the health authority if patients with acute psychiatric and/or other serious illnesses are screened and referred for care when needed and if he has provided a list of specific referral sources.

(b) Ask correctional and booking officers if:

(1) inmates who are recognized as having psychiatric or other serious illnesses are referred for care;

(2) there is a written list of specific referral sources; and

(3) inmates are within sight and/or sound of correctional personnel at all times.

(c) Examine the list of specific referral sources.

g. *Standard lll - <u>Monitoring of Service/Internal Quality Assurance</u>*

Written policy requires that the on-site monitoring of health services rendered by providers other than physicians and dentists, including inmate complaints regarding such, the quality of the health record, review of pharmaceutical practices, carrying out direct orders, and the implementation and status of standing orders, is performed by the responsible physician who reviews the health services delivered as follows:

(1) At least once per month in facilities with less than 50 inmates;

(2) At least every two weeks in facilities of 50 to 200 inmates; and

(3) At least weekly in facilities of over 200 inmates.

(1) Discussion

(a) The responsible health authority must be aware that patients are receiving appropriate care and that all written instructions and procedures are properly carried out.

(1) Except in unusual circumstances, it is felt that this process of internal quality assurance can be accomplished only by on-site monitoring.

(b) In many jails where qualified health care providers are not on staff, the health trained correctional officer may be the only person available to help carry out physicians' direct orders (e.g., administering medications, implementing special diets, etc.).

(c) It is expected that these health related services of the correctional officer/jailer would be included for monitoring by the responsible physician.

(2) To verify compliance, do the following:

(a) Ask the responsible physician if he/she reviews health services delivered at the facility by providers other than physicians/ dentists and if so, how often it is done.

h. *l12 - First Aid Kits*

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

(1) Discussion

(a) Examples of content for first aid kits include: roller gauze, sponges, triangle bandages, adhesive tape, band aids, etc., but not emergency drugs.

(b) Kits can be either purchased or assembled from improvised materials.

(c) All kits, whether purchased or assembled, meet compliance if the following points are observed in their selection.

(1) The kits should be large enough and should have the proper contents for the place where they are to be used.

(2) The contents should be arranged so that the desired package can be found quickly without unpacking the entire contents of the box; and

(3) Material should be wrapped so that unused portions do not become dirty through handling.

(2) To verify compliance, do the following:

(a) Ask the health authority if first aid kits are available in designated areas of the jail and if he/she has approved their contents, number, locations and procedures for monthly inspection.

(b) Ask correctional officers and booking officers if they know where first aid kits are kept.

(c) Ask to be shown where the kits are kept and inspect several to see if they are complete (e.g., if they contain the contents as approved by the health authority).

i. *Standard l13 - Access to Diagnostic Services*

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

(1) Discussion

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

(2) To verify compliance, do the following:

(a) Ask health providers if there is a written document outlining access to laboratory and diagnostic services, and

(b) If yes, review the document.

j. *Standard l14 - Notification of Next of Kin*

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

To verify compliance, do the following:

Ask the person legally responsible for the facility, the health authority and health providers if there is such written policy and procedure and if so, review it.

k. *Standard 115 - Postmortem Examination*

Written policy and defined procedures require that in the event of an inmate's death:

(1) The medical examiner or coroner is notified immediately; and,

(2) A postmortem examination is requested by the responsible health authority if the death is unattended or under suspicious circumstances.

(1) Discussion

(a) If the cause of death is unknown or occurred under suspicious circumstances or the inmate was unattended from the standpoint of not being under current medical care, a postmortem examination is in order.

(b) Laws in some jurisdictions require that in the event of any inmate death, a postmortem examination must be performed.

(2) To verify compliance, do the following:

(a) Ask the person legally responsible for the facility and the health authority if this is done.

(b) Review the written policy statement.

l. *Standard 116 - Disaster Plan*

Written policy and defined procedures require that the health aspects of the facility's disaster plan are approved by the responsible health authority and facility administrator.

(1) Discussion

(a) Policy and procedures for health care services in the event of a man-made or natural disaster, riot or internal or external (e.g., civil defense, mass arrests, etc.) disaster must be incorporated in the correctional system plan and made known to all facility personnel.

(b) Health aspects of the disaster plan, among other items, include the triaging process, outlining where care can be provided and laying out a back-up plan.

(2) To verify compliance, do the following:

(a) Ask the health authority and the person legally responsible for the facility if the jail's disaster plan includes a health component approved by each.

(b) Review the disaster plan for health aspects.*

B. Personnel Standards: Standards pertaining to qualifications, training, work appraisal and supervision of staff are included in this section.

1. Essential Standards

a. *Standard 117 - Licensure*

State licensure, certification or registration requirements and restrictions apply to qualified health care personnel who provide services to inmates. Verification of current credentials is on file at the facility.

(1) Discussion

(a) When applicable laws are ignored, the quality of health care is compromised.

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

(2) To verify compliance, do the following:

Examine copies of current credentials or letters from the state licensing body to ensure that all credentials of qualified health personnel are current.

b. *Standard 118 - Job Description*

Written job descriptions define the specific duties and responsibilities of personnel who provide health care in the facility's health care system. These are approved by the health authority.

* This completes the "Administrative Standards" section. Turn to Appendix A for sample situations for the class to address.

(1) Discussion

The most effective use of health care personnel in a jail health system is achieved through the use of written guidelines, approved by the health authority.

(2) To verify compliance, do the following:

(a) Ask the health authority if s/he has approved the written job descriptions of personnel providing health care in the jail's health care system.

(b) Ask health providers if they have a written job description which defines their duties and responsibilities and if so, if their roles in the jail's health care system are reflected in their job descriptions.

(c) Review samples of these written job descriptions.

c. *Standard 119 - Staff Development and Training*

A written plan approved by the health authority provides for all health services personnel to participate in orientation and training appropriate to their health care delivery activities and outlines the frequency of continuing training for each staff position.

(1) Discussion

(a) Providing health services in a detention/correctional facility is a unique task which requires particular experience or orientation for personnel.

These needs should be formally addressed by the health authority based on the requirements of the institution.

(b) All levels of health care staff require regular continuing staff development and training in order to provide the highest quality of care.

(c) Proper initial orientation and continuing staff development and training may serve to decelerate "burn-out" of health providers and help to re-emphasize the goals and philosophy of the health care system.

(2) Special Note;

(a) Please refer to the following AMA monographs (See Appendix C - "Publications List.")

(1) "Orienting Health Providers to the Jail Culture";

(2) "Orienting Jailers to Health and Medical Care Delivery Systems";

(3) "The Use of Allied Health Personnel in Jails: Legal Considerations."

(3) To verify compliance, do the following:

(a) Ask health providers if they participate in orientation and training sessions which are of value to them in their jobs.

(b) Review the written training plan.

d. *Standard 120 - Basic Training of Correctional Officers/Jailers*

Written policy and a training program established or approved by the responsible health authority in cooperation with the facility administrator, guide the training of all correctional officers regarding:

(1) Types of and action required for potential emergency situations;

(2) Signs and symptoms of an emergency;

(3) Administration of first-aid, with training to have occurred within the past three years;

(4) Methods of obtaining emergency care;

(5) Procedures for transferring patients to appropriate medical facilities or health care providers; and

(6) Signs and symptoms of mental illness, retardation, emotional disturbance and chemical dependency.

A sufficient number of correctional officers are trained in basic cardiopulmonary resuscitation (CPR) so that they can always respond to emergency situations in any part of the facility within four minutes.

Minimally, one health trained correctional officer per shift is trained in the recognition of symptoms of illnesses most common to the inmates.

(1) Discussion

(a) It is imperative that facility personnel be made aware of potential emergency situations, what they should do in facing life-threatening situations and their responsibility for the early detection of illness and injury.

(b) Current first aid certification must be from an approved body (e.g., The American Red Cross (ARC), a hospital, fire or police department, clinic, training academy or any other approved agency), or an individual possessing a current instructor's certificate from an approved body.

(c) Training regarding emotional disturbance, developmental disability and chemical dependency is essential for the recognition of inmates who need evaluation and possible treatment which, if not provided, could lead to life-threatening situations.

(2) Special Notes

(a) Please refer to the following AMA monographs which can be used to help train correctional officers in the above subjects (See Appendix C - "Publications List.")

(1) "The Recognition of Jail Inmates With Mental Illness: Their Special Problems and Needs for Care";

(2) "Guide for the Care and Treatment of Chemically Dependent Inmates";

(3) "Management of Common Medical Problems in Correctional Institutions'; and

(4) "Orienting Jailers to Health and Medical Care Delivery Systems."

(b) Training materials on the recognition of symptoms of common illnesses can be found in the AMA Manual For The Training of Jailers in Receiving Screening and Health Education.

(3) To verify compliance, do the following:

(a) Ask the health authority and the person legally responsible for the facility if there is a training program for all correctional officers who work with inmates to respond to health related emergency situations.

(b) Ask correctional and booking officers if they have received the training as required by the standard.

(c) Review the written training plan and schedule. Note, though, that due to staff turnover and other reasons, this standard may not be completely met.

If, however, the facility can demonstrate that at least 75% of the correctional officers have received this training and that an on-going training program and schedule for training exist, then the facility can be said to be meeting the "spirit" of the standard, though not the "letter" of it.

e. *Standard 121 - Medication Administration Training*

Written policy and defined procedures guide the training of personnel who administer medication and require training from or approved by the responsible physician and the facility administrator or their designees regarding:

(1) Accountability for administering medications in a timely manner according to physician orders; and

(2) Recording the administration of medications in a manner and on a form approved by the health authority.

(1) Discussion

(a) Training from the responsible physician encompasses the medical aspects of the administration of medications.

(b) Training from the facility administrator encompasses security matters inherent in the administration of medications in a correctional facility.

(c) The concept of administration of medications according to orders includes performance in a timely manner.

(2) Special Note

Please refer to Standard 150 for the definition of administration of medications.

(3) To verify compliance, do the following:

(a) Ask the responsible physician and the person legally responsible if they have provided training for all personnel who administer medications.

(b) Ask those who administer medications if they received training from the responsible physician and person legally responsible for the facility.

If yes, ask if the training included:

(1) accountability for administering medications in a timely manner, and

(2) recording the administration of medications in a manner and on a form approved by the health authority.

f. *Standard l22 - Inmate Workers*

Written policy requires that inmates are not used for the following duties:

(1) Performing direct patient care services;

(2) Scheduling health care appointments;

(3) Determining access of other inmates to health care services;

(4) Handling or having access to surgical instruments, syringes, needles, medications or health records; and

(5) Operating medical equipment for which they are not trained.

(1) Discussion

(a) Understaffed correctional institutions are inevitably tempted to use inmates in health care delivery to perform services for which civilian personnel are not available:

(b) Their use frequently violates state laws, invites litigation and brings discredit to the correctional health care field, to say nothing of the power these inmates can acquire and the severe pressure they may receive from fellow inmates.

(2) To verify compliance, do the following:

Ask the health authority, health providers, the person legally responsible for the facility, the pharmacist and the health records person if inmate workers are used in any capacity in the jail's health care system.

2. Important Standards

a. *Standard l23 - Food Service Workers - Health and Hygiene Requirements*

Written policy and defined procedures require that inmates and other persons working in food service:

(1) Are subject to the same laws and/or regulations as food service workers in the community where the facility is located;

(2) Are monitored each day for health and cleanliness by the director of food services or his/her designee; and

(3) *Are instructed to wash their hands upon reporting to duty and after using toilet facilities.*

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

(1) Discussion

All inmates and other persons working in the food service should be free from diarrhea, skin infection and other illnesses transmissible by food or utensils.

(2) To verify compliance, do the following:

Ask the person legally responsible for the facility and the director of food service if the elements as demanded by the standard are performed.

b. *Standard 124 - Utilization of Volunteers*

Written policy and defined procedures approved by the health authority and facility administrator for the utilization of volunteers in health care delivery include a system for selection, training, length of service, staff supervision, definition of tasks, responsibilities and authority.

(1) Discussion

(a) To make the experience of volunteers productive and satisfying for everyone involved -- patients, staff, administration and the public -- goals and purposes must be clearly stated and understood and the structure of the volunteer program well-defined.

(b) Volunteers are an important personnel resource in the provision of human services. As demands for services increase, volunteers can be expected to play an increasingly important part in health care service delivery.

(c) The most successful volunteer programs treat volunteers like staff for all aspects except pay, including requiring volunteers to safeguard the principle of confidentiality.

(2) Special Notes

(a) If the facility does not utilize volunteers in health care delivery, this standard will be not applicable.

(b) Please refer to the AMA monograph on "The Use of Volunteers in Jails." (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

(a) Ask the health authority and the person legally responsible for the facility if volunteers are used in health care delivery.

(b) If yes, review the written policy and procedures pertaining to the utilization of volunteers and see if it has been approved by the health authority.*

C. Care and Treatment Standards: Various aspects of the care and treatment of patients, such as types of services, access to services, practices, procedures and treatment philosophy are included in this section.

1. Essential Standards

a. *Standard 125 - Emergency Services*

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

(1) Emergency evacuation of the inmate from within the facility;

(2) Use of an emergency medical vehicle;

(3) Use of one or more designated hospital emergency departments or other appropriate health facilities;

* This completes the "Personnel Standards" section. Turn to Appendix A for sample situations.

(4) Emergency on-call physician and dentist services when the emergency health facility is not located in a nearby community; and

(5) Security procedures that provide for the immediate transfer of inmates when appropriate.

(1) Discussion

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

(b) Emergency care must be provided with efficiency and speed.

(2) To verify compliance, do the following:

(a) Ask the person legally responsible for the facility, the health authority, correctional and booking officers if all of the elements of the standard are met.

(b) Ask the dentist if there is 24-hour emergency dental care.

(c) Review the written security procedures providing for the immediate transfer of inmates when appropriate.

b. *Standard 126 - Receiving Screening*

Written policy and defined procedures require receiving screening to be performed by health trained or qualified health care personnel on all inmates (including transfers) immediately upon arrival at the facility. Arrestees who are unconscious, semi-conscious, bleeding or otherwise obviously in need of immediate medical attention, are referred immediately for emergency care. If they are referred to a community hospital, their admission or return to the jail is predicated upon written medical clearance. The receiving screening findings are recorded on a printed form approved by the health authority. At a minimum the screening includes:

Inquiry into:

(1) Current illness and health problems including mental, dental and communicable diseases;

(2) Medications taken and special health requirements;

(3) Use of alcohol and other drugs, including types, methods, amounts, frequency, date or time of last use and a history of problems which may have occurred after ceasing use (e.g., convulsions);

(4) Other health problems, as designated by the responsible physician, including mental illness; and

(5) For females, a history of gynecological problems and pregnancies.

Observation of:

(1) Behavior, which includes state of consciousness, mental status, appearance, conduct, tremors and sweating:

(2) Body deformities and ease of movement; and

(3) Condition of skin, including trauma markings, bruises, lesions, jaundices, rashes and infestations and needle marks or other indications of drug abuse.

Disposition such as:

(1) Referral to an appropriate health care service on an emergency basis; or

(2) Placement in the general inmate population and later referral to an appropriate health care service; or

(3) Placement in the general inmate population.

(1) Discussion

(a) Receiving screening is a system of structured inquiry and observation designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population and to get them rapidly admitted to medical care.

(b) Receiving screening can be performed by health personnel or by a trained correctional officer at the time of booking/admission.

(c) Facilities which have reception and diagnostic units and/or a holding room must conduct receiving screening on all inmates immediately upon arrival at the facility as part of the booking/admission procedure. In short, placing two or more inmates in a holding room pending screening the next morning fails to meet compliance.

(d) Some studies indicate that alcohol-related suicide is the number one cause of death in jails; second is "cold turkey withdrawal" from alcohol and other drugs.6/

(1) Hence, it is considered extremely important for booking officers to fully explore the inmate's suicide and/or withdrawal potential.

(2) Reviewing with the inmate any history of suicidal behavior and visually observing the inmate's behavior (delusions, hallucinations, communication difficulties, speech and posturing, impaired level of consciousness, disorganization, memory defects, depression or evidence of self-mutilation) are recommended.

6/ See e.g., Hudson, "Jail and Prison Deaths."

(3) Most jails following this approach, coupled with the training of all jailers regarding mental health and chemical dependency aspects, are able to prevent all or most suicides and "cold turkey withdrawals."

(e) If a copy of the receiving screening form accompanies transferees, a full receiving screening need not be conducted, but the prior receiving screening results should be reviewed and verified.

(f) At the time of receiving screening, inmates should be shown in writing and told how to gain access to medical care (see Standard 128).

(g) To verify compliance, do the following:

(1) You should see the receiving screening form which includes sections on inquiry, observation and disposition as required by the standard (See Appendix E - "Sample Receiving Screening Form").

(2) You should ask health providers who perform receiving screening functions if the disposition process of receiving screening is handled appropriately.

(3) You should ask inmates if, when they were brought to the jail, they were told and shown in writing how to get health care.

(4) If you get conflicting information (i.e., everyone but inmates say receiving screening is performed), check inmate medical records to see if there is a completed receiving screening form. Often, inmates will forget or were in such a state of anxiety when they were brought to the jail they do not even remember being screened.

(5) If correctional personnel (especially booking officers) as well as inmates tell you that no receiving screening occurs, or that it is performed, but not immediately upon an inmate's arrival at the jail, you can be fairly certain that this is the case.

c. *Standard 127 - Detoxification*

Written policy and defined procedures require that detoxification from alcohol, opioids, stimulants and sedative hypnotic drugs is effected as follows:

When performed at the facility, it is under medical supervision; and

When not performed at the facility, it is conducted in a hospital or community detoxification center.

(1) Discussion

(a) Drug detoxification refers to the process by which an individual is gradually withdrawn from a drug by administering decreasing doses either of the same drug upon which the person is physiologically dependent or one that is cross-tolerant to it or a drug which has been demonstrated to be effective on the basis of medical research.

(b) The detoxification of certain patients (e.g., psychotics, seizure-prone, pregnant, juveniles or geriatrics) may pose special risks and thus, require special attention.

(c) Detoxification from alcohol should not include decreasing doses of alcohol; further, supervised "drying out" may not necessarily involve the use of drugs.

(d) Opioids refer to derivatives of opium such as morphine and codeine and synthetic drugs with morphine-like properties.

(e) Medical supervision means that for in-jail alcohol and opioid detoxification, at a minimum, the inmate must be under 24 hour per day, 60 minutes per hour supervision of a health trained correctional officer working under a physician's direction.

(f) For detoxification from barbiturates and other sedative hypnotic drugs, the program in the jail must be under the 24 hour supervision of a licensed nurse at a minimum.

(g) Fixed drug regimens (e.g., every patient gets the same dose of medication regardless of individual symptoms and medical condition) are generally not recommended.

(2) Special Note

Please refer to the AMA monograph "Guide for the Care and Treatment of Chemically Dependent Inmates" for further information on the subject. (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

Ask health providers if detoxification services are provided within the facility and if so, whether they are performed under medical supervision. If not performed within the facility, ask health providers where detoxification is done.

d. *Standard 128 - Access to Treatment*

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

(1) Discussion

(a) The facility should follow the policy of explaining access procedures orally to all inmates, especially those unable to read.

(b) Where the facility frequently has non-English speaking inmates, procedures should be explained and written in their language.

(c) Signs posted in the dayroom/living area do satisfy compliance; signs posted in the booking area do not.

(2) To verify compliance, do the following:

(a) Ask correctional and booking officer if inmates are told how to get access to medical care and if they are given anything in writing (if yes, what is it?)

(b) Ask inmates, if when they were brought to the facility, they were told and shown in writing how to get medical/dental care.

(c) Review a copy of the written document.

e. *Standard l29 - Daily Triaging of Complaints*

Written policy and defined procedures require that inmates' health complaints are documented and processed at least daily as follows:

*Solicited daily and acted upon by health trained correctional personnel;*and*

Followed by appropriate triage and treatment by qualified health personnel where indicated.

(1) Discussion

(a) Triage is the sorting of complaints and allocation to treatment according to a priority system.

(b) Some jails note on the complaint slip the action taken regarding triaging and file such slips in the inmate's medical record; others use a log. These are examples of health complaints being documented.

* See Glossary for definitions.

(2) To verify compliance, do the following:

(a) Ask health providers if inmates' health complaints are processed daily and if triage and treatment are performed by qualified health personnel.

(b) Ask correctional and booking officers if inmates' health complaints are processed at least on a daily basis and referred to qualified health care personnel.

(c) Review the documentation of inmates' health complaints.

f. *Standard l30 - Sick Call*

Written policy and defined procedures require that sick call is conducted by a physician and/or other qualified health personnel and is available to each inmate as follows:

(1) In small facilities of less than 50 inmates, sick call is held once per week at a minimum;

(2) In medium-sized facilities of 50 to 200 inmates, sick call is held at least three days per week; and

(3) Facilities of over 200 inmates hold sick call a minimum of five days a week.

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

(2) Discussion

(a) Some people refer to sick call as a "clinic visit."

(b) Clinic care or "sick call" is care for an ambulatory inmate with health care complaints which are evaluated and treated at a particular point in time.

(c) Sick call is the system through which each inmate reports for and receives appropriate medical services for non-emergency illness or injury.

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

(2) To verify compliance, do the following:

(a) Ask health providers, correctional and booking officers and inmates how often sick call is held.

(b) Ask the health authority and correctional and booking officers if arrangements are made to provide sick call services in the place of an inmate's detention if his/her custody status precludes attendance at sick call.

g. *Standard 131 - Health Appraisal*

Written policy and defined procedures require that:

Health appraisal is completed for each inmate within 14 days after arrival at the facility. In the case of an inmate who has received a health appraisal within the previous 90 days, a new health appraisal is not required except as determined by the physician or his/her designee. Health appraisal includes:

(1) Review of the earlier receiving screening;

(2) Collection of additional data to complete the medical, dental and psychiatric histories;

(3) Laboratory and/or diagnostic tests (as determined by the responsible physician with recommendations from the local public health authority) to detect communicable disease, including venereal diseases and tuberculosis;

(4) Recording of height, weight, pulse, blood pressure and temperature;

(5) Other tests and examinations as appropriate;

(6) Medical examination (including gynecological assessment of females) with comments about mental and dental status;

(7) Review of the results of the medical examination, tests and identification of problems by a physician and/or his/her designee when the law allows such; and

(8) Initiation of therapy when appropriate.

The collection and recording of health appraisal data are handled as follows:

(1) The forms are approved by the health authority;

(2) Health history and vital signs are collected by health trained or qualified health personnel; and

(3) Collection of all other health appraisal data is performed only by qualified health personnel.

(1) Discussion

(a) The extent of the health appraisal, including medical examinations, is defined by the responsible physician, but should include at least the above. When appropriate, additional investigation should be carried out regarding:

(1) The use of alcohol and/or drugs including the types of substances abused, mode of use, amounts used, frequency of use and date or time of last use.

(2) Current or previous treatment for alcohol or drug abuse and if so, when and where;

(3) Whether the inmate is taking medication (such as disulfiram, methadone hydrochloride or others) for an alcohol or drug abuse problem.

(4) Current or past illnesses and health problems related to substance abuse such as hepatitis, seizures, traumatic injuries, infections, liver diseases, etc.; and

(5) Whether the inmate is taking medication for a psychiatric disorder and if so, what drugs and for what disorder.

(b) Further assessment of psychiatric problems identified at receiving screening or after admission should be provided by either the medical staff or the psychiatric services staff within 14 days.

(In most facilities, it can be expected that psychiatric assessment will be done by a general practitioner or family practitioner.)

(c) Psychiatric services staff can include psychiatrists, family physicians with psychiatric orientation, psychologists, psychiatric nurses, social workers and trained correctional counselors.

(d) Refer to Standard 106 for definitions of the different levels of health personnel.

(2) Special Note

Regarding waiver of laboratory tests for tuberculosis and venereal diseases, a letter from the public health authority citing the incidence of the disease(s) in that locality and the justification for not conducting such tests on all inmates is required for consideration of waiver.

(3) To verify compliance, do the following:

(a) Examine the health record files to see that health appraisals include:

(1) Medical, dental and psychiatric histories;

(2) Laboratory and/or diagnostic tests to detect communicable disease;

(3) Height, weight, pulse, blood pressure and temperature;

(4) Other tests and examinations as appropriate;

(5) A medical examination (including gynecological assessment of females) with comments about mental and dental status;

(6) Review of results of medical examination, tests and identification of problems by a physician and/or his/her designee when the law allows such; and

(7) Initiation of therapy when appropriate.

(b) Ask the health authority and responsible physician if the collection and recording of health appraisal data are handled as demanded by the standard.

(c) Ask health providers if health appraisals are completed for each inmate within 14 days after arrival at the facility.

(d) Ask inmates if they have been in the facility for more than 14 days.

(1) If the answer is yes, ask the inmate if he/she was offered a venereal disease and tuberculosis test and a medical examination before the 14th day, and

(2) Ask him/her if height, weight, pulse, temperature and blood pressure were taken.

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It is important to note that it is not unusual for inmates to respond negatively to these questions.

When an inmate gives negative responses to questions concerning this standard, you should refer to his/her medical record to verify the responses.

h. *Standard 132 - Direct Orders*

Treatment by qualified and health trained personnel other than a physician or dentist is performed pursuant to direct orders written and signed by personnel authorized by law to give such orders.

(1) Discussion

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

(2) To verify compliance, do the following:

(a) Ask health providers if direct orders are written and signed by personnel authorized by law to give such orders (e.g., physicians, psychiatrists, etc.).

(b) Examine health records to see if direct orders have been written and signed by such personnel.

(c) If a physician gives a direct order over the telephone and then signs it the next time he/she is at the facility, this will satisfy compliance.

i. *Standard 133 - Skilled Nursing/Infirmary Care*

Written policy and defined procedures guide skilled nursing or infirmary care and require:

(1) A definition of the scope of skilled nursing care provided at the facility;

(2) A physician on call 24 hours per day;

(3) Supervision of the infirmary by a registered nurse on a daily basis;

(4) A health trained person on duty 24 hours per day;

(5) All inmate patients being within sight or sound of a staff person;

(6) A manual of nursing care procedures; and

(7) A separate individual and complete medical record for each inmate.

(1) Discussion

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

(b) Skilled nursing/infirmary care is defined as inpatient bed care by or under the supervision of a registered nurse for an illness or diagnosis which requires limited observation and/or management and does not require admission to a licensed hospital.

(c) Supervision is defined as overseeing the accomplishment of a function or activity.

(d) Advancement of the quality of care in this type of medical area begins with the assignment of responsibility to one physician.

Depending upon the size of the infirmary, the physician may be employed part or full-time.

(e) Nursing care policies and procedures should be consistent with professionally recognized standards of nursing practice and in accordance with the Nurse Practice Act of the state.

Policies and procedures should be developed on the basis of current scientific knowledge and take into account new equipment and current practices.

(2) Special Note

If the facility does not operate an infirmary, this standard will not be applicable.

(3) To verify compliance, do the following:

(a) Ask health providers if the facility has an infirmary and, if the answer is yes, ask them if the elements as required by the standard exist.

(b) Examine the manual of nursing procedures for nursing care delivered in the infirmary.

(c) Ask to see the defined list of the scope of infirmary care services at the facility.

(d) Verify that separate and complete medical records are kept for each inmate in the infirmary.

2. Important Standards

a. *Standard 134 - Hospital Care*

If a facility operates a hospital, it meets the legal requirements for a licensed general hospital in the state.

(1) Discussion

(a) Even though a hospital operated by a correctional facility may not be considered a "general" hospital, and therefore not reviewed by a state

licensing body, it is important that the care provided be consistent with that provided generally within the state.

(b) Where conditions in the facility are inadequate to meet state standards, the quality of care is compromised.

(2) Special Note

If the facility does not operate a hospital, this standard will not be applicable.

(3) To determine compliance, do the following:

Ask the health authority, the pharmacist and the health records person if the facility operates a hospital and if so, if it meets the legal requirements for a licensed general hospital in the state.

b. *Standard 135 - Treatment Philosophy*

Medical procedures are performed in privacy, with a chaperone present when indicated, and in a manner designed to encourage the patient's subsequent utilization of appropriate health services.

When rectal and pelvic examinations are indicated, verbal consent is obtained from the patient.

(1) Discussion

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

(b) Please refer to the discussion in Standard 102, which outlines the American Medical Association's policy on the conducting of body cavity searches.

(2) To verify compliance, do the following:

Ask health providers and inmates if medical procedures are performed in privacy, with a chaperone present if indicated.

c. *Standard 136 - Use of Restraints*

Written policy and defined procedures guide the use of medical restraints and include an identification of the authorization needed, and when, where, duration and how restraints may be used. The health care staff do not participate in disciplinary restraint of inmates, except for monitoring their health status.

(1) Discussion

(a) This standard applies to those situations where the restraints are part of health care treatment.

(b) The same kinds of medical restraints that would be appropriate for individuals treated in the community may likewise be used for medically restraining incarcerated individuals (e.g., leather or canvas hand and leg restraints, chemical restraints and straight jackets).

(c) Written policy should identify authorization needed, and when, where, duration and how restraints may be used.

(d) If a facility does not use medical restraints, it should develop a negative policy statement to this effect.

(e) The health care staff should not participate in the disciplinary restraint of inmates. However, inmates who are restrained for disciplinary reasons should be monitored regularly (e.g., at least once per shift) by qualified or health-trained personnel.

(2) To verify compliance, do the following:

(a) Ask health providers if written policy and defined procedures guide the use of medical restraints.

(b) Ask if they monitor individuals who are restrained for disciplinary reasons.

d. *Standard 137 - Special Medical Program*

Written policy and defined procedures guide the special medical program which exists for inmates requiring close medical supervision, including chronic and convalescent care. A written individualized treatment plan, developed by a physician, exists for these patients and includes

directions to health care and other personnel regarding their roles in the care and supervision of these patients.

(1) Discussion

(a) The special medical program services a broad range of health problems (e.g., seizure disorders, diabetes, potential suicide, chemical dependency and psychosis).

(1) These are some of the special medical conditions which dictate close medical supervision.

(2) In these cases, the facility must respond appropriately by providing a program directed to individual needs.

(b) The program need not necessarily take place in an infirmary, although a large facility may wish to consider such a setting for the purposes of efficiency (see Standard 133).

(c) When a self-contained type of program does not exist, the following are provided:

(1) Correctional staff officer trained in health care;

(2) Sufficient staff to help prevent suicide and assault;

(3) At a minimum, all inmate patients are within sight of a staff person; and

(4) Qualified health personnel to provide treatment.

(d) Chronic care is medical service rendered to a patient over a long period of time; treatment of diabetes, asthma and epilepsy are examples.

(e) Convalescent care is medical service rendered to a patient to assist in recovery from illness or injury.

(f) A treatment plan is a series of written statements which specify the particular course of therapy and the roles of medical and non-medical personnel in carrying out the course of therapy.

(1) It is individualized and based on assessment of the patient's needs and includes a statement of the short and long term goals as well as the methods by which the goals will be pursued.

(2) When clinically indicated, the treatment plan provides inmates with access to a range of supportive and rehabilitative services (e.g., individual or group counseling and/or self-help groups) that the physician deems appropriate.

(2) Special Note

Refer to the following AMA monographs for further suggestions: "Management of Common Medical Problems in Correctional Institutions" and "Guide for the Care and Treatment of Chemically Dependent Inmates." (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

(a) Ask health providers if there is a special medical program for inmates who require close medical supervision.

(1) If the answer is yes, ask if there is a written individualized treatment plan for each of these patients; and

(2) Ask if this treatment plan includes direction to health care and other personnel regarding their roles in the care and supervision of these patients.

(b) Check health records to ascertain that individualized treatment plans exist for patients who require close supervision.

e. *Standard 138 - Standing Orders*

If standing medical orders exist, written policy requires that they are developed and signed by the responsible physician. When utilized, they are countersigned in the medical record by the physician.

(1) Discussion

Standing medical orders are written for the definitive treatment of identified conditions and for on-site treatment of emergency conditions for any person having the condition to which the order pertains.

(2) Special Note

If there are no standing medical orders, then this standard will be not applicable.

(3) To verify compliance, do the following:

(a) Ask the responsible physician and health providers if standing medical orders exist.

(b) If the answer is yes, do the following:

(1) review them to see if they have been signed by the responsible physician; and

(2) review health records to verify that when utilized, they are countersigned in the inmates' medical records.

f. *Standard 139 - Continuity of Care*

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

(1) Discussion

(a) As in the community, health providers should obtain information regarding previous care when undertaking the care of a new patient.

(b) Likewise, when the care of the patient is transferred to providers in the community, appropriate health information is shared with the new providers in accord with consent requirements.

(2) To verify compliance, do the following:

Ask the health authority, responsible physician and health providers if continuity of care is provided all inmates/patients.

g. *Standard 140 - Health Evaluation - Inmates in Segregation*

Written policy and defined procedures require that inmates removed from the general population and placed in segregation are evaluated at least three (3) days per week by health trained personnel and that the encounters are documented.

(1) Discussion

(a) Due to the possibility of injury and/or depression during such periods of isolation, health evaluations should include notation of any bruises or other trauma markings, and comments regarding the inmate's attitude and outlook.

(b) Carrying out this policy may help to prevent suicide or prevent an illness from becoming serious.

(2) To verify compliance, do the following:

(a) Ask the health authority and health providers if this is done.

(b) Ask correctional and booking officers if health-trained personnel perform this evaluation as the standard requires.

(c) Ask inmates if they were ever held in isolation and if yes, how often health-trained personnel evaluated them.

Also, check their health records to determine if the encounters were documented.

h. *Standard 141 - Health Promotion and Disease Prevention*

Written policy and defined procedures require that medical preventive maintenance is provided to inmates of the facility.

(1) Discussion

(a) Medical preventive maintenance includes health education and medical services (such as inoculations and immunization) provided to take advance measures against disease and instruction in self-care for chronic conditions.

Self-care is defined as care for a condition which can be treated by the inmate and may include "over-the-counter" type medications.

(b) Subjects for health education may include:

(1) Personal hygiene and nutrition;

(2) Venereal disease, tuberculosis and other communicable diseases;

(3) Effects of smoking;

(4) Self-examination for breast cancer;

(5) Dental hygiene;

(6) Drug abuse and danger of self-medication;

(7) Family planning, including, as appropriate, both services and referrals;

(8) Physical fitness; and

(9) Chronic diseases and/or disabilities.

(2) To verify compliance, do the following:

(a) Ask health providers if health education and inoculations and/or immunizations are provided to inmates (if needed), and

(b) Examine health records to ascertain that medical preventive maintenance is provided.

i. *Standard 142 - Chemically Dependent Inmates*

Written policy and defined procedures regarding the clinical management of chemically dependent inmates require:

(1) Diagnosis of chemical dependency by a physician or properly qualified designee (if authorized by law);

(2) A physician deciding whether an individual needs pharmacological or non-pharmacological supported care;

(3) An individualized treatment plan which is developed and implemented; and

(4) Referral to specified community resources upon release when appropriate.

(1) Discussion

(a) Existing community resources should be utilized if possible.

(b) The term chemical dependency refers to individuals who are physiologically and/or psychologically dependent on alcohol, opium derivatives and synthetic drugs with morphine-like properties (opioids), stimulants and/or depressants.

(2) Special Note

Please refer to the AMA monograph "Guide For The Care and Treatment of Chemically Dependent Inmates." (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

Ask health providers if the four elements as required by the standard are performed. Review inmate medical records.

j. *Standard 143 - Pregnant Inmates*

Written policy and defined procedures require that comprehensive counseling and assistance are provided to pregnant inmates in keeping with their expressed desires in planning for their unborn children, whether desiring abortion, adoption service or to keep the child.

(1) Discussion

(a) It is advisable that a formal legal opinion as to the law relating to abortion be obtained and based upon that opinion, written policy and defined procedures should be developed for each jurisdiction.

(b) Counseling and social services should be available from either facility staff or community agencies.

(2) Special Note

If the facility never houses female inmates, this standard will be not applicable.

(3) To verify compliance, do the following:

(a) Ask health providers if such comprehensive counseling and assistance are provided to pregnant inmates.

(b) If there are any pregnant inmates at the facility, ask them if counseling was offered.

k. *Standard 144 - Dental Care*

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

(1) Dental screening within 14 days of admission;

(2) Dental hygiene service within 14 days of admission;

(3) *Dental examinations within three months of admission; and*

(4) *Dental treatment, not limited to extractions, when the health of the inmate would otherwise be adversely affected as determined by the dentist.*

(1) Discussion

(a) While the usual definition of dental hygiene includes clinical procedures taken to protect the health of the mouth and chewing apparatus, minimum compliance will be instruction in the proper brushing of teeth.

(b) The dental examination should include taking or reviewing the patient's dental history and examination of hard and soft tissue of the oral cavity by means of an illuminator light, mouth mirror and explorer

(1) X-rays for diagnostic purposes should be available if deemed necessary.

(2) The results are recorded on an appropriate uniform dental record utilizing a number system such as the Federation Dentaire Internationale System.

(2) Special Note

Refer to the AMA monograph "Dental Care for Jail Inmates." (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

(a) Ask the dentist if the dental program is under the direction of a designated dentist and if dental care is provided under the direction and supervision of a dentist licensed in the state.

(b) Ask dentists and inmates if the four items required by the standard are provided on a routine basis.

In case of negative responses by inmates, you should check their medical records to see if there is any record of dental care.

l. *Standard 145 - Delousing*

Written policy approved by the responsible physician defines delousing procedures used in the facility.

(1) Discussion

Even if no delousing is done, a written negative policy is needed.

(2) To verify compliance, do the following:

Ask the responsible physician if he approved written policy defining the delousing procedures used in the facility, and if so, review the policy.

m. *Standard 146 - Exercising*

Written policy and defined procedures outline a program of exercising and require that each inmate is allowed a daily (i.e., 7 days per week) minimum of one hour of exercise involving large muscle activity, away from the cell, on a planned, supervised basis.

(1) Discussion

(a) Examples of large muscle activity include walking, jogging in place, basketball, ping pong and isometrics.

(b) Facilities meet compliance of a planned, supervised basis under the following conditions:

(1) It is recognized that many facilities do not have a separate facility or room for exercising;

(2) The dayroom adjacent to the cell may be used for this purpose;

(3) However, the dayroom meets compliance only if planned, programmed activities are directly supervised by staff and/or trained volunteers. Otherwise, the designated

hour would not be different from any of the other hours of the day;

(4) Television and table games do not meet compliance;

(5) Regarding the use of outside yards, gymnasiums and multi-purpose rooms, making available exercising opportunities (e.g., basketball, handball, jogging, running and calisthenics) does satisfy compliance even though inmates may not take advantage of them;

(6) While such activities may be more productive under the supervision of a recreational staff person, this is not required; and

(7) For supervision purposes, inmates should be within sight or sound of a staff person.

(2) Refer to the AMA publication "Exercising Manual." (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

Ask correctional and booking officers and inmates if:

(a) Each inmate is allowed a daily minimum of one hour of exercise involving large muscle activity;

(b) It is done away from the cell; and

(c) It is done on a planned, supervised basis.

n. *Standard 147 - Personal Hygiene*

Written policy and defined procedures outline a program of personal hygiene and require that every facility that would normally expect to detain an inmate at least 48 hours:

(1) Furnish bathing facilities in the form of either a tub or shower with hot and cold running water;

(2) Permit regular bathing at least twice a week;

(3) Permit daily bathing in hot weather in facilities without air temperature control; and

(4) Provide the following items:

Soap;
Toothbrush;
Toothpaste or powder;
Toilet paper;
Sanitary napkins when required; and
Laundry services at least weekly.

Haircuts and implements for shaving are made available to inmates, subject to security regulations.

(1) To verify compliance, do the following:

(a) Ask the person legally responsible for the facility, correctional and booking officers and inmates if all the elements of the standard are met; and

(a) Examine the bathing facilities with hot and cold running water.

o. *Standard 148 - Prostheses*

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

(1) Discussion

Prostheses are artificial devices to replace missing body parts or compensate for defective bodily functions.

(2) To verify compliance, do the following:

(a) Ask the responsible physician and health providers if medical and dental prostheses are provided to inmates when the health of the inmate/patient would otherwise be adversely affected;

(b) Ask the dentist if dental prostheses would be provided; and

(c) Check health records to ascertain that medical and dental prostheses are provided when necessary.

p. *Standard 149 - Food Service*

An adequate diet involving the four basic food groups, based on the Recommended Dietary Allowances, is provided to all inmates.

Written policies and defined procedures require provision of special medical and dental diets which are prepared and served to inmates according to the orders of the treating physician and/or dentist and/or as directed by the responsible physician.

(1) Discussion

(a) Adequate diets frequently are based on those developed by other agencies which utilize the recommended national allowances/guidelines;

(b) Equivalent nutritional guidelines containing the four basic groups, satisfy compliance;

(c) The four basic food groups are:

(1) Milk and milk products;

(2) Meats, fish and other protein foods (e.g., eggs, dried beans and peas and cheese);

(3) Breads and cereals; and

(4) Vegetables and fruits.

(d) The adequate diet referred to in the standard applies to inmates in segregation/isolation as well as all others.

(2) To verify compliance, do the following:

Ask the health authority and the director of food service if an adequate diet, as demanded by the standard, is provided; and ask for copies of recent menus.*

* This completes the "Care and Treatment Standards" section. Turn to Appendix A for sample situations for discussion.

D. Pharmaceutical Standards: This standard addresses the management of pharmaceuticals in line with state and federal laws and/or regulations and requirements for the control of medications. Prescribing practices, stop orders and re-evaluations regarding psychotropic medications are also addressed.

1. Essential Standards

a. *Standard 150 - Management of Pharmaceuticals*

Written policy and defined procedures require that the proper management of pharmaceuticals includes:

(1) Compliance with all applicable state and federal laws and regulations regarding prescribing, dispensing and administering of drugs;

(2) At a minimum, a formulary specifically developed for both prescribed and non-prescribed medications stocked by the facility;

(3) Discouragement of the long-term use of tranquilizers and other psychotropic drugs;

(4) Prescription practices which require that:

(a) Psychotropic medications are prescribed only when clinically indicated (as one facet of a program of therapy) and are not allowed for disciplinary reasons;

(b) "Stop-order" time periods are stated for behavior modifying medications and those subject to abuse; and

(c) Re-evaluation be performed by the prescribing provider prior to renewal of a prescription.

(5) Procedures for medication dispensing, distribution, administration, accounting and disposal; and

(6) Maximum security storage and weekly inventory of all controlled substances, syringes and needles.

(1) Discussion

(a) A formulary is a written list of prescribed and non-prescribed medications stocked in the facility.

This does not restrict the prescribing of medications generated by outside community health care providers.

(b) Dispensing is the issuance of one or more doses of medication from a stock or bulk container.

The dispensed medication should be correctly labeled to indicate the name of the patient, the contents and all other vital information needed to facilitate correct patient usage and drug administration.

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

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

(e) Accounting is the system of recording, summarizing, analyzing, verifying and reporting the results of medication usage.

(f) Disposal involves destruction of the medication upon discharge of the inmate from the facility or providing the inmate with the medication, in line with the continuity of care principle.

(1) The latter procedure is preferred.

(2) However, when a facility uses the sealed, pre-packaged unit dose system, the unused portion can be returned to the pharmacy.

(g) A controlled substance is a drug or other substance that is subject to special controls due to its abuse potential.

(2) To verify compliance, do the following:

(a) Ask health providers if all of the elements of the standard are adhered to;

(b) Ask the pharmacist if all of the elements of the standard are adhered to; and

(c) You should see the following in order to verify compliance:

(1) Formulary specifically developed for the facility;

(2) Maximum security storage of all controlled substances as well as syringes and needles; and

(3) Weekly inventory of syringes and needles and all controlled substances.*

E. Health Records Standards: The contents, form and format, confidentiality, transfer and retention of the health care records are covered in these standards, based upon practices in the jurisdiction.

1. Essential Standard

a. *Standard 151 - Health Record Format and Contents*

At a minimum, the health record file contains:

(1) The completed receiving screening form;

(2) Health appraisal data forms;

(3) All findings, diagnoses, treatments and dispositions;

(4) Prescribed medications and their administration;

(5) Laboratory, X-ray and diagnostic studies;

* See Appendix A for situations on the pharmaceutical standard.

(6) Signature and title of each documenter;

(7) Consent and refusal forms;

(8) Release of information forms;

(9) Place, date and time of health encounters;

(10) Discharge summary of hospitalizations;

(11) Health service reports (e.g., dental, psychiatric and other consultations); and

(12) Specialized treatment plan (if such exists).

The method of recording entries in the record and the form and format of the record are approved by the health authority.

(1) Discussion

(a) The problem-oriented medical record structure is suggested.

(1) However, whatever the record structure, every effort should be made to establish uniformity of record forms and content throughout the correctional system.

(2) The record is to be completed and all findings recorded including notations concerning psychiatric, dental and other consultative services.

(b) A health record file is not necessarily established on every inmate.

(1) However, any health intervention after the initial screening requires the initiation of a record.

(2) The receiving screening form becomes a part of the record at the time of the first health encounter.

(3) If an inmate is incarcerated more than once, existing medical records should be re-activated .

(c) Where patients are seen only at the physician's office, the record generally is kept there. However, a form for recording the disposition should accompany the inmate, so that the physician can provide instructions regarding follow-up care.

(2) Special Note

Please refer to the AMA monograph "Health Care in Jails: Inmates' Medical Records." (See Appendix C - "Publications List.")

(3) To verify compliance, do the following:

(a) Ask the health authority if she/he has approved of the method of recording entries and the form and format of the medical records;

(b) Ask the dentist if dental records are filed in the inmates' health record file;

(c) Ask the health records person (or health providers) if the health record file contains:

(1) The completed receiving screening form;

(2) Health appraisal data forms;

(3) Findings;

(4) Diagnoses

(5) Treatments

(6) Disposition

(7) Prescribed medications

(8) The administration of medications;

(9) Laboratory studies;

(10) X-ray studies;

(11) Diagnostic studies;

(12) Signature of documenter;

(13) Title of documenter;

(14) Consent forms;

(15) Refusal forms;

(16) Release of information forms;

(17) Place of health encounters;

(18) Date of health encounters;

(19) Time of health encounters

(20) Discharge summary of hospitalization; and

(21) Miscellaneous health service reports such as: dental, psychiatric and other consultations.

(d) Ask the health records person if the health authority has approved the method of recording entries in the health record and the form and format of the health record.

(e) Review health records to see that they contain all of the elements required by the standard.

2. Important Standards

a. *Standard l52 - Confidentiality of the Health Record*

Written policy and defined procedures which effect the principle of confidentiality of the health record require that:

(1) The active health record is maintained separately from the confinement record under lock and key; and

(2) Access to the health record is controlled by the health authority.

(1) Discussion

(a) The principle of confidentiality protects the patient from disclosure of confidences entrusted to a physician during the course of treatment.

(b) Any information gathered and recorded about alcohol and drug abuse is confidential under federal regulations and cannot be disclosed without written consent of the patient or the patient's parent or guardian (see 42 Code of Federal Regulations Sec. 2.1 et. seq.)

(c) The health authority should share information with the facility administrator regarding an inmate's medical management and security.

(1) The confidential relationship of doctor and patient extends to inmate/patients and their physician.

(2) Thus, it is necessary to maintain active health record files under security, completely separate from the patient's confinement record.

(2) To verify compliance, do the following:

(a) Ask the health authority, health providers, correctional and booking officers and the health records person if the active health records are kept separate from the confinement records, and verify that this is the case.

(b) Ask the health authority if she/he controls access to health records;

(c) Ask health providers if the health authority controls access to health records;

(d) Ask correctional and booking officers if they have access to health records, and if so, under what circumstances.

(e) Ask the health records person if there are written policy and defined procedures which effect the principle of confidentiality of the health record; and

(f) Ask the health records person how the health authority controls access to health records.

b. *Standard l53 - Transfer of Health Records and Information*

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

(1) Summaries or copies of the health record are routinely sent to the facility to which the inmate is transferred;

(2) Written authorization by the inmate is necessary for transferring health records and information unless otherwise provided by law or administrative regulation having the force and effect of law; and

(3) Health record information is also transmitted to specific and designated physicians or medical facilities in the community upon the written authorization of the inmate.

(1) Discussion

An inmate's health record or summary follows the inmate in order to assure continuity of care and to avoid the duplication of tests and examinations.

(2) To verify compliance, do the following:

Ask the health authority, health providers and the health records person if the elements of the standard are complied with.

c. *Standard l54 - Records Retention*

Written policy and defined procedures require that inactive health record files are retained according to legal requirements of the jurisdiction.

(1) Discussion

Regardless of whether inactive health records are maintained separately or combined with confinement records, they need to conform to legal requirements for records retention.

(2) To verify compliance, do the following:

(a) Ask the health authority and the health records person if:

(1) there are written policies and defined procedures regarding record retention;

(2) inactive health record files are retained as permanent records; and

(3) the legal requirements of the jurisdiction regarding records retention are followed.

(b) Verify that the inactive health record files are retained as permanent records.*

F. Medico-Legal Issues: These two standards address the inmate's right to informed consent and the right to refuse treatment and guidelines for the inmate's participation in medical research.

1. Important Standards

a. *Standard l55 - Informed Consent*

All examinations, treatments and procedures governed by informed consent in the jurisdiction are likewise observed for inmate care. In the case of minors, the informed consent of parent, guardian or legal custodian applies when required by law.

* See Appendix A for situations on "Health Record Standards."

(1) Discussion

(a) Informed consent is the agreement by the patient to a treatment, examination or procedure after the patient receives the material facts regarding the nature, consequences, risks and alternatives concerning the proposed treatment, examination or procedure.

(b) Medical treatment of an inmate without his or her consent (or without the consent of parent, guardian or legal custodian when the inmate is a minor) could result in legal complications.

(c) Obtaining informed consent may not be necessary in all cases. These exceptions to obtaining informed consent should be reviewed in light of each state's law as they vary considerably. Examples of such situations are:

(1) An emergency which requires immediate medical intervention for the safety of the patient;

(2) Emergency care involving patients who do not have the capacity to understand the information given; and

(3) Public health matters, such as communicable disease treatment.

(d) Physicians must exercise their best medical judgment in all such cases;

(e) It is advisable that the physician document the medical record for all aspects of the patient's condition and the reasons for medical intervention. Such documentation facilitates review and provides a defense from charges of battery;

(f) In certain exceptional cases, a court order for treatment may be sought, just as it might in the free community.

(g) The law regarding consent to medical treatment by juveniles and their right to refuse treatment, varies greatly from state to state;

(h) Some states allow juveniles to consent to treatment without parental consent, as long as they are mature enough to comprehend the consequences of their decision; others require parental consent until majority, but the age of majority varies among the states;

(i) The law of the jurisdiction within which the facility is located should be reviewed by legal counsel, and based upon counsel's written opinion, a facility policy regarding informed consent should be developed; and

(j) In all cases, however, consent of the person to be treated is of importance.

(2) To verify compliance, do the following:

(a) Ask the health authority, the responsible physician and all other qualified health personnel if informed consent practices applicable in the general community are the same for all inmate care within the institution and in the case of minors, if the informed consent of parents, guardian or legal custodian is obtained.

(b) Review copies of consent and refusal forms.

b. *Standard 156 - Medical Research*

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

(1) Discussion

(a) This standard recognizes past abuses in the area of research on involuntarily confined individuals and stresses the protective measures and prisoner/patient autonomy interests that must be considered in a decision to include such persons in clinical research.

(b) There should be adequate assurance of safety to the subject, the research should meet standards of design and control and the inmate must have given his/her informed consent.

(2) Special Note

If medical research involving inmates is never performed, then this standard will be not applicable.

(3) To verify compliance, do the following:

Ask the health authority, health providers and the person legally responsible for the facility if there is any biomedical or behavioral research involving inmates and if so, if ethical, medical and legal standards for human research are met.*

G. Glossary

1. Accounting (Medications) - Accounting is the system of recording, summarizing, analyzing, verifying and reporting the results of medication usage.

2. Administrative Meetings - Meetings are held at least quarterly between the health authority and the official legally responsible for the facility or their designees. At these meetings, problems are identified and solutions sought.

3. Alcohol Detoxification - (See "Detoxification")

4. Annual Statistical Report - The annual statistical report should indicate the number of inmates receiving health services by category of care as well as other pertinent information (e.g., operative procedures, referrals to specialists, ambulance service, etc.). See Appendix D for sample statistical forms.

5. Chemical Dependency - Chemical dependency refers to individuals who are physiologically and/or psychologically dependent on alcohol, opium derivatives and synthetic drugs with morphine-like properties (opioids), stimulants and depressants.

6. Chronic Care - Chronic care is medical service rendered to a patient over a long period of time (e.g., treatment of diabetes, asthma and epilepsy).

7. Clinic Care - Clinic care is medical service rendered to an ambulatory patient with health care complaints which are evaluated and treated at sick call or by special appointment.

* See Appendix A for situations on "Medical Legal Standards."

Glossary (cont'd.)

8. Controlled Substance - A controlled substance is a drug or other substance that is subject to special controls due to its abuse potential. There are five federally established schedules/categories of controlled substances.

9. Convalescent Care - Convalescent care is medical service rendered to a patient to assist in recovery from illness or injury.

10. Dental Examination - The dental examination should include taking or reviewing the patient's dental history and examination of hard and soft tissue of the oral cavity by means of an illuminator light, mouth mirror and explorer. X-rays for diagnostic purposes should be available if deemed necessary. The results are recorded utilizing a number system such as the Federation Dentaire Internationale System.

11. Dental Hygiene - While the usual definition of dental hygiene includes clinical procedures taken to protect the health of the mouth and chewing apparatus, minimum compliance will be instruction in the proper brushing of teeth.

12. Detoxification - Drug detoxification refers to the process by which an individual is gradually withdrawn from a drug by administering decreasing doses either of the same drug upon which the person is physiologically dependent or one that is cross-tolerant to it or a drug which has been demonstrated to be effective on the basis of medical research.

    Detoxification from alcohol should not include decreasing doses of alcohol; further, supervised "drying out" may not necessarily involve the use of drugs.

13. Disaster Plan, Health Aspects - Health aspects of the disaster plan, among other items, would include the triaging process, outlining where care can be provided and laying out a back-up plan.

14. Dispensing, Medication - Dispensing is the issuance of one or more doses of medications from a stock or bulk container. The dispensed medication should be correctly labeled to indicate the name of the patient, the contents and all other vital information needed to facilitate correct patient usage and drug administration.

15. Disposal, Medication - Disposal refers to the destruction of the inmate's medication upon his/her discharge from the facility, the return of sealed unused pre-packaged medications to the pharmacy or providing the inmate with the medication, in line with the continuity of care principle.

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

17. Documented Inmates' Health Complaints - Examples of health complaints being documented are:

    (a) Some jails note on the complaint slip the action taken regarding triaging and file such slips in the inmate's medical record; and

    (b) Others use a log and record the complaint and its disposition.

18. Drug Detoxification - (See "Detoxification")

19. Emergency Care (Medical, Dental and Mental) - Emergency care is care for an acute illness or unexpected health care need that cannot be deferred until the next scheduled sick call or clinic.

20. Formulary - A formulary is a written list of prescribed and non-prescribed medications stocked in the facility.

21. Four Basic Food Groups - The four basic food groups are:

    Milk and milk products;
    Meats, fish and other protein foods (e.g., eggs, dried beans and peas and cheese);
    Breads and cereals; and
    Vegetables and fruits.

22. Health Administrator - A health administrator is a person who by education (e.g., RN, MPH, MHA* or related disciplines) is capable of assuming responsibility for arranging for all levels of health care and assuring quality and accessibility of all services provided to inmates.

* RN=Registered Nurse; MHA=Master of Health Administration; MPH=Master of Public Health.

23. Health Appraisal - Health appraisal is the process whereby the health status of an individual is evaluated. The extent of health appraisal, including medical examinations, is defined by the responsible physician, but does include at least the items noted in Standard 131.

24. Health Aspects (Disaster Plan) - Health aspects of the disaster plan, among other items, include the triaging process, outlining where care can be provided and laying out a back-up plan.

25. Health Authority - The health authority is the individual who has been delegated the responsibility for the facility's health care services, including arranging for all levels of health care and assuring quality and accessibility of all health services provided to inmates.

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

27. Health Trained Staff - Health trained staff may include correctional officers and other personnel without health care licenses who are trained in limited aspects of health care as determined by the responsible physician.

28. Hospital Care - Hospital care is inpatient care for an illness or diagnosis which requires optimal observation and/or management in a licensed hospital.

29. Infirmary - An infirmary is an area established within the correctional facility in which organized bed care facilities and services are maintained and operated to accommodate two or more inmates and which is operated for the express or implied purpose of providing skilled nursing care for persons who are not in need of hospitalization.

30. Infirmary Care - Infirmary care is defined as inpatient bed care by or under the supervision of a registered nurse for an illness or diagnosis which requires limited observation and/or management and does not require admission to a licensed hospital.

31. Informed Consent - Informed consent is the agreement by the patient to a treatment, examination or procedure after the patient receives the material facts regarding the nature, consequence, risks and alternatives concerning the proposed treatment, examination or procedure.

32. Large Muscle Activity - Examples of large muscle activity include walking, jogging in place, basketball, ping pong and isometrics.

33. Medical Preventive Maintenance - (See "Preventive Maintenance")

34. Medical Restraints - (See "Restraints")

35. Medical Supervision/Detoxification - Medical supervision means that for in-jail alcohol and opioid detoxification, at a minimum, the inmate must be under 24 hour per day, 60 minutes per hour supervision of a health trained correctional officer working under a physician's direction. For detoxification from barbiturates and other sedative hypnotic drugs, the program in the jail must be under the 24 hour supervision of a licensed nurse at a minimum.

36. Medication Accounting - (See "Accounting")

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

38. Medication Dispensing - (See "Dispensing, Medication")

39. Medication Disposal - (See "Disposal, Medication")

40. Medication Distribution - (See "Distribution, Medication")

41. Monitoring of Services/Internal Quality Assurance - Monitoring is the process for assuring that quality health care services are being rendered in the facility by non-physician providers of health care. The monitoring is accomplished by on-site observation and review (e.g., studying inmates' complaints regarding care; reviewing the health records, pharmaceutical processes, standing orders, and performance of care).

42. Opioids - Opioids refer to derivatives of opium, (e.g., morphine and codeine and synthetic drugs with morphine-like properties).

43. Peer Review - Peer review is the evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. The American Medical Association's Resolution 121 (A-76) on assurance passed by the AMA House of Delegates (1976) reads: "RESOLVED, That the American Medical Association endorse the principle that correctional facilities provide adequate medical care to their inmates which is subject to physician peer review in each community."

44. Planned, Supervised Basis (Exercising) - Facilities meet compliance of exercise on a "planned, supervised basis" under the following conditions:

    It is recognized that many facilities do not have a separate facility or room for exercising. The dayroom adjacent to the cell may be used for this purpose. The dayroom meets compliance if planned, programmed activities are directly supervised by staff and/or trained volunteers. Otherwise, the designated hour would not be different from any of the other hours of the day. Television and table games do not meet compliance.

    Regarding the use of outside yards, gymnasiums and multi-purpose rooms, making available exercising opportunities (e.g., basketball, handball, jogging, running and calisthenics) does satisfy compliance even though inmates may not take advantage of them. While such activities may be more productive under the supervision of a recreational staff person, this is not required. For supervision purposes, inmates should be within sight or sound of a staff person.

45. Preventive Maintenance (Medical) - Medical preventive maintenance refers to health promotion and disease prevention. This includes the provision of individual or group health education and medical services, such as inoculations and immunizations provided to take advance measures against disease and instruction in self-care for chronic conditions.

46. Prostheses - Prostheses are artificial devices to replace missing body parts or compensate for defective bodily functions.

47. Psychiatric Personnel - Psychiatric services staff are psychiatrists, general family physicians with psychiatric orientation, psychologists, psychiatric nurses, social workers and trained correctional counselors.

48. Public Advisory Committee - The public advisory committee represents the local medical and legal professions and may include key lay community representatives. While grand juries and public health department inspection teams play an important role in advising jails in some communities, they are more "official" than "public" bodies.

    The role of the advisory committee is to review the facility's program and advise those responsible. Such a monitoring process helps staff identify problems, solutions and resources.

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

50. Receiving Screening - Receiving screening is a system of structured inquiry and observation designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population and to rapidly get newly admitted inmates to medical care.

51. Responsible Physician - The responsible physician is the individual physician who is responsible for the final decisions regarding matters of medical judgment.

52. Restraints (Medical) - Medical restraints are physical and chemical devices used to limit patient activity as a part of health care treatment. The same kinds of restraints that would be medically appropriate for the general population within the jurisdiction may likewise be used for medically restraining incarcerated individuals (e.g., leather or canvas hand and leg restraints, chemical restraints and straight jackets).

53. Self Care - Self care is defined as care for a condition which can be treated by the inmate and may include "over-the-counter" type medications.

54. Sick Call - Sick call is the system through which each inmate reports for and receives appropriate medical services for non-emergency illness and injury. Some people refer to "sick call" as a "clinic visit."

55. Skilled Nursing Care - (See "Infirmary Care")

56. Special Medical Program - The special medical program refers to care developed for patients with certain medical conditions which dictate a need for close medical supervision (e.g., seizure disorders, diabetes, potential suicide, pregnancy, chemical dependency and psychosis).

57. Standing Medical Orders - Standing medical orders are pre-existing written medical orders for the definitive treatment of identified conditions and for on-site treatment of emergency conditions for any person having the condition to which the order pertains.

58. Supervision - Supervision is defined as overseeing the accomplishment of a function or activity.

59. Treatment Plan - A treatment plan is a series of written statements which specify the particular course of therapy and the roles of medical and non-medical personnel in carrying out the current course of therapy. It is individualized and based on assessment of the individual patient's needs and includes a statement of the short and long term goals and the methods by which the goals will be pursued.

60. Triage is the sorting of complaints and allocation to treatment according to a priority system.

UNIT IV

INSTRUCTOR'S MANUAL

UNIT IV

HOW TO SURVEY JAIL HEALTH CARE SYSTEMS AND MEASURE COMPLIANCE

UNIT TITLE: How to Survey Jail Health Care Systems and Measure Compliance

TIME: Two Hours

OBJECTIVES: Upon completion of this unit, each trainee will be aware of:

1. Who should be interviewed/questioned when inspecting a facility.
2. How to resolve conflicting information from different data sources.
3. What documents should be reviewed by an inspector.
4. What forms to use and where the AMA Standards fit into a sample U.S. Marshals Service (USMS) audit format.
5. The end results of systematic inspection.

FORMAT: Lecture, discussion and "response situations."

AUDIO-VISUAL AIDS: None.

PROCEDURE:
1. Present the lecture, based on the CONTENT OUTLINE which follows.
2. Allow time for trainee questions and discussion throughout the lecture and at the end of the session. Encourage trainees to ask questions freely.

CONTENT OUTLINE: Prior to inspecting a jail, the inspector should thoroughly review the inspection form to be used and the AMA Standards For Health Services In Jails. Knowing the requirements of the standards is an essential forerunner to any on-site inspection.

If not already done on the printed inspection form, it would be helpful to cross index those items with the respective AMA standards.

Whenever questions arise on the meaning of terms, definitions are contained in the "Discussion" section following the standards, and they are repeated in the Glossary.

I. SELECTION OF INTERVIEWEES BY AN INSPECTOR

A. When inspecting a jail, the inspector will usually wish to interview or ask questions of a variety of people to gain as broad a view as possible of the jail's health care system.

B. The jail administrator should be the first person interviewed.

1. The administrator needs to know that he/she is the first in a series of people in the facility to be interviewed.
2. In most instances the administrator will handle those parts of the questions about which he/she has first-hand knowledge and then refer the inspector to other staff such as the health authority, health providers and/or correctional staff.
3. It is important that there be other interviews, independent of the administrator and the health authority, so as to gain the widest perspective of the health care system.

C. The jail inspector may wish to interview various levels of health care and jailer/correctional officer staff and consumers (inmates) of the system.

1. All interviews should be conducted on a one-to-one basis to preserve confidentiality.
2. Experience has shown that subjects of the criminal justice system, whether awaiting disposition or sentenced, are very perceptive about system operations.

a. This is partically due to the fact that, because it is a "justice" system, there seems to be a natural tendency to talk about "injustices" or deficiencies.

b. Agencies with extensive survey experience have found that many persons charged with crimes or convicted can be as perceptive as staff of not only the deficiencies but improvements which have been made to overcome them.

D. Interviews for the purpose of auditing a jail's compliance with a set of standards must be carried out on a patterned approach.

1. When sufficient persons are interviewed on a random basis, true conditions will be determined with little margin of error.

2. Most staff and inmates will be very frank and speak honestly regarding the situation, if they know that what they have to say is considered important and will not be used against them.

3. Thus, it is important not to single out only one person for interviewing about a specific subject area, if it can be avoided.

4. The actual number of staff and inmate interviews to be done is dependent on the size of the facility and setup of the health care delivery system. In general, the rule is that the larger the facility, the more people who should be interviewed.

E. Selection of Interviewees

1. Administrative and professional staff should be asked who it would be best to interview to learn about the health care delivery system.

a. Health care providers and correctional staff should be selected by the inspector from those who service different wings or housing units, as practices can vary considerably within a facility.

b. If the correctional and health care staff do not operate under a system of rotating shifts, the inspector should interview representatives from all shifts, as practices may vary from shift to shift.

c. Regarding inmates to be interviewed, they should be selected at random by the inspector (preferably, at least one from each wing, cellblock or housing unit).

II. HOW TO RESOLVE CONFLICTING INFORMATION

A. An inspector should not be alarmed by obtaining conflicting information in regard to the various standards.

B. If a preponderance of information about meeting or not meeting certain standards is obtained from other staff, which is significantly different from that provided by the jail administrator and/or the health authority, go back to the latter to explain the conflicting information and possibly reach an understanding on the matter.

C. In some instances, the administrator and/or health authority may recognize why the discrepancies occur (e.g., practices which vary by shifts or different sections of the jail). Some remedies may be obvious and quick to come by. Others may involve the need for technical assistance from the inspector.

1. Most conflicts are resolved in the direction of the majority response (e.g., four of the five correctional officers interviewed and seven of the ten inmates say there is no scheduled sick call at the jail; you can feel reasonably sure that there is no regularly scheduled sick call).

2. The exceptions to the above "rule of thumb" are "negative" responses from the administrator, health authority, responsible physician and/or other critical person (e.g., if most of the jailers said that they had training in the recognition and handling of mentally ill persons and the health authority and administrator said they really didn't - "there was just a quick reference to it in the academy" - it would be wise to accept the opinion of the administrator and health authority that the officers really are not properly trained).

III. REVIEW OF DOCUMENTATION

A. A number of documents should be reviewed by the inspector to insure that they are in accordance with the Standards.

B. These documents include:

1. The written agreement, contract or job description of the responsible health authority. (Standard 101)

2. The documentation of quarterly (at a minimum) administrative meetings between the health authority and the person legally responsible for the facility or quarterly reports on the progress and problems of the health care delivery system. (Standard 103)

3. The annual (at a minimum) statistical report outlining the types of health care rendered and their frequency. (Standard 103)

4. The manual of written policies and procedures, including its annual review with signature of the reviewer. (Standard 104)

5. The written list of referral sources for patients with acute illnesses. (Standard 110)

6. The current credentials of qualified health care personnel. (Standard 117)

7. The written job descriptions of personnel who provide health care. (Standard 118)

8. The written plan for orientation and training of all health care personnel appropriate to their duties. (Standard 119)

9. The receiving screening form. (Standard 126)

10. The written information outlining access to treatment. (Standard 128)

11. The health appraisal form. (Standard 131)

12. The written and signed direct orders. (Standard 132)

13. The manual of nursing care procedures for the infirmary, if applicable. (Standard 133)

14. Standing medical orders, if applicable. (Standard 138)

15. Recent menus. (Standard 149)

16. The formulary, specifically developed for both prescribed and non-prescribed medications stocked by the facility. (Standard 150)

17. Health records of inmates. (Standard 151)

C. Experience has shown that while written documentation may exist, this does not always mean that the stated practices are in effect (operational).

1. Documentation may reflect an initial period wherein revised practices were implemented but subsequently were changed or dropped.

2. Frequently, when a new administrator assumes responsibilities, changes are made which are not reflected in written documentation.

3. Jail inspectors should verify in their interviews that practices as reported are in fact operational.

EXERCISE: The instructor should now refer to Appendix F, pertaining to the above three sections, and have trainees discuss "Response Situations Regarding 'Inspection of Health Services'."

IV. FORMS TO BE USED: THE U.S. MARSHALS SERVICE(USMS) AUDIT FORMAT AS SAMPLE[1]/

A. It is recognized that the forms used in an inspection of a jail will be different,depending upon the agency performing the inspection.

B. It is also important to note that a federal or state jail inspector's usual function is to inspect all aspects of a jail's operations, not just the health care delivery system.

1. This training manual is not intended to prepare the inspector to audit a facility's compliance with the Standards as thoroughly as it would be audited for accreditation.

2. This unit is intended to illustrate, along with Unit III - Review of the AMA Standards for Health Services in Jails (1981) - how an inspector can evaluate a jail's compliance with any given standard.

C. In the first column of the sample audit form (see Appendix G) the typed number in parenthesis below the written number is the individual AMA standard which corresponds to that item.

[1]Portions of a sample USMS Audit Form are located in Appendix G.

If there is no typed number under the written one, it means that there is no AMA standard corresponding to that item.

D. Any jail inspector, whether state or federal, should compare the items on the audit form used by his/her agency with the numbers of any corresponding AMA standards. This gives the jail inspector a quick reference to any corresponding AMA standards.

For example, USMS inspection form, item number 253H-NA corresponds with AMA Standard 147. The latter requires laundry services at least weekly. If the jail provides weekly laundry services for personal clothing, the item "confirmed" would be checked.

USMS inspection item 255 requires bathing at least three times weekly, whereas AMA (Standard 147) requires bathing "at least twice per week". The USMS tighter restriction should prevail.

USMS inspection item 300 relates to AMA Standard 101, outlining the existence of and requirements for a "health authority". The term is defined not only in the standard but in the "Discussion" and the Glossary. The inspector will need to read the written agreement, contract or job description in order to determine compliance with this aspect of the standard. If the required duties are stipulated and the health authority is a physician, the standard is met. If the authority is a non-physician, there must be a physician designated to render final medical judgements.

USMS item 301 pertains to AMA Standard 102. If the sheriff or jail administrator, health authority/responsible physician, other health providers, correctional officers and inmates all verify compliance, the standard is obviously complied with. However, if some health providers, correctional officers and, possibly inmates, say that non-medical personnel prohibit inmates from having access to sick call, overrule medical classifications for work assignments or refuse to allow certain medical diets, then it is reasonable to conclude that the standard is not being met.

USMS items 304, 309, 315 and 316 relate to AMA Standards 110 and 120. Regarding USMS item 304 which asks, "Are inmates within sight or sound of at least one health-trained correctional officer at all times?", a number of factors must be considered:

1. Are <u>all</u> officers <u>health trained</u>, as required by Standard 120? For compliance, at least 75% need to be currently trained in all of the six areas outlined in the standard, with a definite, continuing schedule set up to train the balance (usually new employees) within a reasonable period of time.

2. Do the administrator and preponderance (preferably all) of the officers respond positively to the question about officers being health trained? There should be a sufficient number of health-trained officers to be within sight or sound of all inmates (to prevent suicides and assaults) as well as a sufficient number trained in cardio-pulmonary resuscitation (CPR) to respond to all emergencies within four minutes maximum. More than just a majority of positive responses from officers would be needed in the above instances because it could be that only one part of the jail precludes carrying out the standard. In short, <u>all</u> sections of the jail must have adequate supervision. (This is a major reason why it is essential for officers and inmates from all living units to be interviewed.)

3. How do you evaluate response time for emergencies? The inspector can make a "man down" call in the most remote part of the jail during his/her inspection to see if the call is responded to within four minutes, as required by the standard.

Standard 120 also calls for at least one jailer/correctional officer per shift who is trained in the recognition of symptoms of illnesses most common to inmates; he/she would do the receiving screening.

E. Exercise

With these several examples of how an inspection form can be utilized to determine compliance in conjunction with the AMA <u>Standards</u>, the instructor should now ask each of the trainees to select one or more inspection item(s) and outline procedures for determining compliance. This actual practice is essential for inspectors to really assimilate the process.

V. THE END RESULTS OF SYSTEMATIC INSPECTION

A. If a careful job of inspecting is done, the inspection will have credibility.

B. If a systematic approach is not taken, the inspection process, as well as the individual inspector, will lose credibility.

C. If an open system is followed in which careful inspecting is clearly outlined to all involved beforehand, the inspection is bound to proceed with strong credibility and validity.

INSTRUCTOR'S MANUAL

UNIT V

HOW TO PROVIDE TECHNICAL ASSISTANCE TO JAILS AND ADVISE THEM REGARDING THE EFFECTIVE UTILIZATION OF EXISTING COMMUNITY RESOURCES

UNIT TITLE: How to Provide Technical Assistance to Jails and Advise Them Regarding the Effective Utilization of Existing Community Resources

TIME: 3 Hours

OBJECTIVES: Upon completion of this unit, each trainee will be aware of:

1. Major factors influencing greater use of community resources.
2. The role of state and local medical societies.
3. Getting "supply" and "demand" resources together through the efforts of jail advisory committees.
4. Other sources of assistance in the community.
5. The advantages of in-jail health care.

FORMAT: Lecture, discussion and exercise.

AUDIO-VISUAL AIDS: None

PROCEDURES:
1. Explain the basic objectives for this unit, as specified above.
2. Present the lecture, based on the CONTENT OUTLINE which follows.
3. Allow time for trainee questions and discussion throughout the lecture and at the end of the session.

CONTENT OUTLINE: I. MAJOR FACTORS INFLUENCING GREATER USE OF COMMUNITY RESOURCES

A. Improved communications between jail administrators and health care providers in the community result in significantly increased use of already existing health care resources in the community.

1. When jail administrators and community health care providers learn about each other's agencies, the services offered, the problems which exist and so forth, more positive working relationships result.

2. Positive attitude changes stemming from better working relationships on the part of facility administrators and health care personnel are a direct result of the improved communications, leading to improved health care in jails through a greater use of community resources.

3. Sheriffs and jail administrators who follow the practice of informing the media and citizen groups of problems and progress regarding their programs, usually fare better than those officials who "go it alone". A better informed and involved public, including community agencies, will support sound policies and provide the tools necessary to do the job properly.

B. "Why should inmates be provided with adequate medical care?" is a common question posed by members of the community. There are several good reasons:

1. It provides better <u>protection</u> to the community as well as the jail staff and inmates if diseases are detected <u>early</u>, particularly contagious diseases. An inmate who gets infected in the jail may transmit the disease to family members, friends and fellow workers.

2. Early detection, early referral, early diagnosis and early treatment are more <u>effective</u> and <u>economical</u> in the long run. Finding cases of people contagiously infected in the community by a released inmate is very expensive. In the case of mental illness, several months of expensive hospitalization can frequently be avoided if the onset of illness is detected early and "blow-ups" and injuries are avoided.

3. Federal Court suits have been successfully pursued by inmates in facilities which did not have adequate medical care. The denial of such care has been ruled to be "cruel and unusual punishment" in violation of the Eighth Amendment of the U.S. Constitution (e.g., see <u>Estelle v. Gamble</u>, 429 U.S. 97, 1976).

4. In some instances, resolving an inmate's medical problem in the jail saves monies which would be spent later by the welfare system to treat a possibly worsened condition. Further, early detection and treatment of diseases may spare the potential wage earner from several months on the welfare rolls.

5. There has been enough experience to show that people who feel better act better. Various sheriffs and jail administrators have described how inmate morale has gone up with improved medical care, resulting in "cooler" jails, with fewer hassles and behavior incidents.

C. Improving jail health care has often been more a matter of changing attitudes and philosophy than obtaining bigger budgets. With agencies working together and learning more about each other, already existing resources which have been lying dormant, so to speak, become used either without any additional expenditure or at a small cost to the jail. This has been seen over and over again in the AMA's Jail Project.

D. The important point to stress is to look toward the community for services which the jail needs - because the jail <u>is</u> part of the community.

1. The jail should be viewed as a component in the area's health care delivery system.

2. Diseases identified and treated appropriately in the jail will prevent problems for the surrounding community.

a. The jail generally holds local residents, most of whom will return to the community in a relatively short period of time.

b. This makes it appropriate for local agencies to extend their services to inmates and deal with their health problems at the earliest possible time.

E. In addition, the health care related training of jailers/correctional officers enhances the ability of the jail to provide more for itself, rather than inappropriately utilizing medical resources. For example, jailers who are trained to recognize common illnesses and make earlier referrals to qualified health care providers, rather than waiting for a "man down!" situation, frequently save ambulance and emergency room costs and transportation expenses, including lost officer's time.

II. THE ROLE OF STATE AND LOCAL MEDICAL SOCIETIES

A. The major role of state and local medical societies has been that of coordinator, catalyst and information provider.

Each county either has its own medical society/association or is part of a district one. Each state likewise has its own independent society/association. While the locals are affiliates of the state societies and the latter are affiliates of the American Medical Association, each is an independent legal entity.

In order to upgrade medical care and health services in jails, the most important thing is that local and state medical societies involve their members in finding out why better medical care is needed, how it can be made more effective and then going about getting it done.

1. In various communities, health care delivery systems have been improved because their medical societies took the initiative and demonstrated a real interest in the total health care delivery system, including the jails and correctional institutions.

2. In some instances, that is all that has been necessary to change things. With medical society help, physicians were recruited to service the jails, health departments were encouraged to do communicable disease screening and mental health agencies became involved in working with jail inmates, at least on a crisis basis.

3. In most places, however, a concerted effort approach is necessary. Some medical societies are contacted by the sheriffs and requested to assist in locating physicians and to provide support for the development of the jails' health care systems. In one state the state medical society president wrote a letter to all local societies and within several months physicians were located for eight jails. Some state medical societies have established a standing committee on jail health care which can be an important resource for the local jails.

III. JAIL ADVISORY COMMITTEES

A concerted effort approach to jail medicine sometimes can best be realized through the operation of jail advisory committees. Sheriffs who have appointed representative citizen advisory committees generally are very supportive of them. The committee should reflect geographical, political, ethnic, economic, occupational and other interests in the county. To the greatest extent possible members should have reputations for "getting things done", i.e., they are goal-oriented.

For details on the organization and operation of citizen advisory committees, please refer to the AMA monograph on "Organizing and Staffing Citizen Advisory Committees to Upgrade Jail Medical Programs." (see Appendix C)

A. A jail advisory committee can result in "supply" and "demand" resources getting together around the table, perhaps for the first time, to discuss matters of mutual interest.

1. Local and state bar associations have done a good job in various communities in joining with medical societies.

2. So have the chambers of commerce.

3. Both the bar associations and the chambers of commerce have national platforms on crime handling, are generally acquainted with the problems of jails and frequently have special committees on the subject.

4. There are other groups with national platforms in the criminal justice field such as:

a. Councils of Churches, Church Women United and several major religious denominations.

b. Leagues of Women Voters, Junior Leagues of America and National Councils of Jewish Women.

c. Various labor organizations, which join industry and other segments of the public to work on common causes.

B. Frequently, representatives from the above and other concerned groups are willing to participate on the committee or to serve on an advisory basis to the committees, including the state jail inspector, local/regional/state planning agencies, county commissioners, county/state health departments, mental health departments and dental societies.

C. What can advisory committees do?

1. They can get the job done.

a. The advisory committee can be the eyes and ears of the community regarding jail operations.

b. The public has a right to know the public's business and if the jail had been more of the public's business in the past, we would not have had to wait for over a century to see needed, long over-due basic changes brought about.

2. They can study the jail for the sake of action (not research).

3. They can help to determine medical care and health service needs and develop priorities for action.

4. They can inform the public regarding problems and proposed solutions.

5. They can offer a concentrated effort program in which the major groups in the community speak with one strong voice.

D. When these action-oriented groups are banded together around a common cause, positive things happen. With periodic meetings, open two-way discussions and a sharing of experiences - the major contribution which

members can make, good public support usually results from the public's greater involvement.

1. Alone, strength is frequently missing and the right decisions may not be made.

2. Concerted, joint efforts frequently open up avenues for accomplishment.

3. In working together, sometimes the "impossible" can be achieved.

IV. OTHER SOURCES OF ASSISTANCE IN THE COMMUNITY

A. There are resources within the community that potentially are available to a jail administrator to help fill the gaps in the jail's health care delivery system.

1. Potentially, the local health department is by far the best resource available to a jail (especially a small jail). This model has been the most popular for providing primary care in AMA project jails.

2. Depending on the locale, the health department often is funded to provide medical and dental care, communicable disease detection, nutritional counseling, training programs and environmental services.

3. Since local health departments are supported by the same monies as the jail, local (county or city) finance board members should be urged to utilize one local agency to provide services to the other.

4. To require jails to pay for health department services is like taking money from one pocket and placing it in the other.

5. It should be stressed that the health department is responsible for serving community residents, and the jail is populated by these same people.

6. A close working relationship between the jail and the health department can change a non-existent health care system into a functioning, viable one.

B. Even though the local health department is potentially the best resource available to a jail, there are many other agencies/organizations which can provide a variety of services. Some of these would be:

1. Local hospitals (physician services/consultation on cases, programs, policies and hospital care and services, including laboratory/diagnostic tests, medications administration training, receiving screening and health education for jailers/correctional officers).

2. Local nursing homes (nursing services/consultation).

3. Local physicians/clinic (physician services/consultation, receiving screening training).

4. Local dentists/clinics (dental services/consultation).

5. Medical and/or nursing schools (physician and/or nursing services/consultation).

6. Dental and/or dental hygientists' schools (dental services/consultation).

7. Community college/university (criminal justice interns).

8. Ambulance company/rescue squad (emergency medical services).

9. Fire/police department (emergency medical services).

10. County coroners office (medical-legal situations).

11. Military base/V.A. hospital (medical services)

12. American Heart Association (patient education, training of staff regarding first aid and cardiopulmonary resuscitation and professional publications).

13. American Cancer Society (patient education, counseling).

14. American Red Cross (first aid, CPR and EMT training,* health education and professional publications).

15. Civil Defense (first aid, CPR and EMT training).

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*CPR = Cardiopulmonary resuscitation
EMT = Emergency Medical Technician

16. Local Mental Health Center (mental health services, including testing/diagnosis and counseling).

17. Local Drug Abuse Centers (drug addiction services).

18. Detoxification programs (detoxification services).

19. Alcoholics Anonymous (detoxification and alcoholism counseling).

20. Salvation Army (clothing, housing, counseling).

C. It has been said that "A lack of information breeds fear and prejudice".

1. This has been one of the major stumbling blocks to upgrade jail health care systems.

2. As a rule, agencies/organizations within the community do not go around offering their services to jails.

3. However, when the jail administrator sits down with an agency/organization administrator and explains the problems faced by the jail, the chances are that the community agency/organization will respond favorably.

In short, untapped resources are going to waste because the people who have them and the people who need them do not talk with each other.

D. At this point, the instructor should divide the class into small groups and have each group work up a chart listing the various agencies/organizations which might exist in their areas and what services these agencies/organizations could provide to jails.

(See Appendix H - Sample "Linkages with the Community").

1. This exercise will enable the trainees to better familiarize themselves with the types of assistance available in the community.

2. By having a more thorough understanding of how jails can better utilize community resources to upgrade their health care delivery systems, the trainees will be able to provide a greater level of technical assistance to various facilities.

V. THE ADVANTAGES OF IN-JAIL HEALTH CARE

A. Use of hospital emergency rooms and downtown physicians' offices for all primary health care for inmates has been and continues to be the major, most costly model for jail health care.

B. Changing this to providing regular health care in the jail has been an important factor in upgrading jail health care delivery systems.

C. Based on a special Ten Jail Case Study and Analysis[1] by an independent evaluator, it appears that two of three jails can implement AMA Standards for Health Services in Jails with little more or even less money than previously.

D. This was due in part to better use of already existing resources, which had gone untapped because agencies did not get together.

E. In two years in the AMA Jail Project there was a 70% increase in health care services in the project jails with very little overall expenditure of monies.[2]

F. During another year, with $7,500 of demonstration monies for improving health care in an average of eight jails per state, several states did not even spend all of the money.[3]

G. What all of this means is that better health care protection for the community, staff and inmates can result when community resources are more fully utilized, based upon good two-way communications and cooperation. This means greater efficiency and better use of tax dollars, in addition to improved health services for inmates.

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1. B. Jaye Anno and Allen H. Lang, Ten Jail Case Study and Analysis, Silver Spring, Maryland: B. Jaye Anno Associates (June, 1979).

2 See B. Jaye Anno and Allen H. Lang, Analysis of Pilot Jail Post-Profile Data, Silver Spring, Maryland: B.Jaye Anno Associates (April, 1978).

3 B. Jaye Anno, Final Evaluation Report of the American Medical Association's Program to Improve Health Care in Jails (Year Two), Silver Spring, Maryland: B. Jaye Anno Associates (June, 1978).

APPENDIX A

RESPONSE SITUATIONS

TO THE AMA'S STANDARDS FOR HEALTH SERVICES IN JAILS (1981)

I. Administrative Standards

A. Standard 101 - Responsible Health Authority

A county health department director with a Master's degree in Public Health Administration volunteers to be the health authority for the jail. How do you respond?

This is fine. As defined in Standard 101, the health authority may be a health administrator (a person who by education is capable of assuming responsibilities for arranging for all levels of health care and assuring quality and accessibility of all services provided to inmates).

B. Standard 102 - Medical Autonomy

The new jail physician arrives with his black bag to conduct sick call. The rules of the jail are that all incoming bags and packages must be inspected by the jailer at the control post. After the first day's experience he calls you and says, "I didn't realize I had to get searched each time I entered the jail! Can you get this matter cleared up for me?" How do you respond?

Determine if this jail rule is applicable to all security personnel at the jail. If it is, then the practice of inspecting the physician's bag at the control post is acceptable. However, if this security regulation is not applicable to the physician, you should have the physician confer with the person legally responsible for the facility to resolve this conflict.

C. Standard 103 - Administrative Meetings and Reports

The sheriff said that, with Dr. Johnson having recently been hired as the health authority and responsible physician, he wanted to understand fully what must be done in order to comply with this standard from the standpoint of meetings and so forth. What do you tell him?

Tell Dr. Johnson that he should meet at least on a quarterly basis with the sheriff to discuss health services provided by the jail, identify problem areas and look for solutions. These meetings should be documented, but if they are not, then Dr. Johnson should submit a quarterly report to the sheriff which includes:

the effectiveness of the health care system, description of any health environment factors which need improvement, changes effected since the last reporting period, and, if necessary, recommended corrective action.

D. Standard 103 - Administrative Meetings and Reports

The County Jail at the time of the inspection produces monthly statistical summaries rather than an annual one, and the sheriff tells you that they don't have quarterly reports on the health care delivery system and health environment because those are taken care of by the minutes of the quarterly administrative meetings which he prepares. How do you respond to this situation?

The jail is in compliance with the standard.

E. Standard 104 - Policies and Procedures

The sheriff asks why the jail needs to develop a manual of written policies and defined procedures. How do you respond?

The inspector should tell the sheriff that the manual serves several purposes. First, written policies outline services provided to inmates, statements which staff and outside providers need to know. Second, written procedures guide staff and others in providing those services; and third, written down, such rules serve as a defense in a possible lawsuit. Fourth, the manual is an excellent training vehicle for orienting new staff.

F. Standard 104 - Policies and Procedures

The sheriff seemed to be somewhat agitated over this standard, declaring, "We revise our manual whenever the need calls for it. Isn't that good enough?" What do you say?

Periodic review of policies, procedures and programs is considered good management practice. This process allows the various changes made during the year to be formally incorporated into the agency manual instead of accumulating a series of scattered documents. More importantly, the process of annual review facilitates decision-making regarding previously discussed but unresolved matters.

G. Standard 105 - Support Services

You recruited Dr. Brown through the County Medical Society to serve as jail physician. A week later he calls and says, "The sheriff asked me what he needed to provide for my practice at the jail. I wanted to check with you first to see what other jails are doing around the state. What do you recommend I tell him?" What do you tell him?

As outlined in the "Discussion" of Standard 105, the following basic items should be provided:

Thermometers;
Blood pressure cuff
Stethoscope;
Ophthalmoscope;
Otoscope;
Percussion hammer;
Scale;
Examining table;
Goose neck light;
Wash basin;
Transportation equipment (e.g., wheelchair and litter);
Drug and medications books, such as the Physician's Desk Reference or AMA Drug Evaluations; and
Medical dictionary.

If female inmates receive medical services in the facility, appropriate equipment should be available for pelvic examinations.

H. Standard 106 - Liaison Staff

When the county medical society approached Dr. Jones about being the jail physician, he expressed reluctance because the jail had no nurse nor any qualified health personnel. As an inspector you responded, "While they don't have any qualified health personnel at the jail, I do want to give you some good news! They have what we call a liaison staff person. Here's who he is and what he does". What do you explain?

A health-trained corrections officer or social worker would be designated as the liaison officer whose duties would include coordinating the health services in the jail under the joint supervision of the jail administration and the

responsible physician. The liaison officer would (full or part-time) review receiving screening forms for followup attention, facilitate sick call by having inmates and records available for the health provider and help to carry out physician's orders regarding such matters as diets, housing and work assignments.

I. Standard 107 - Peer Review

When you approached Dr. Williams, health authority for the County Jail, about peer review, he explained, "Why, we don't even do any of that where I practice in the community? Since when do we have to treat jail inmates better than the free citizens?" What is your response?

Tell him/her that this standard requires that a peer review mechanism exist in the jail for complaints against services provided by a physician, the same as it does in the community. Formal, periodic peer review by an outside agency is not required by this standard.

J. Standard 108 - Public Advisory Committee

The sheriff said he does not have a public advisory committee and wondered what the advantages were of having one. "Tell me something about it," he said. What do you tell him?

Advisory committees fill an important need in bringing the best talent in the community to help in problem-solving. The role of the advisory committee is to review the facility's program and advise those responsible. Such a monitoring process helps the staff identify problems, solutions and resources.

The committee may be an excellent resource for better public support for budgets and programs needed at the jail. The composition of the committee should be representative of the community and the size and character of the jail. The advisory committee should represent the local medical and legal professions and include key lay community representatives.

I would then refer him to the AMA monographs "The Role of State and Local Medical Society

Jail Advisory Committees" and "Organizing and Staffing Citizen Advisory Committees to Upgrade Jail Medical Programs."

K. Standard 109 - Decision Making - Special Problem Patients

When you inspected the jail the chief jailer said that the sheriff resisted developing any policy on Standard 109 because they have a classification committee which determines housing and program assignments, disciplinary measures and related activities. "Aren't they qualified to make those decisions without a doctor being on the committee? What's he got to contribute?" he inquired. What do you say?

If the classification committee has as one of its members a person designated by the responsible physician, this is satisfactory. Maximum cooperation between custody personnel and health care providers is essential so that both groups are made aware of movements and decisions regarding special problem patients. Medical or psychiatric problems may complicate work assignments or disciplinary arrangements. Medication may have to be adjusted for safety at the work assignment or prior to transfer.

L. Standard 109 - Decision Making - Special Problem Patients

During the inspection when the defined procedures were reviewed, what factors did you consider in determining whether they met compliance?

1. Suitability for travel based on medical evaluation;

2. Preparation of a summary or copy of pertinent health record information;

3. Medication or other therapy required en-route; and

4. Instructions to transporting personnel regarding medication or other special treatment.

M. Standard 110 - Special Handling: Patients with Acute Illnesses

The County Jail failed to meet the sanitation, safey and health codes of the state. All of the jail cells are in

the back end of the facility with two doors separating them from the control booth up front. There is no audio-visual equipment to help provide observation of inmate activity. Two suspected mentally ill inmates, both former patients of the state hospital, have been confined in the jail for over two weeks. This matter was brought to your attention during the inspection. What do you advise the administrator and health care provider to do about this situation in the post inspection meeting?

You should advise them that the jail should work to meet the sanitation, safety and health codes of the state. You should also advise them to provide adequate staffing/security to help inhibit suicides and assaults (i.e., staff within sight or sound of all inmates) and have trained personnel available to provide treatment and close observation.

N. Standard 110 - Special Handling: Patients with Acute Illnesses

This standard requires post-admission screening and referral for care for those mentally ill or retarded inmates whose adaptation to the correctional environment is significantly impaired. What does the standard require from the standpoint of the care and treatment of inmates awaiting emergency evaluation? What is your definition of "specific referral resources"?

Inmates awaiting emergency evaluation should be housed in a specially designated area with constant supervision by trained staff.

Specific referral resources means all sources of assistance for mentally and other acutely ill inmates.

O. Standard 111 - Monitoring of Services/Internal Quality Assurance

Dr. Weber, new jail physician recently recruited by the County Medical Society for a facility averaging 75 inmates, asks "What am I supposed to do to really comply with that monitoring standard?" What do you tell him?

Tell him it is a system of internal monitoring to see that patients are receiving appropriate care and that all written instructions and procedures are properly carried out. Monitoring is required every two weeks in a jail of this size.

P. Standard 112 - First Aid Kit

Dr. Wilson, health authority for the County Jail, said that, because there is a dispensary and 24-hour nursing service at the jail, the facility ought to be excused from having to meet this standard. What is your response?

Tell him they must still be on hand, because regardless of how well staffed the dispensary may be, there could be two emergencies happening at one time, and a nurse cannot respond to both situations. Further, life-sustaining emergency procedures may need to be implemented by the correctional officer/jailer pending the arrival of the qualified health care person. Also, some minor situations can be handled by a health-trained corrections officer at the scene, without necessitating a special trip to the dispensary (i.e., the inmate/patient could be seen at the next regularly scheduled sick call).

Q. Standard 113 - Access to Diagnostic Services

The sheriff asked, "Why do we need this standard? We provide those needed laboratory tests. Isn't that enough?" What do you say to him?

It provides the documentation and justification for budgetary purposes, as well as verification that these services exist.

R. Standard 114 - Notification of Next of Kin

In reviewing the written policy and defined procedures for this standard, what factors did you consider in determining whether they met compliance?

Check to see if the written policy and defined procedures require notification in the case of serious illness, injury or death.

S. Standard 115 - Postmortem Examination

In your state the law requires that a postmortem examination be conducted on all inmates who die in a detention or correctional facility. What is your response to the sheriff who asked, "Isn't a simple policy stating this fact sufficient?"

Yes.

T. Standard 116 - Disaster Plan

In reviewing the documents during the inspection, what factors do you look for in determining whether there is compliance?

First, it must be determined if there is a disaster plan (some jails do not have one). If so, review what types of health care services will be provided, where and by whom. Is there a triaging or prioritizing plan? Also, is there a back-up plan?

II. Personnel Standards

A. Standard 117 - Licensure

The health authority asks why it is necessary to have verification of current credentials of all qualified health personnel providing services to inmates on file at the facility. Your response is:

To determine that all qualified health personnel are licensed, certified or registered to practice in the state. This is important because, over the years, some criminal justice facilities have had lawsuits or charges placed against them because they had unlicensed, unregistered or uncertified providers who reportedly were not providing proper care.

B. Standard 118 - Job Description

In reviewing the documents during the on-site survey, you note that the job description for the nurse is actually one developed by the state prison system rather than the jail. When you inquired about this, the sheriff said, "Doc is satisfied with it. Won't this suffice for compliance?" How do you respond?

This would be o.k. only if the job description accurately describes all of the duties performed by the nurse. In short, any job description must describe all of the services provided at a particular facility by the nurse.

C. Standard 119 - Staff Development and Training

The jail administrator said to you that he could understand the reason for most of the other standards but

this one had him puzzled. "Why do we need a written plan for staff development and training, particularly when it is the policy of the jail to encourage staff to further education as much as possible?" What do you explain to him regarding rationale and benefits of this standard?

This standard is directed toward health services personnel. All levels of health care staff require regular continuing staff development and training in order to provide the highest quality of care. Proper initial orientation and continuing staff development and training may serve to decelerate "burnout" of health providers and help to reemphasize the goals and philosophy of the health care system.

D. Standard 120 - Basic Training of Correctional Officers/Jailers

In determining whether the jail meets compliance with this standard, what types of potential emergency situations do you look for in training?

What is your definition of "signs and symptoms of an emergency"?

Potential emergency situations are those life-threatening situations which are common in a jail, e.g., diabetic coma, heart attack, stab wounds, head trauma, delirium tremons, shock, internal bleeding, etc.

Signs and symptoms of an emergency would include those conditions commonly associated with a life-threatening situation, e.g., stroke: unconsciousness, paralysis of one or both sides of the body, slurring speech, difficult breathing, etc.

E. Standard 120 - Basic Training of Correctional Officers/Jailers

What are the minimum requirements in a jail for compliance with this standard?

The training must include all of the elements as enumerated in the standard: i.e.,

1) Types of and action required for potential emergency situations;

2) Signs and symptoms of an emergency;

3) Administration of first-aid, with training to have occurred within the past three years;

4) Methods of obtaining emergency care;

5) Procedures for transferring patients to appropriate medical facilities or health care providers; and

6) Signs and symptoms of mental illness, retardation, emotional disturbance and chemical dependency.

At a minimum, 75% of all correctional officers must have undergone this training. There must be an on-going training program to attempt to have all officers trained, and un-trained officers are never permitted to work alone.

F. Standard 121 - Medications Administration Training

The sheriff said that his jailers had been prohibited in the past from distributing medication and that whenever any of the inmates need it, he calls in the county health nurse. He said he was interested however, for a variety of reasons, in having his jailers trained in distributing medications. "What are the positive aspects of it? What all is involved?" What do you say?

Training by the responsible physician encompasses the medical aspects of the administration of medications. Training by the facility administrator encompasses security matters inherent in the administration of medications in a correctional facility.

The positive aspects of this are that it will be done on a timely basis and usually at no additional (or sometimes even less) cost.

G. Standard 122 - Inmate Workers

The chief jailer said that they have had a trustee system operating at the jail for the past seven years and "it has gone along beautifully without any hitches." Because of a lack of nursing help, he said that a trustee accompanies the jailer in his medication rounds and, frankly, he knows the jail inmates much better and helps to keep things straight as far as each inmate getting his own medication

is concerned. He stressed that all of this is done under the strictest of staff supervision. What are your reactions to this situation?

This is wrong. Inmate workers should never be used in this manner. It puts undue pressure as well as temptation on the inmate. The jail would not be in compliance with this standard.

H. Standard 123 - Food Service Workers - Health and Hygiene Requirements

If your state does not require pre-service physical examinations for work in restaurants and, consequently does not require periodic re-examinations, is this standard not applicable in your state?

No, the standard is still applicable. The facility must still monitor persons working in food services each day for health and cleanliness, as well as instruct them to wash their hands upon reporting to duty and after using toilet facilities.

I. Standard 124 - Utilization of Volunteers

One of your sheriffs said that, when he attended the last National Sheriffs' Association Convention he heard several sheriffs praise the volunteer concept. He asks you, "Could you fill me in on volunteers? What are the advantages and problems? What would I need to do to get a volunteer system going?" Response?

The advantages of a volunteer system are:

1) It is cost effective;

2) Community support is an expected by-product;

3) Inmates generally like the services of volunteers; hence, inmate morale goes up; and

4) Frequently, staff feel better about having community involvement.

One of the best ways to get a volunteer system going is to hire a volunteer coordinator to get it started. Another approach is to enlist a reputable service organization to conduct it, e.g., Junior League, Jaycees, the Church Federation, etc.

I would tell the sheriff that about one-fourth of the jails in the country use volunteers of one kind or another, and it is a very viable concept when the administrator supports and recognizes it. Further, one staff person should be appointed to supervise/monitor the program.

For detailed information on volunteers I would give to or refer the sheriff to the AMA monograph: "The Use of Volunteers in Jails."

III. Care and Treatment Standards

A. Standard 125 - Emergency Services

The County Jail is located 17 miles from the nearest hospital. They do have a written agreement with the hospital for use of its emergency room and also with an ambulance service. Do these factors constitute compliance for the jail regarding the standard?

These factors, in and of themselves, do not constitute compliance. For compliance, there must also exist a written plan which includes arrangements for emergency evacuation of the inmate from within the jail, an emergency on-call physician and dentist (17 miles is not considered "nearby") and security procedures that provide for the immediate transfer of inmates when appropriate.

B. Standard 126 - Receiving Screening

Inmates who are arrested during midnight to 8 a.m. are placed in the holding room near the booking office for processing at 8 a.m. when the day shift comes to work.

The sheriff says that the inmates are not really formally admitted to the jail proper until 8 a.m., particularly because a number of them are bonded out early in the morning and there is no sense in admitting them only to release them a few minutes later. How does all of this stack up with requirements for compliance?

The jail is not in compliance with the standard. The standard calls for receiving screening to be done on all inmates immediately upon arrival at the facility. Inmates have been known to die from lack of medical care in holding pens, awaiting transfer to a permanent section of the jail.

C. Standard 126 - Receiving Screening

A person arrested for drunken driving has just been brought to the jail in a stupor. He is in a nearly unconscious condition and none of the receiving screening process seemingly can be carried out. The chief jailer asks you "How do you advise we handle situations like this?" How do you respond?

Get him to the hospital emergency room. He may not be drunk; he may be diabetic and in insulin shock. Get a medical clearance from the emergency room to ensure that he is O.K. before he is booked. If the hospital confirms that he is drunk, he may be brought back to the jail and kept under 60-minutes-per-hour supervision by at least a health-trained correctional officer until he sobers up. Then proceed with the complete booking/receiving screening process.

D. Standard 127 - Detoxification

At the County Jail the jailers who are trained in chemical dependency and recognition of symptoms of other common health problems supervise inmates that are going through the detoxification process. They work under the guidance of the jail physician. Can the health-trained jailer perform this function or must there be a qualified health care person?

The health-trained correctional officer, under supervision of a physician, can supervise inmates undergoing detoxification for alcohol and opioids. But for detoxification from barbiturates and other relative hypnotic drugs, the program must be under the 24-hour supervision of a licensed nurse, at a minimum.

E. Standard 128 - Access to Treatment

The jail rules and regulations have one sentence pertaining to sick call which reads "Inmates wishing to see the nurse or doctor should ask the cell officer to put their names on the sick call list." Does this satisfy compliance?

NO. Inmates must be told as well as shown in writing, upon arrival at the facility, how to gain access to care.

F. Standard 129 - Daily Triaging of Complaints

Which of the following situations met compliance?

1. Inmates are advised upon admission, in writing, that if they want to go to sick call they must inform the correctional officer who places their name on a list which is then processed.

2. Sick call complaint slips are located at the control post in each cell block where the inmate may fill one out at any time and submit it to the officer on duty who routes it to the clinic.

3. Inmates must request a sick call complaint slip which is then provided to them by the officer on duty for filling out and processing.

4. No list is developed by the correctional officer on duty nor are any complaint slips provided. Instead, the paramedic makes the rounds of the jail every morning at 8:15 a.m. and yells out, "Does anybody want to go on sick call?" He conducts a cursory examination of each inmate wanting to go to sick call, refers the more serious ones to sick call and hands out over-the-counter medications on the spot to the others who need it.

All of the above situations are in compliance with the standard.

G. Standard 130 - Sick Call

Are the following sick call approaches in compliance?

1. The County Jail has an on-call physician who handles more serious cases referred to him by the certified EMT, who conducts sick call three mornings each week.

2. Over the past few months, you have noticed that all jails do not have the same procedures for sick call. You are puzzled by this and ask Dr. Olson (who is the responsible physician for the County Jail) to describe how he conducts sick call. He describes sick call as follows: "Inmates let you know when they're sick. The guards pass out slips and we pick them up once a week. If they're real sick, the guards bring them downstairs and the nurse looks them over. There is not a lot to it - no formal thing."

1. The system would be in compliance if the state medical practice acts allow a certified EMT to perform such services (few do). The standard calls for sick call to be conducted by a physician and/or other qualified health personnel.

2. This system would not be in compliance, since triage is conducted only once a week (must be daily), and the guards decide who is or is not sick (i.e., make medical decisions).

In each case the frequency of sick call would depend upon the size of the jail.

H. Standard 131 - Health Appraisal

How would you respond to the following health appraisal items?

1. What, if any, communicable disease tests are required in the health appraisal?

2. If the medical practice act and/or case law permit the family nurse practitioner to "review the results of the medical examination, tasks and identification of problems", which is required to be performed by a physician in our standards, how would you handle this in the on-site survey?

1. The standard does not provide for any specific communicable disease tests as such. What is required are laboratory and/or diagnostic tests (as determined by the responsible physician with recommendations from the local public health authority) to detect communicable disease, including veneral disease and tuberculosis.

2. This practice is satisfactory under these conditions of law in that specific state.

I. Standard 131 - Health Appraisal

What responses do you make concerning these health appraisal factors?

1. When must a health appraisal be conducted on an inmate?

2. Must a health appraisal be conducted on every inmate?

1. The health appraisal is to be completed for each inmate within 14 days after his arrival at the jail.

2. NO. If an inmate is incarcerated less than 14 days, a health appraisal does not have to be conducted. Also, if he/she had an appraisal within 90 days prior to incarceration, a re-examination is determined by the physician or designee.

J. Standard 132 - Direct Orders

Dr. Carey issues a lot of direct orders over the telephone and the next time he is at the jail initials the entry in the medical record made by the nurse who carried the order out. Does this meet compliance?

Yes.

K. Standard 133 - Skilled Nursing/Infirmary Care

The jail infirmary has nursing staff on duty during the morning and evening shifts but a certified EMT handles the midnight to 8 a.m. shift. Does the jail meet this standard?

The infirmary must have 24-hour coverage by a health-trained person who may be a health-trained correctional officer. Supervision of the infirmary must be done by a registered nurse on a daily basis. Compliance is satisfied.

L. Standard 134 - Hospital Care

The jail hospital does not meet the legal requirements of a licensed general hospital. Like other jail and **prison** hospitals in the state, it is exempt from the licensing laws. Both the administrator and health authority feel that credit should be given for compliance with the standard. How would you handle this matter during the on-site visit?

If the care provided is consistent with that generally provided within the state, even though it is exempt from the licensing laws, and it meets the legal requirements for a licensed general hospital in the state, then the jail would be in compliance. (Note: There are virtually no jail hospitals in the country.)

M. Standard 135 - Treatment Philosophy

All the treatment rooms at the jail are equipped with two examination tables, separated by a moveable screen. Would this meet compliance with this standard?

Yes, as long as the screens are used.

N. Standard 136 - Use of Restraints

During the on-site survey it was noted that over half of the inmates in the mental health ward of the jail were under four-point restraints. Is the use of such restraints appropriate as outlined? Also, how would you determine whether such practice was appropriate? Is the jail in compliance?

The use of these restraints would be appropriate only if it could be documented that they are in use as part of health care treatment. In the above case, one can be fairly certain that this is not so.

O. Standard 137 - Special Medical Program

The sheriff said that there is no way his jail can meet this standard because he does not have one square foot of extra space to house such a program. Do you agree with him? If no, why not?

Disagree; the program need not take place in an infirmary or specific area as long as the following are provided:

1. Correctional staff officers, trained in health care;

2. Sufficient staff to help prevent suicide and assault;

3. At a minimum, all inmate patients are within sight of a staff persons; and

4. Qualified health personnel to provide treatment.

P. Standard 138 - Standing Orders

A newly elected sheriff said, "I just got in office and I really need to get this matter of standing orders cleared up in my mind. What do they mean?" What do you tell him?

Standing medical orders are standard operating procedures or protocols/guidelines written for the definitive treatment of identified conditions and for on-site treatment of emergency conditions for any person having the condition to which the order pertains. They generally are used by non-physician personnel who provide treatment for minor, self-limited illnesses or for emergencies during the absence of the physician.

Q. Standard 139 - Continuity of Care

Upon release of inmates from the jail, staff collect all of their individually prescribed medications from the locked medicine cabinet and destroy them. As far as you know, each of your jails follows this policy on the premise that the jail could be endangering its position legally if the inmate, upon discharge, took an overdose of medication and death resulted. Reactions?

If the inmate is an adult and has a prescription, it is O.K. to give it to the inmate upon discharge, a practice followed by some jails.

R. Standard 140 - Health Evaluation - Inmates in Isolation

The new sheriff and his chief jailer said that inmates in segregation have not had the opportunity to go to sick call but instead they must have an emergency before medical care is provided. They ask, "What must we do to meet the standards in this regard?" What do you advise?

Have health-trained personnel evaluate all inmates in segregation at least three days per week and document the encounters.

S. Standard 141 - Health Promotion and Disease Prevention

What is meant by preventive maintenance?

Medical preventive maintenance includes health education and medical services (such as inoculations and immunization) provided to take advance measures against disease and instruction in self-care for chronic conditions.

T. Standard 142 -Chemically Dependent Inmates

In your state the family nurse practitioner does diagnose chemical dependency. Further, she makes the decision

whether an individual requires pharmacological or non-pharmacologically supported care. Are these procedures in compliance with the standard?

These procedures are in compliance with the standard if the medical and/or nursing practice acts of the state allow this.

U. Standard 143 - Pregnant Inmates

What types of services must be provided under this standared?

Comprehensive counseling and assistance are to be provided pregnant inmates in keeping with their expressed desire in planning for their unborn children. Counseling and social services should be available from either facility staff or community agencies.

V. Standard 143 - Dental Care

At a meeting with the sheriff, he complained about the "excessive dental standards," making particular reference to dental hygiene and the need to have a dental hygienist on staff to clean teeth. What do you tell him in explaining what Standard 143 requires?

Tell the sheriff that it is not necessary to have a dental hygienist on staff to clean teeth. By dental hygiene service is meant, at minimum, instruction in the proper brushing of teeth.

W. Standard 145 - Delousing

The jail delouses newly admitted inmates only on a selected basis when it is obvious that it must be done. Written policy outlines this practice. Is the jail in compliance?

Yes.

X. Standard 146 - Exercising

What are the minimum requirements for a jail to meet compliance with this standard?

1. Exercise is available daily (seven days per week);

2. It involves large muscle activity (walking, jogging in place, basketball, ping pong, etc.);

3. It is planned (activities are available even though inmates might not take advantage of them); and

4. It is supervised (within sight or sound of a health-trained staff person).

Y. Standard 147 - Personal Hygiene

The jail furnishes the usual personal hygiene items upon admission to those inmates who cannot buy them. Thereafter, all inmates must purchase any additional items needed. Is this jail in compliance with the standard?

NO. If an inmate is indigent, the items must be furnished to him free.

Z. Standard 148 - Prostheses

Must a jail always provide medical and dental prostheses to inmates?

NO. Only when the responsible physician or dentist determines that the health of the inmate would otherwise be adversely affected.

AA. Standard 149 - Food Service

What is considered an adequate diet?

An adequate diet is one containing the four basic food groups, based on the recommended Dietary Allowances.

IV. Pharmaceuticals Standards

A. Standard 150 - Management of Pharmaceuticals

Do the following four situations meet compliance with the standards? Why or why not?

1. The county jail uses a formulary developed for the local hospital;

2. "Stop order" time periods are not stated for dilantin prescriptions for epilepsy;

3. A common practice at the jail is for obstreperous inmates to be tranquilized, thus making it easier to control their behavior;

4. When an inmate is discharged from the jail, any medications which he/she has been taking are given to him/her for use in the community.

1. No. The formulary is to be specifically developed for both prescribed and non-prescribed medication, stocked by the jail. However, the formulary developed by the hospital could be adapted for use by the jail's physician.

2. No. "Stop order" time periods must be stated for all behavior modifying medications and those subject to abuse.

3. No. Long-term use of tranquilizers and other psychotropic drugs is discouraged. They may be used for medical reasons only, not disciplinary ones.

4. Yes, if the medication has been prescribed for the inmate.

V. Health Records Standards

A. Standard 151 - Health Record Format and Contents

The county jail has a log book in which prescribed medications and their administration/distribution are recorded. Hence, entrees regarding these items are not made in the individual medical record. Is this jail in compliance with the standard?

No. The standard calls for the health record file to contain prescribed medications and their administration.

B. Standard 152 - Confidentiality of Health Record

The county jail has only one filing cabinet due in great part to its very small jail size and lack of room for another filing cabinet. One locked drawer of the file contains the health records, with the three remaining files containing the confinement records. Is this practice in compliance with the standards?

Yes.

C. Standard 152 - Confidentiality of Health Record

The county jail, having an average population of four inmates, does not have qualified health care personnel on duty and therefore uses a liaison officer. The health authority/responsible physician has given him access to the health record as needed. Is this in compliance with the standard?

Yes; the access is controlled by the health authority/responsible physician.

D. Standard 153 - Transfer of Health Record and Information

The law and administrative regulations are silent about the matter of transfer of summaries or copies of health records from jails to the state prison system. However, the standard practice is for summaries of the health record to be transferred with each inmate patient who goes from the county jail to the state prison. Written authorization of the inmate is not sought. How would you handle this matter during the inspection?

Since the law is silent on this matter, the jail should get written authorization from the inmate to transfer the health record summaries.

E. Standard 154 - Records Retention

What factors do you look for during the inspection, from the standpoint of compliance:

Are there a written policy and defined procedures regarding the retention of health record files? Does this conform to legal requirements for records retention in the jurisdiction? Ask to see where the inactive record files are kept and finally, check them to see that they are kept.

VI. Medical-Legal Issues

A. Standard 155 - Informed Consent

The practice at the county jail is for force to be used in testing an inmate for communicable diseases when he does not voluntarily allow these procedures to be carried out. Is this practice in compliance with the standards?

This practice may be in compliance with the standard if state law allows it. However, the same procedure must be followed as for a resident in the community. Usually this means

petitioning the court for intervention. Isolating the inmate should be done, at least until the question of contagion is cleared up. In all cases of this nature, the physician should document the medical record as to what was done.

B. Standard 156 - Medical Research

Can biomedical or behavioral research involving inmates be done?

Yes, but only when ethical, medical and legal standards for human research are met. There should be adequate assurance of safety to the inmate, the research should meet standards of design and control and the inmate must have given his/her informed consent.

APPENDIX B

AWARDS OF ACCREDITATION

DATE: 2/13/82

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATI
ALABAMA (1)					
1. Mobile Co.	L	260	VI-A	2 yr	6/81
CALIFORNIA (2)					
2. Placer Co.	M	85	IV-B	2 yr	10/82
3. Yolo Co.	M	87	VII-B	2 yr	7/83
COLORADO (3)					
4. Boulder Co.	M	88	VII-B	2 yr	7/83
5. Mesa Co.	M	64	VII-B	2 yr	7/83
6. Pueblo Co.	M	85	VIII-B	2 yr	10/83
FLORIDA (1)					
7. Orange Co.	L	754	I-B	2 yr	7/82
GEORGIA (8)					
8. Chatham Co.	L	266	VI-A	1 yr	6/80 E
9. Cobb Co.	M	155	IV-A VI-B	2 yr 2 yr	10/80 4/83
10. DeKalb Co.	L	410	I-A	1 yr	8/78 E
11. Monroe Co.	S	25	III-A V-A VII-B	1 yr 2 yr 2 yr	6/79 3/81 7/83
12. Randolph Co.	S	16	II-B	2 yr	7/82
3. Richmond Co.	M	113	III-B	2 yr	8/82
14. Upson Co.	S	18	II-A	1 yr	2/79 E
15. Walton Co.	S	15	IV-B	2 yr	10/82

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATIO	
ILLINOIS (3)						
16. Champaign Co.	M	69	V-B	2 yr	1/83	
17. Kane Co.	M	84	VI-A VIII-B	1 yr 2 yr	6/80 10/83	
18. McHenry Co.	M	50	VI-B	2 yr	4/83	
INDIANA (12)						
19. Allen Co.	M	154	III-A VI-A IV-B	1 yr 1 yr 2 yr	6/79 6/80 10/82	
20. Boone Co.	S	8	II-B	2 yr	6/82	
21. Greene Co.	S	10	I-A III-A IV-B	1 yr 2 yr 2 yr	8/78 6/80 10/82	
22. Henry Co.	S	24	VIII-B	2 yr	10/83	
23. Lake Co.	L	230	VI-A	1 yr	6/80	E
24. LaPorte Co.	M	66	III-A VI-A	1 yr 2 yr	6/79 6/81	E
25. Marion Co.	L	606	I-A IV-A	1 yr 2 yr	8/78 10/80	E
26. Monroe Co.	S	40	II-A VI-A IV-B	1 yr 1 yr 2 yr	2/79 6/80 10/82	
27. Montgomery Co.	S	12	VI-B	2 yr	4/83	
28. St. Joseph Co.	M	80	V-A	2 yr	3/81	E
29. Vanderburgh Co.	M	140	III-A VI-A VI-B	1 yr 2 yr 2 yr	6/79 6/81 4/83	
30. Wayne Co.	M	55	IV-B	2 yr	10/82	

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATIO	
KENTUCKY (1)						
31. Jefferson Co.	L	725	VIII-B	2 yr	10/83	
LOUISIANA (1)						
32. Jefferson Parish	L	425	II-B	2 yr	5/82	
MARYLAND (7)						
33. Anne Arundel Co.	M	167	I-A III-A VI-A	1 yr 1 yr 2 yr	8/78 6/79 6/81	E
34. Baltimore	L	1247	II-A IV-A IV-S	1 yr 2 yr 2 yr	2/79 10/80 10/82	
35. Baltimore Co.	L	229	I-A III-A III-B	1 yr 1 yr 2 yr	8/78 6/79 8/82	
36. Calvert Co.	M	60	VI-A IV-B	1 yr 2 yr	6/80 10/82	
37. Frederick Co.	M	58	VI-A	2 yr	6/81	E
38. Montgomery Co.	L	272	I-A III-A IV-B	1 yr 1 yr 2 yr	8/78 6/79 10/82	
39. Prince George's Co.	L	450	I-A III-A	1 yr 1 yr	8/78 6/79	E
MASSACHUSETTS (12)						
40. Barnstable Co.	M	74	VI-A VII-B	2 yr 2 yr	6/81 7/83	
41. Berkshire Co.	M	70	III-B	2 yr	8/82	
42. Bristol Co.	M	146	III-B	2 yr	8/82	
43. Dukes Co.	S	2	V-B	2 yr	1/83	

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATION	
MASSACHUSETTS (Cont.)						
44. Franklin Co.	M	55	VI-A III-B	1 yr 2 yr	6/80 8/82	
45. Hampden Co.	L	342	VI-A VII-B	2 yr 2 yr	6/81 7/83	
46. Hampshire Co.	M	91	VI-B	2 yr	4/83	
47. Middlesex Co.	L	337	IV-A I-B	1 yr 2 yr	10/79 2/82	E
48. Norfolk Co.	M	130	V-B	2 yr	1/83	
49. Plymouth Co.	M	142	VIII-B	2 yr	10/83	
50. Suffolk Co.	L	223	III-B	2 yr	8/82	
51. Worcester Co.	L	278	VI-A VII-S	2 yr 2 yr	6/81 7/83	
MICHIGAN (12)						
52. Berrien Co.	L	220	IV-A III-B	1 yr 2 yr	10/79 8/82	
53. Cass Co.	S	21	VI-B	2 yr	4/83	
54. Ingham Co.	L	223	V-A	2 yr	3/81	E
55. Kalamazoo Co.	L	250	VI-A VII-B	2 yr 2 yr	6/81 7/83	
56. Kent Co.	L	470	IV-B	2 yr	10/82	
57. Lake Co.	S	1	I-A VI-A	1 yr 1 yr	8/78 6/80	E
58. Midland Co.	S	45	VI-B	2 yr	4/83	
59. Muskegon Co.	M	138	II-A III-A	1 yr 1 yr	2/79 6/79	E

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATION
MICHIGAN (Cont.)					
60. Oakland Co.	L	548	I-A IV-A III-B	1 yr 1 yr 2 yr	8/78 10/79 8/82
61. Saginaw Co.	M	180	VI-A III-B	1 yr 2 yr	6/80 8/82
62. Shiawassee Co.	S	35	I-A III-A III-B	1 yr 1 yr 2 yr	8/78 6/79 8/82
63. Washtenaw Co.	L	205	I-A VI-A VIII-B	1 yr 2 yr 2 yr	8/78 6/81 10/83
MISSISSIPPI (6)					
64. Copiah Co.	S	25	II-B	2 yr	5/82
65. Greenville	S	40	V-B	2 yr	1/83
66. Harrison Co.	M	80	VIII-B	2 yr	10/83
67. Lauderdale Co.	M	64	VII-B	2 yr	7/83
68. Newton Co.	S	15	VII-B	2 yr	7/83
69. Simpson Co.	S	35	VII-B	2 yr	7/83
NEVADA (4)					
70. Douglas Co.	S	19	III-B	2 yr	8/82
71. Eureka Co.	S	1	VI-A	2 yr	6/81 E
72. Las Vegas	L	533	V-B	2 yr	1/83
73. Pershing Co.	S	2	IV-B	2 yr	10/82
NEW YORK (4)					
74. Dutchess Co.	M	107	VII-B	2 yr	7/83

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATION	
NEW YORK (Cont.)						
75. Onondaga Co.	M	175	VIII-B	2 yr	10/83	
6. St. Lawrence Co.	S	39	I-C	2 yr	2/84	
77. Suffolk Co.	L	500	IV-B	2 yr	10/82	
NORTH CAROLINA (3)						
78. Buncombe Co.	M	107	IV-B	2 yr	10/82	
79. Cumberland Co.	M	163	VIII-B	2 yr	10/83	
80. Mecklenburg Co.	L	264	VI-A VII-B	2 yr 2 yr	6/81 7/83	
NORTH DAKOTA (1)						
81. Cass Co.	S	30	VI-B	2 yr	4/83	
OHIO (16)						
82. Allen Co.	M	154	III-A VI-A IV-B	1 yr 1 yr 2 yr	6/79 6/80 10/82	
83. Ashtabula Co.	S	40	VIII-B	2 yr	10/83	
84. Cincinnati Comm. Corr. Center	L	425	III-B	2 yr	8/82	
85. Clinton Co.	S	13	II-B	2 yr	5/82	
86. Columbus Co.	M	167	II-B	2 yr	5/82	
87. Cuyahoga Co.	L	620	VI-A	2 yr	6/81	E
88. Defiance Co.	S	25	III-B	2 yr	8/82	
89. Lorain Co.	M	88	III-B	2 yr	8/82	
90. Lucas Co.	L	295	VI-A I-C	2 yr 2 yr	6/81 2/84	
91. Mahoning Co.	M	110	II-B	2 yr	5/82	

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATION	
OHIO (Cont.)						
92. Marion Co.	S	32	V-A VIII-B	2 yr 2 yr	3/81 10/83	
93. Medina Co.	S	40	II-B	2 yr	7/82	
94. Montgomery Co.	M	199	I-B	2 yr	3/82	
95. Sandusky Co.	S	30	V-A VII-B	2 yr 2 yr	3/81 7/83	
96. Shelby Co.	S	28	II-B	2 yr	5/82	
97. Wayne Co.	M	58	I-C	2 yr	2/84	
OREGON (10)						
98. Benton Co.	S	25	VI-A VII-B	1 yr 2 yr	6/80 7/83	
9. Clackmas Co.	M	90	VII-B	2 yr	7/83	
100. Douglas Co.	M	86	VI-A	2 yr	6/81	E
101. Jackson Co.	M	100	VI-A IV-B	1 yr 2 yr	6/80 10/82	
102. Josephine Co.	M	60	IV-B	2 yr	10/82	
103. Lane Co.	L	242	VI-B	2 yr	4/83	
104. Linn Co.	S	40	IV-B	2 yr	10/82	
105. Marion Co.	M	107	VI-A	2 yr	6/81	E
106. Multnomah Co.	L	560	VI-B	2 yr	4/83	
7. Washington Co.	M	103	V-B	2 yr	1/83	
PENNSYLVANIA (7)						
108. Bucks Co.	L	220	V-A IV-B	1 yr 2 yr	3/80 10/82	

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATIO
PENNSYLVANIA (Cont.)					
109. Delaware Co.	L	328	IV-A V-B	2 yr 2 yr	10/79 1/83
110. Erie Co.	M	179	VI-B	2 yr	4/83
111. Mercer Co.	S	39	III-B	2 yr	8/82
112. Montgomery Co.	L	255	IV-A V-B	1 yr 2 yr	10/79 1/83
113. Northampton Co.	M	117	VII-B	2 yr	7/83
114. Philadelphia	L	3100	VII-B	2 yr	7/83
SOUTH CAROLINA (7)					
115. Columbia	S	47	V-B	2 yr	1/83
116. Fairfield Co.	S	40	V-B	2 yr	1/83
117. Florence Co.	M	102	VI-B	2 yr	4/83
118. Greenville Co.	L	218	VI-A I-C	2 yr 2 yr	6/81 2/84
119. Oconee Co.	M	65	V-B	2 yr	1/83
120. Richland Co.	L	229	VI-A VIII-B	2 yr 2 yr	6/81 10/83
121. Saluda Co.	S	7	V-B	2 yr	1/83
TEXAS (3)					
122. Harris Co.	L	1902	V-B	2 yr	1/83
23. Orange Co.	S	48	VI-A VII-B	2 yr 2 yr	6/81 7/83
124. Scurry Co.	S	27	VI-B	2 yr	4/83
VIRGINIA (3)					
125. Fairfax Co.	M	150	VI-B	2 yr	4/83

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATIO	
VIRGINIA (Cont.)						
126. Newport News	M	142	VIII-B	2 yr	10/83	
27. Virginia Beach	L	264	VI-B	2 yr	4/83	
WASHINGTON (3)						
128. Okanogan Co. (RESCINDED 6/78)	S	30	I-A	1 yr	6/78	E
129. Whatcom Co.	M	60	I-A III-A V-B	1 yr 1 yr 2 yr	8/78 6/79 1/83	
130. Whitman Co.	S	17	I-A III-A	1 yr 2 yr	8/78 6/80	E
WISCONSIN (11)						
131. Adams Co.	S	7	II-A V-A	1 yr 2 yr	2/79 3/81	E
132. Dane Co.	M	135	II-A	1 yr	2/79	E
133. Dunn Co.	S	11	VI-A	2 yr	6/81	E
134. Eau Claire Co.	S	48	I-A III-A	1 yr 2 yr	8/78 6/80	E
135. Milwaukee Co.	L	306	I-A	1 yr	8/78	E
136. Pierce Co.	S	10	V-A	2 yr	3/81	E
137. Racine Co.	M	38	VI-A	2 yr	6/81	E
138. St. Croix Co.	S	36	VI-A VI-B	2 yr 2 yr	6/81 4/83	
39. Walworth Co.	S	32	V-A V-B	2 yr 2 yr	3/81 1/83	
140. Washington Co.	S	24	III-B	2 yr	8/82	
141. Waukesha Co.	M	55	VI-B	2 yr	4/83	

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATION
WYOMING (2)					
142. Campbell Co.	S	14	I-C	2 yr	2/84
3. Natrona Co.	S	46	VIII-B	2 yr	10/83

NOTE: AN "E" APPEARING IN THE LAST COLUMN (DATE OF EXPIRATION) MEANS THAT THE FACILITY'S ACCREDITATION HAS EXPIRED.

TOTAL NUMBER OF FACILITIES EVER ACCREDITED.....143
TOTAL NUMBER OF FACILITIES PRESENTLY ACCREDITED.....115
TOTAL NUMBER OF FACILITIES EXPIRED..... 28
TOTAL NUMBER OF AWARDS EVER GRANTED.....103

APPENDIX C

Jail Health Care Accreditation

A PROGRAM TO IMPROVE HEALTH CARE IN CORRECTIONAL INSTITUTIONS

SUPPORTED BY GRANTS FROM THE ROBERT WOOD JOHNSON FOUNDATION AND THE COMMONWEALTH FUND TO THE AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION

PUBLICATIONS LIST - 1981

Distribution of the American Medical Association's (AMA) correctional health care publications has been assumed by American Health Care Consultants, Inc. Publications available are listed below along with postage and handling charges.

I Monographs

Set A - Personnel, Models and Community Involvement

1. The Use of Allied Health Personnel in Jails. A brief description of some potential ways of extending physician services in institutional settings.

2. Models for Health Care Delivery in Jails. A discussion paper describing different kinds of health care system existing in correctional settings which can be modified to meet the needs of a local jail population.

3. The Role of State & Local Medical Society Jail Advisory Committees. A brochure presenting ways in which state and county medical societies can impact on the problems of health care in jails.

4. Organizing and Staffing Citizen Advisory Committees to Upgrade Jail Medical Programs. A how-to-do-it guide to operations for citizen advisory committees.

5. The Use of Volunteers in Jails. A booklet which describes the practical steps to implement volunteers programs in jails and identifies a number of existing programs utilizing volunteers which are model programs.

Postage and handling charges for set A = $1.50
(Note: Single copies 50¢ each)

Set B - Training for Jailers and Health Professionals

6. Orienting Health Providers to the Jail Culture. A discussion of jails and jail inmates designed to provide background information to health care providers who may be interested in providing service to a jail population.

7. Orienting Jailers to Health and Medical Care Delivery Systems. A description of the basics relating to health care provider roles and organizational structure.

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CONTINUED

2 OF 3

I Monograph (cont.)

8. The Recognition of Jail Inmates with Mental Illness: Their Special Problems and Needs for Care. A monograph providing practical information on the identification and care of the mentally ill jail inmate.

9. Management of Common Medical Problems in Correctional Institutions. A monograph outlining clinical management of tuberculosis and epilepsy, two of the most common medical problems encountered in correctional facilities.

10. Health Delivery System Models for the Care of Inmates Confined in Jails. A booklet describing successful replicable approaches and structures for delivering health care in jails.

11. Guide for the Care and Treatment of Chemically Dependent Inmates. Guidelines are presented for the screening, referral and clinical management of chemically dependent inmates. Also presented are potential model programs and processes in the continuum of care for the chemically dependent inmate.

Postage and handling charges for set B = $3.00
(Note: Single copies 75¢ each)

Set C - Legal Issues

12. Constitutional Issues of the Prisoner's Right to Health Care. A medicolegal monograph examining what the courts understand to be constitutionally acceptable levels of medical care.

13. Health Care in Jails: Legal Obligations to the Pre-Trial Detainee. This medicolegal monograph discusses the constitutional issues regarding medical care provided to persons who are innocent in the eyes of law and are awaiting trial as distinct from convicted inmates.

14. The Use of Allied Health Personnel in Jails: Legal Considerations. This medicolegal monograph describes the requirements of professional supervision where ancillary personnel are included in the health care delivery system of a correctional facility.

15. Health Care in Jails: Inmates' Medical Records and Jail Inmates' Right to Refuse Medical Treatment. A discussion of the legal and ethical considerations involving the confidentiality of inmate medical records and a discussion of the right of a competent adult to refuse medical treatment although confined.

Postage and handling charges for set C = $3.00
(Note: Single copies $1.00 each)

I Monographs (cont.)

Set D - Juvenile Health Care

16. Profile Study of Selected Juvenile Health Care Facilities. A survey of juvenile health care facilities in three pilot states outlines approaches utilized for health care delivery to juveniles.

17. Common Health Problems of Juveniles in Correctional Facilities. This monograph presents an epidemiologic survey of health problems of juveniles confined in correctional facilities, effected through a national review of literature on the subject.

Postage and handling charges for set D = $1.00
(Note: Single copies 75¢ each)

Set E - Dental and Eye Care

18. Dental Care of Jail Inmates. Guidelines for dental care of jail inmates are outlined, as well as approaches for their implementation.

19. Vision and Eye Care for Jail Inmates. This monograph was developed by the Interprofessional Education Committee of the American Academy of Ophthamology. It suggests guidelines for screening and treating inmates' visual problems.

Postage and handling charges for set E = $1.00
(Note: Single copies 75¢ each)

Set F - Spanish versions

Available only for the following :

20. The Recognition of Jail Inmates with Mental Illness: Their Special Problems and Needs for Care

21. Guide for the Care and Treatment of Chemically Dependent Inmates

22. Dental Care of Jail Inmates

Postage and handling charges for set F = $2.00
(Note: Single copies $1.00 each)

COMPLETE SET OF MONOGRAPHS 1-19 (ALL EXCEPT SPANISH VERSIONS) = $6.00

II Evaluation Results of the AMA's Jail Program (Years One - Five)
This set includes four separate publications which describe the evaluation results for Years One - Five of the AMA's Jail Program. Various impact measures are described including a pre/post measure of the availability of health care services in thirty pilot sites, a pre/post measure of inmates' health status in these same sites, a special case study of ten jails to determine the factors accounting for accreditation and pre/post measures of the participatnt jails compliance with AMA standards during years Three, Four and Five.

Postage and handling charges for complete set = $5.00

III Standards and Support Materials

Standards for Health Services in Jails. This document contains standards which describe acceptable levels of medical, psychiatric and chemical dependency care in jails. (Revised 1981)
(Single copies $2.50 each)

Standards for Health Services in Prisons. This document contains standards which describe acceptable levels of medical, psychiatric and chemical dependency care in prisons. (Revised 1979)
(Single copies $2.50 each)

Standards for Health Services in Juvenile Correctional Facilities. This document contains standards which describe acceptable levels of medical, psychiatric and chemical dependency care in juvenile correctional facilities. (Revised 1979)
(Single copies $2.50 each)

Manual on Exercising for the Incarcerated. This manual suggests an exercise program which can be utilized by individual inmates. A series of exercises are described and illustrated including warm-up, work-out and warm-down movements. Sample forms are provided, so inmates can keep track of their own progress.
(Single copies $2.50 each)

Practical Guide to Improving Medical Care and Health Services in Jails. A manual containing samples of medical records forms, receiving screening forms, pharmacy policies, standing orders, physician contracts, etc., which may be readily adapted to local jail situations. These aids can assist the jail, health authority and responsible physician to develop written guidelines in compliance with the AMA Standards.
(Single copies $2.00 each)

IV Conference Proceedings

2nd National Conference on Medical Care and Health Services in Correctional Institutions (October 1978)
(Single copies $2.00 each)

IV Conference Proceedings (cont.)

3rd National Conference on Medical Care and Health Services in Correctional Institutions (November 1979)
(Single copies $3.00 each)

Both proceedings = $4.00

V Correctional Health Care Program (CHCP) Manuals (Prison Health Care)

These manuals were developed under a grant from the Law Enforcement Assistance Administration to the Michigan Department of Corrections. They address key issues of concern to correctional health care administrators and providers. Geared primarily to prisons, the manuals include the following topics: dental services, policies and procedures, diet services, health education programs, protocols, staff development, first aid, information systems, informed consent, make-buy decision analysis, legislative concerns, pharmacy services, medical records, quality assurance, self-care and nursing procedures as well as an annotated bibliography.

Postage and handling charges for complete set of 19 manuals = $15.00

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Jail Health Care Accreditation

A PROGRAM TO IMPROVE HEALTH CARE IN CORRECTIONAL INSTITUTIONS

SUPPORTED BY GRANTS FROM THE ROBERT WOOD JOHNSON FOUNDATION
AND THE COMMONWEALTH FUND TO THE AMERICAN
MEDICAL ASSOCIATION EDUCATION
AND RESEARCH FOUNDATION

AMA Correctional Health Care Publications

ORDER FORM

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I	**Monographs**			
	Set A (Numbers 1-5)	$1.50	____	____
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	Set C (Numbers 12-15)	3.00	____	____
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	Set F (Spanish versions)	2.00	____	____
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	Single Copies:			
1.	The Use of Allied Health Personnel in Jails	50¢	____	____
2.	Models for Health Care Delivery in Jails	50¢	____	____
3.	The Role of State and Local Medical Society Jail Advisory Committees	50¢	____	____
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7.	Orienting Jailers to Health and Medical Care Delivery Systems	75¢	____	____
8.	The Recognition of Jail Inmates with Mental Illness: Their Special Problems and Needs for Care	75¢	____	____
9.	Management of Common Medical Problems in Correctional Institutions	75¢	____	____
10.	Health Delivery System Models for the Care of Inmates Confined in Jails	75¢	____	____
11.	Guide for the Care and Treatment of Chemically Dependent Inmates	75¢	____	____
12.	Constitutional Issues of the Prisoner's Right to Health Care	1.00	____	____
13.	Health Care in Jails: Legal Obligations to the Pre-Trial Detainee	1.00	____	____
14.	The Use of Allied Health Personnel In Jails: Legal Considerations	1.00	____	____
15.	Health Care in Jails: Inmates' Medical Records and Jail Inmates' Right to Refuse Medical Treatment	1.00	____	____

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17.	Common Health Problems of Juveniles in Correctional Facilities	75¢	____	____
18.	Dental Care of Jail Inmates	75¢	____	____
19.	Vision and Eye Care for Jail Inmates	75¢	____	____
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	Juvenile Standards	2.50	____	____
	Exercising Manual	2.50	____	____
	Practical Guide	2.00	____	____
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NOTE: For more than 10 copies of any publication or set of publications, call 312-440-1574 or write for a quote.

SAMPLE - APPENDIX D

Annual Statistical Report Form

	MD	PA	RN	Total
I. Ambulatory Clinical Services (patients treated)				
A Sick Call (in house)				
B Physical Examinations (in house)				
C Specialty referral visits (outside jail)				
1) Emergency Room				
2) Pulmonary				
3) Cardiac				
4) Dermatology				
5) Metabolic Endocrine				
6) EENT				
7) Orthopedic				
8) Gynecologic Obstetric				
9) Surgery				
10) Psychiatric				
11) Dental				
12) Other				

II. Hospitalization (# patients treated by type of service)

A Medical
B Surgical
C OB-Gyn
D Psychiatric

III. Pharmaceutical prescriptions dispensed (# prescriptions filled or refilled)

IV. Chemical Laboratory Procedures (ambulatory care # of tests performed at the jail or in the community)

1) U A
2) Hematology
3) Bacteriology
4) Chemistry
5) Serology
6) Cytology

V. X-Rays (ambulatory care--# of tests)

VI. Immunizations (patients)

VII. Disease Reports (patients)

1) Tuberculosis (presumed active)
2) Infectious Syphilis (primary & secondary)
3) Infectious Gonorrhea
4) Other venereal diseases
5) Viral hepatitis
   a) infectious
   b) serum
   c) not defined
6) Other notifiable diseases (as determined by the responsible physician)

VIII. Special procedures performed (by type and # of patients)

IX. Inmate Deaths (specify cases and numbers)
comments

X. Ambulance transfers to and from this jail (number)

XI. Narrative Comments

MD

date

APPENDIX E

SAMPLE RECEIVING SCREENING FORM

DATE _____
TIME _____

_____
(Name of Institution)

INMATE NAME _____ SEX _____ D.O.B. _____

INMATE NO. _____ OFFICER/EXAMINER NAME: _____

BOOKING OFFICER/EXAMINER OBSERVATIONS
(Where applicable, circle specific condition)

	YES	NO	COMMENTS
1. Unconscious?			
2. Visible signs of trauma or illness requiring immediate emergency or doctor's care? Describe: _____			
3. Obvious fever, swollen lymph nodes, jaundice or other evidence of infection which might spread through the jail? Describe: _____			
4. Poor skin condition, vermin, rashes, or needle marks?			
5. Under the influence of alcohol, barbiturates, heroin or other drugs?			
6. Visible signs of alcohol/drug withdrawal? (Extreme perspiration, pinpoint pupils, shakes, nausea, cramping, vomiting)			
7. Behavior suggests risk of suicide or assault?			
8. Carrying medication or report being on medication? List: _____			
9. Deformities (List): _____			

OFFICER/EXAMINER-INMATE QUESTIONNAIRE

10. Admits To The Following (Indicate by number and letter below):

1. (Over one year ago)
2. (Within one year)
3. (Present now)

H (Hospitalized)
M (Medications - current)

_____	Allergies	_____	Hepatitis
_____	Arthritis	_____	High Blood Pressure
_____	Asthma	_____	Physician Prescribed Diet
_____	Delirium Tremens(DT's)	_____	Psychiatric Disorder
_____	Dental Condition	_____	Tuberculosis
_____	Diabetes	_____	Ulcers
_____	Epilepsy	_____	Urinary Tract Problems
_____	Fainting	_____	Venereal Disease (VD) (Which)?
_____	Heart Condition	_____	Other (Specify): _____

11. Use alcohol?
    a) If yes, how often? _____ b) How much? _____

    c) When were you drunk last? _____

    d) When did you drink last? _____

12. Use any "street" drugs?

    a) If yes, what type (s)? _____

    b) How often? _____ (c) How much? _____

    d) When did you get high last? _____

    e) When did you take drugs last? _____

13. If female, is she:

    a) Pregnant? _____ (Months)

    b) Delivered recently? _____ (Date)

    c) On birth control pills? _____

REMARKS (i.e. Unusual behavior, special diet, type of VD, etc)

_____

_____

_____

DISPOSITION/REFERRAL TO (Please underline applicable response):

a) General population b) Emergency care c) Sick call d) Isolate

Developed by: The American Medical Association
Jail Medical Technical Assistant Program
March 18, 1980 Rev. July 1, 1980

(A copy of this form is included in the inmates medical record)

Sample Form

Receiving Screening: Guidelines for Disposition

Question

1. If yes, arrange for immediate transfer to hospital and refer to page 30 in "Emergency Care Guidelines." (E.C.G.)
2. If yes, call doctor now and describe symptoms.
3. If yes, isolate from other inmates, monitor condition frequently and call doctor immediately if condition of inmate appears to get worse. Use paper plates-plastic utensils, dispose of immediately. Keep all bedding separate from others-sterilize. In case of fever administer aspirin as ordered by doctor. Call doctor during next regular office hours and describe symptoms.
4. If yes because of rash or other unusual skin eruptions, isolate and follow instructions in question number 3. If vermin is present, isolate and instruct inmate in use of Kwell or other scabicide.
5. If yes to alcohol, transfer to detoxification unit at hospital. Refer to page 14 in E.C.G. If yes to drugs, find out if possible what and how much the inmate has been taking (refer to page 14 in E.C.G.) and call doctor now.
6. If yes, monitor closely and call doctor now. (See page 14 in E.C.G.)
7. If yes for suicide risk, follow instructions on page 28 in E.C.G. for suicide. If yes for risk of assualt, isolate, monitor closely, call a doctor or mental health center now. (See page 5 in E.C.G.)
8. If yes to carrying medications, place in inmate's locker, check that medications in bottle are actually what was prescribed, and try to check with prescribing doctor whether medication is to be continued. If cannot accomplish the preceding, check with jail doctor for instructions before administering any medication. If inmate reports being on medication, check with doctor to get prescriptions.
9. If yes, note and inform appropriate personnel.
10. If the inmate admits to the following specifics:

    Currently on medications = check with doctor to get prescriptions.

    Currently on special diet = inform doctor and notify kitchen staff.

    Recently hospitalized = report to doctor during next regular office hours unless there are symptoms indicating need for immediate attention.

    Allergic to mediciations = note names of drugs and inform doctor.

    Painful Dental Condition = Refer to page 29 in E.C.G.

    Diabetes now = report to doctor for orders for appropriate medication and or diet plan.

Epilepsy now = check for any medication being taken and follow steps in question 8.

Fainting = check for recent head injury and refer to page 6 in E.C.G.

Hepatitis now = isolate and report to doctor during next regular office hours.

Tuberculosis history or now = isolate and report to doctor during regular office hours.

Venereal Disease = isolate and have testing done as soon as possible, follow by administration of appropriate prescribed medication.

13. If pregnant or delivered recently, report to doctor during next regular office hours. If on birth control pills follow sequence in question number 8.

APPENDIX F

RESPONSE SITUATIONS REGARDING

"INSPECTION OF HEALTH SERVICES"

RESPONSE SITUATIONS REGARDING "INSPECTION OF HEALTH SERVICES"

1. Why should correctional officers or jailers, who are not health care providers, be interviewed in the inspection?

   They are "caught in between" the inmates and health care system and usually are pragmatically objective about the operation of the health care system. If it isn't working satisfactorily, they hear complaints from the inmates and, knowing inmates, can balance their appraisal of the system.

2. There is a feeling on the part of some officials that "inmates as a group are not to be trusted because otherwise they wouldn't be in jail." What response would you give to someone who expressed that viewpoint?

   When a representative sample of inmates is interviewed, experience of national survey agencies is that inmates will be frank to outline both positives and problems of a system, much like jailers/correctional officers do.

3. What are your preferences for the selection of staff to interview during the inspection?

   It is best to select at least one from each of the living units/cell blocks. The inspector should do the selecting.

4. What are your preferences for the selection of inmates to interview during the inspection?

   The inspector should randomly select them from each housing unit, using a list or the control board which lists all inmates, their location and race.

5. What approach do you recommend be taken to put interviewees in the right frame of mind to talk freely and frankly in response to your questions during inspection interviews?

   Explain the motive of the inspection and guarantee that the information provided will not ever be revealed as coming from them. Further, explain that their input is important and will be pooled with that obtained from other interviews.

6. What value do you place on written documentation?

   Written documentation which reflects actual practices is absolutely essential from an operational and legal protection standpoint. However, if certain policies and procedures are not operational, their value/existence in written form only is considerably downplayed.

7. During an inspection what are your feelings on interviewing staff persons from only one shift?

   This is not good because practices vary by shifts. Every effort should be put forth to interview persons from at least the day and evening shifts.

8. Upon arriving for the inspection, the chief administrator at the jail hands you a list of names of inmates and staff that should be interviewed for the survey. How would you handle this situation?

   The inspector should interview some of them and then select some of his/her own candidates randomly. Usually, when interviews of administrators' selected interviewees have been conducted, the results have not been shown to favor the administration any more than surveyor-selected interviewees. However, it is good research practice not to rely on a sample selected for you, just in case the administration has deliberately biased the sample.

APPENDIX G

UNITED STATES MARSHALS SERVICE (USMS) AUDIT FORMAT

USMS AUDIT FORMAT

(Sections Pertaining to
AMA Standards For Health Services In Jails)

INMATE CLOTHING AND HYGIENIC LIVING CONDITIONS			In compliance	Not in compliance	Exceptions Noted	Staff Information Confirmed
250 H-NA	*	Do written policy and procedure provide for the issue of suitable clothing to new inmates?				
		Is present practice acceptable?				
251	*	Do written policy and procedure provide for the issue of suitable bedding, linen, and towels for new inmates?				
		Is present practice acceptable?				
252		Does written policy specify accountability for inmate clothing and bedding?				
		Is present practice acceptable?				
253 H-NA (147)	*	Are laundry services sufficient to permit regular exchange of all inmate clothing, bedding, linen, and towels?				
254		Does the store of clothing, linen, and bedding exceed that required for the facility's maximum inmate population?				
255 (147)	*	Are there sufficient facilities in the housing areas to permit inmates to bathe upon admission to the facility and at least three times a week thereafter?				
256 (147)		Are hair care services available to inmates?				

		INMATE CLOTHING AND HYGIENIC LIVING CONDITIONS	In compliance	Not in compliance	Exceptions Noted	Staff Information	Confirmed
257 (147)	*	Does the facility provide articles necessary for maintaining personal hygiene including soap, toothbrush, toothpaste, or powder, comb, toilet paper and shaving equipment upon request and the special hygiene needs of women?					
258 11-NA	*	Does the facility provide for the cleaning and disinfecting of inmate personal clothing before storage, when necessary?					

		FOOD SERVICES	In compliance	Not in compliance	Exceptions Noted	Staff Information	Confirmed
270 (149)	*	Can the facility document that its food service meets or exceeds the dietary allowance stated in the Recommended Dietary Allowances of the National Academy of Sciences?					
271		Do written policy and procedure require advance menu preparation with the approval of a dietician?					
		Is present practice acceptable?					
272 (149)	*	Do written policy and procedure provide for special diets as prescribed by appropriate medical personnel?					
		Is present practice acceptable?					
273		If inmates' religious beliefs require their adherence to dietary laws, is provision made for such special diets?					
274		Do written policy and procedure require that accurate records are maintained of all meals served?					
		Is present practice acceptable?					
275	*	Does written policy provide for no more than 14 hours between the evening meal and breakfast and a minimum of two hot meals every 24 hours?					
		Is present practice acceptable?					

	MEDICAL AND HEALTH CARE SERVICES	In compliance	Not in compliance	Exceptions Noted	Staff Information	Confirmed
300 (101)	Is there a designated health authority with responsibility and authority for health care services?					
	Is there a written agreement, contract or job description designating the health authority? The health authority is a: Physician Health Administrator Agency		•			
	If the health authority is other than a physician, do final medical judgments rest with a single designated responsible physician licensed in the state?					
301 (102)	Are matters of medical and dental judgment the sole province of the responsible physician and dentist, respectively?					
	Do security regulations, applicable to facility personnel, also apply to health personnel?					
302 (103)	Is there minimally a quarterly report on the following? Health care delivery system?					
	Health environment					
	Is there an annual statistical summary?			•		

	MEDICAL AND HEALTH CARE SERVICES	In compliance	Not in compliance	Exceptions Noted	Staff Information	Confirmed
303 (contd) (104)	Health evaluation: inmates in isolation?					
	Chemically dependent inmates?					
	Detoxification?					
	Special Medical Program?					
	Infirmary care?					
	Preventive care?					
	Emergency services?					
	Chronic and convalescent care?					
	Pregnant inmates?					
	Special diets?					
	Use of restraints?					
	Prostheses?					
	Exercising?					
	Personal hygiene?					
	Management of pharmaceuticals?					
	Confidentiality of health record?					
	Transfer of health records and information?					
	Record retention?					
304 (120)	Are inmates within sight or sound of at least one health-trained correctional officer at all times?					
	Is there, minimally, one health-trained correctional officer per shift trained in: Basic cardiopulmonary resuscitation (CPR)?					
	Recognition of symptons of illnesses most common to the inmates?					
305 (117)	Do the state's licensure, certification or registration requirements and restrictions apply to health care personnel who provide services to inmates?					
	Is verification of current credentials on file in the facility.					

MEDICAL AND HEALTH CARE SERVICES			In compliance	Not in compliance	Exceptions Noted	Staff Information	Confirmed
306 (118)		Are the duties and responsibilities of personnel who provide health care defined in job descriptions in accordance with their roles in the facility's health care system?					
		Are the job descriptions approved by the health authority?					
307 (131)		Are the health history and vital signs collected by health-trained or qualified health personnel?					
		Is the collection of all other health appraisal data performed only by qualified health personnel?					
		Is all health appraisal data recorded on forms approved by the health authority?					
308 (111)		Is a physician available at least once a week to respond to inmate complaints regarding service received from other medical providers?					
309 (120)		Do all personnel have current training in basic first aid equivalent to that defined by the American Red Cross?					
310 (148)		As determined by the responsible physician, is medical or dental prothesis provided					

MEDICAL AND HEALTH CARE SERVICES			In compliance	Not in compliance	Exceptions Noted	Staff Information	Confirmed
310 (contd) (148)		when the health of the inmate-patient would otherwise be adversely affected?					
311 (144)		Is dental care provided to each inmate under the direction and supervision of a dentist, licensed in the state as follows: Dental screening within 14 days of admission?					
		Dental hygiene services within 30 days of admission?					
		Dental examinations within three months of admission?					
		Dental treatment, not limited to extractions, within three months of admission when health of inmate would otherwise be adversely affected?					
312 (110)		Are screening and referral for care provided to mentally ill or retarded inmates whose adaptation to the detention environment is significantly impaired?					
313 (110)		Does the responsible physician provide a written list of symptoms and behaviors indicative of mental illness and retardation and designate, in advance, specific referral sources?					
314 (121)		Are the personnel who administer or distribute medication: Trained by the responsible physician and the facility administrator or their designees?					
		Accountable for administering or distributing medications in a timely manner?					

		MEDICAL AND HEALTH CARE SERVICES	In compliance	Not in compliance	Exceptions Noted	Staff Information	Confirmed
315 (120)		Do all correctional personnel who work with inmates have training for health related emergency situations?					
		If yes, is the training program established by the responsible health authority in cooperation with the facility administrator?					
		Does the training include: Types of and action required for potential emergency situations?					
		Signs and symptoms of an emergency?					
		Administration of first aid?					
		Methods of obtaining emergency care?					
		Procedures for patient transfers to appropriate medical facilities or health care providers?					
316 (120)		Are all correctional personnel who work with inmates trained to recognize signs of:					
		Chemical dependency?					
		Emotional disturbance and/or developmental disability?					
		Mental retardation?					
		Was this training done by the responsible physician or designee?					

		MEDICAL AND HEALTH CARE SERVICES	In compliance	Not in compliance	Exceptions Noted	Staff Information	Confirmed
317 (122)		Are inmates prohibited from the following Performing direct patient care services?					
		Scheduling health care appointments?					
		Determining access of other inmates to health care services					
		Handling or access to: Surgical instruments?					
		Syringes?					
		Needles?					
		Medications?					
		Health records?					
		Operating equipment for which they are not trained?					
318 (128)		Upon arrival to the facility, is information communicated orally and in writing to inmates ragarding: Access to health care or services?					
		Processing of complaints regarding health care or services?					
319 (132)		Is treatment by health care personnel other than the physician or dentist performed pursuant to direct orders written and signed by personnel authorized by law to give such orders?					
320 (126)		Is receiving screening performed by health trained or qualified health care personnel on all inmates, (other than holdovers there less than 72 hours), including transfers, upon arrival at the facility?					
		If yes, does the screening include: Inquiry into: Current illness and health problems, including venereal diseases?					
		Medications taken and special health requirements?					

	MEDICAL AND HEALTH CARE SERVICES	In compliance	Not in compliance	Exceptions Noted	Staff Information Confirmed
320 (contd) (126)	Use of alcohol and other drugs which includes types of drugs used, mode of use, amount and frequency used, date or time of last use?				
	A history of problems which may have occurred after ceasing use (e.g., convulsions)?				
	Observation of: Behavior which includes state of consciousness, mental status, appearance, conduct, tremor, and sweating?				
	Disposition to: General population?				
	General population and later referral to appropriate health care service?				
	Referral to appropriate health care service on an emergency basis?				
	Are the findings recorded on a printed screening form approved by the health service?				
321 (131)	Is a health appraisal for each inmate completed within 14 days after arrival at the facility?				

	MEDICAL AND HEALTH CARE SERVICE	In compliance	Not in compliance	Exceptions Noted	Staff Information Confirmed
321 (contd) (131)	In the case of an inmate who has received a health appraisal within the previous 90 days, is the need for a new health appraisal determined by the physician or his designate?				
	Does the health appraisal include? Review of the earlier receiving screening?				
	Collection of additional data to complete the medical, dental, psychiatric and immunization histories?				
	Laboratory and/or diagnostic test results to detect communicable disease, including venereal diseases and tuberculosis?				
	Recording of height, weight, pulse, blood pressure, and temperature?				
	Other tests and examinations as appropriate?				
	Medical examinations with comments about mental and dental status?				
	Review of the results of the medical examination, tests and identification of problems by a physician?				
	Initiation of therapy when appropriate?				
322 (129)	Are inmates' health complaints processed at least daily?				
	Are all inmate health complaints solicited and acted upon by health trained personnel?				
	Does appropriate triage and treatment by qualified health personnel follow?				

		MEDICAL AND HEALTH CARE SERVICES	In compliance	Not incompliance	Exceptions Noted	Staff Information	Confirmed
324 (130)		Is sick call conducted by a physician and/or other qualified health personnel? In small facilities of less than 50 inmates is sick call held once per week at a minimum?					
		In medium-sized facilities of 50 to 200 inmates is sick call held at least three times per week?					
		In facilities of over 200 inmates is sick call held a minumum of five times per week?					
		If an inamte's custody status precludes attendance at sick call, are arrangements made to provide sick call services in the place of the inmate's detention?					
325 (127)		Is detoxification from alcohol, opioids, stimulants, and sedative hypnotic drugs effected as follows: When performed at the facility is it under medical supervision?					
		When not performed in the facility is it conducted in a hospital or community detoxification center?					
326 (133)		Is the scope of infirmary care services available defined?					
		Is a physician on call 24 hours per day?					
		Is nursing service under the direction of a registered nurse on a full-time basis?					
		Are health care personnel on duty 24 hours per day?					
		Are all inmates with sight or sound of a staff person?					

		MEDICAL AND HEALTH CARE SERVICES	In compliance	Not incompliance	Exceptions Noted	Staff Information	Confirmed
326 (contd) (133)		Does a manual of nursing care procedures exist?					
		Is a separate individual and complete medical record maintained for each inmate?					
327 (125)		Is there 24-hour emergency medical and dental care availability? If yes , do arrangements include:					
		Emergency evacuation of the inmate from within the facility?					
		Use of an emergency medical vehicle?					
		Use of one or more designated hospital emergency rooms or other appropriate health facilities?					
		Emergency on-call physician and dentist services when the emergency health facility is not located in a near-by community?					
		Security procedures providing for the immediate transfer of inmates when appropriate?					

		MEDICAL AND HEALTH CARE SERVICES	In compliance	Not in compliance	Exceptions Noted	Staff Information Confirmed
328 (150)		Does the management of pharmaceuticals include: Adherence to state law as related to the practice of pharmacy?				
		A formulary specifically developed for the facility?				
		Adherence to regulations established by the Federal Controlled Substances Act relating to controlled substances?				
		Prescription practices which require that: Psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy and are not allowed for disciplinary reasons?				
		"Stop order" time periods are stated for behavior modifying medications and those subject to abuse?				
		Reevaluation by the prescribing provider prior to renewal of a prescription?				
		Maximum security storage and weekly inventory of all controlled substances, syringes and needles?				
329 (151)		Does the health record file contain: Completed receiving screening form?				
		Health appraisal form?				
		Findings, diagnoses, treatments, dispositions?				
		Prescribed medications and their administration?				
330 (152)		Is the medical record file kept separate from the confinement record?				
331 (153)		Are summaries or copies of the medical record file routinely sent to the facility to which the inmate is transferred?				

APPENDIX H: AGENCIES IN THE COMMUNITY*

'NKAGES WITH
.E COMMUNITY

Agency/Organization

Service	City/County Health Dept.	Local Hospital	Local Nursing Home	County Nurse	School Nurse	County Medical Society	ocal Physicians/Clinics	.ocal Dentists/Clinics	Medical School	Nursing (RN/LPN) School	Dental School	Dental Hygienists School	Community College/University (Interns in criminal justice)	Ambulance Company/Rescue Squad	Fire/Police Dept.	County Coroner's Office	Military Base/VA Hospital	HMOs/IPAs	American Heart Assoc.	American Cancer Society	American Red Cross	Civil Defense	Epilepsy Foundation	Cooperative Extension Service	Local Mental Health Center	Local Drug Abuse Agencies	Detoxification Programs	Alcoholics Anonymous	Regional Criminal Justice Planning Agency	Church Groups	Auxiliaries	Civic Groups	Salvation Army	Family Planning Groups
Physician services/consultation on cases, programs, policies, forms	X	X	X	X		X	X	X	X	X	X	X	X		X		X	X	X	X	X	X	X	X	X	X	X	X	X				
Nursing services/consultation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Mental services/consultation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Lab & diagnostic tests for disease	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
EMT - A services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Mental health services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Hospital services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Detoxification	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Drug addiction services	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
CPR training-Basic/instructor	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
First aid training - Basic/ Advanced	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Receiving screening training	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Mental health/retardation assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Counseling	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Clothing	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Volunteers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Medical-Legal situations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Medication administration, training and documentation	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Professional publications	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Health education materials	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					

* Developed by Illinois State Medical Society Jail Project, Larry S. Boress, Director

END