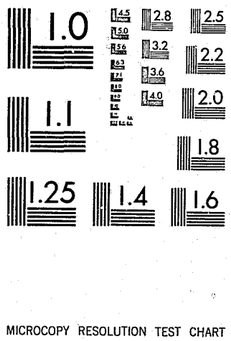

TRAINING PACKAGE FOR FEDERAL AND STATE JAIL INSPECTORS TO REVIEW HEALTH CARE SERVICES

MANUAL FOR STUDENTS

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

MANUAL FOR STUDENTS

NATIONAL INSTITUTE OF CORRECTIONS
Bureau of Prisons, U.S. Department of Justice

TRAINING PACKAGE DEVELOPED BY
THE
AMERICAN MEDICAL ASSOCIATION

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OVERVIEW OF CONTENTS OF TRAINING PACKAGE

UNIT I: Introduction to the Course: Orientation and Motivation (1½ hours)

UNIT II: Legal Issues: The Growing Demands of Regulations, Standards and Court Orders (2½ hours)

UNIT III: Review of the American Medical Association's Standards for Health Care in Jails (12 hours)

UNIT IV: How to Survey Jail Health Care Systems and Measure Compliance (2 hours)

UNIT V: How to Provide Technical Assistance to Jails and Advise Them Regarding the Effective Utilization of Existing Community Resources (3 hours)

APPENDICES:

A - Response Situations to the AMA's Standards for Health Services in Jails (1981)

B - Awards of Accreditation as of February 1982.

C - Jail Health Care Accreditation Publications' List - 1981.

D - Sample "Annual Statistical Report Form"

E - Sample "Receiving Screening Form"

F - Response Situations Regarding "Inspection of Health Services"

G - United States Marshals Service (USMS) Audit Format

H - Agencies in the Community

STUDENT'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 and Motivation

TIME: 90 minutes

OBJECTIVES: Upon completion of this unit, you 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.

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

Note: Some ideas/concepts herein were brought out in film "Out of Sight, Out of Mind." Can you relate them?

A. Over 158,000 people occupy 3,493 jails daily[1]/

1. Idleness, boring routines characterize jail life

2. Most inmates await disposition, with some serving short sentences

B. Few citizens demonstrate interest in their jails

However, jails impact society considerably:

1. Nearly all federal and state prisoners once were confined in local jails

2. Treatment in jail may influence future conduct, including either more serious crimes or deterring them from further crime

3. Jails serve as a holding facility for various medical/social problems:

a. Drug-alcohol abuse

b. Mental illness or deficinecy

c. Infectious diseases, like tuberculosis and venereal disease

C. Common problems of jails due to decades of neglect are:

1. Overcrowding

2. Understaffing

3. Old decrepit facilities

4. Idleness due to lack of program

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

5. General apathy and negative public attitudes

D. More people today recognize role and importance of jails

E. Greater attention to health care is being given

F. 1972 AMA national survey[2]/ revealed shocking conditions

1. Regarding health care delivery:

a. Two-thirds of responding jails had only first-aid capability

b. 17% had no in-jail medical facilities

c. Only 17% had facilities for alcoholics

d. Only 13% had facilities for mentally ill

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

2. "Wait until they drop"/"emergency care only" was predominant pattern of care

3. Availability of health care personnel greatly limited:

a. physician regularly available in 38% of jails

b. on-call physicians available in 51% of jails

c. no physicians available - 31%

d. nurse available - 18%

e. psycholgists - only 15%[4]/

G. 1977 independent survey of 30 AMA Project jails revealed gross inadequacy of health care and alarming statistics on pathology:[5]/

[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.

[3] Ibid, p. ii.

[4] Ibid.

[5]

Of 641 inmates examined:

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

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

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

SUMMARY: The above and other studies show great disparity between incidence of diseases among jail inmates and general population

H. 1977 study[8] also revealed:

1. Of 502 inmates interviewed:

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

b. almost 26% unable to obtain medical care because:

i. not available

ii. blocked by jailers or medical staff

c. about 60% said care in jail not as good as in community

d. 40% felt health status declined since incarceration

2. Major significance, above data, not that inmates have health problems

Lack of regular care in community and extensive use of alcohol/drugs rendered above statement an expected finding.[9]

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

[9]Ibid.

3. Most significant finding not disease incidence per se but:

a. conditions not having been previously known by jail

b. inmates therefore not having been treated[10]

I. Clear need for improved medical care in jails

1. Common problems: infectuous diseases, drug/alcohol problems and mental illness

2. Little has been done regarding above

3. Much can and should be done.

4. This course will equip you with know-how and skills to do your part

II. Rationale For This Course (Why You should learn about the need for adequate health care in jails)

A. Professional

1. You the jail inspector have a great responsibility

2. Your inspection duties cover all aspects of jail operations, with health care being a major one

3. Your knowledge, attitude and behavior have an impact on jails, especially how you feel about your job and handle yourself

4. Professional attitudes most important in dealing with health care

a. jail administrators/others will be influenced by;

i. your positive attitudes about welfare of inmates

ii. your concern about health care adequacy

iii. its effect on community and staff

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[10]Ibid.

b. knowing what to do evidences your professionalism

i. this course excellent means for equipping you

ii. increased capacity to function will be end result of your learning/applying skills from course

c. Summary: increased professional status comes from:

i. knowledge

ii. skills

iii. right attitude

B. Job Efficiency

1. Greater job efficiency comes from:

a. knowing what you're doing

b. systematizing your efforts

2. Course will acquaint you with clear-cut procedures for inspecting health care

3. You will learn skills to determine adequacy of health care system

III. Purpose of This Course

A. Upgrade health care in jails/stimulate actual improvements

B. Reduce potential for expensive litigation, with some cases costing hundreds of thousands of dollars.[11]

[11] 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.

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

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).

STUDENT'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.

CONTENT OUTLINE: I. INMATES' CONSTITUTIONAL RIGHT TO CARE

A. Have Prisoners Forfeited Their Legal Rights?

Generally not. Only eight states suspend civil rights, with two of them limited to life termers.

B. Constitutional Right is Basic.

Eighth Amendment guarantees prisoners that "cruel and unusual punishments /shall not be/ inflicted."1/

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 the landmark case Estelle v. Gamble (Supra) 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 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"?

"Adequate" medical care must be "reasonable" or adequate under the totality of circumstances. (Mills v. Olivier, 366 F. Supp. 77, E.B.Va, 1973).

E. The Standard of "Deliberate Indifference."

In assessing "adequate" or "reasonable" medical care, the standard of "deliberate indifference" is used by the courts. In Estelle v. Gamble (Supra.) the Court clearly indicated that indifference could be:

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

1. On the part of doctors in their response to prisoners' medical needs; or

2. By denial of access to care by security staff; or

3. By intentional interference with care once started.

The courts will generally not find "deliberate indifference" if act or failure to act is only difference in medical opinion. In short, it must be the wanton infliction of unnecessary pain.2/

F. Inadequate Health Care.

Such exists if:

1. The lack of it is such to "shock the conscience of the Court," i.e., "deliberate indifference," or

2. Treatment is "grossly negligent" or constitutes "barbarous acts," or

3. Deprivation of care would in judgement of physician exercising ordinary skill and care, seriously endanger prisoner's well being.

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

1. What constitutes adequate medical care is a medical determination, with which courts do not interfere.

Hence, mere disagreement between prisoner and physician over needed treatment does not constitute civil rights action. (See Coppinger v. Townsend, 378 F. 2d. 392, C.A.10, 1968.)

2. When some care has been provided, prisoner must show previous intentional acts to support claim that care has been denied.

H. The Relation of Degree of Care to Size of Institution

It is recognized that large state penitentiaries are more likely to have in-house infirmaries than are local

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

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 Factor

Many courts have said costs should not be a factor in determining adequate care for prisoners.

J. Some Cases. Various court decisions have found correctional institutions liable for failure to provide "reasonable"/"adequate" medical care:

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 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.

Courts have given lesser deference to "hands off" policy on interference with prison management in the medical area than in others, e.g., security (see Bucks v. Teasdale, 492 F.Supp. 650, 1980) (citing also Todaro v. Ward, 565 F. 2d 48, 1977).

II. LEGAL OBLIGATIONS TO PRE-TRIAL DETAINEE

A. Pre-trial detainee, not yet convicted (i.e., innocent until proven guilty), should not be punished because of the conditions of the facility.

Further, had bail money been available, defendant would be free like many others, not subject to possible treatment as convicted prisoner.

B. Regarding health care, "distinctions, if any are conceivable," would have to be made in favor of pre-trial detainees.3/

1. Conditions for pre-trial detainees must be not only only equal to but superior to those for convicted prisoners.4/

2. 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) stated that conditions which constitute cruel and usual punishment for convicted prisoners certainly are forbidden for pre-trial detainees.

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

1. Appearingly excessive conditions of confinement not reasonably related to government objectives not upheld by Supreme Court in Bell v. Wolfish (441 U.S. 520, 1979).

2. While arbitrary restrictions justify interference by Federal Courts, legitimate interests in maintaining security and order and presence at trial do not constitute cruel and unusual punishment, as noted by Court in Bell v Wolfish.5/

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

A. Who Delivers Care

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[3] Isele, op. cit., pp. 1-3.

[4] 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.

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

1. Basic ingredients of an unconstitutional act discussed so far are:

   a. Withholding of treatment;

   b. Inacessibility of medical attention;

   c. Failure to deliver care once it is prescribed.

2. Now we turn to a look at quality of care from the standpoint of those delivering the care, i.e., are they licensed, certified or registered?

B. Health providers are termed: "allied," "paramedical," "paraprofessional" and "licensed."

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.6/ 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. Working "under the direction" of licensed professional personnel or under their immediate supervision is required.

4. In most jails and prisons the doctor and dentist have primary responsibility for health care, but the bulk of the day-to-day care is provided by allied health professionals.

C. The adequacy of medical and health services is sometimes challenged on basis of number of "medical" people employed and their quality.7/

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

7 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 Palmigiana v. Garrahy (443 F. Supp. 956, 1977).

1. Court will find staffing/quality inadequate when prisoners suffer because of delay or denial of care.8/

2. Except in severe cases, courts not likely to specify specific numbers of staff needed.

   Courts may find numbers inadequate or order standards of nationally recognized bodies, e.g., American Medical Association, to be met.

3. Quality addressed by looking at training of staff, i.e., licensure or certification.

   These personnel must not work beyond their training/state prescribed authority or constitutional violation may occur.

D. Use of "Untrained" Personnel

1. Many facilities supplement work of qualified staff with non-licensed/certified personnel.

2. Heavy reliance on untrained staff likely to be struck down by courts.

3. Use of inmates in health care fairly common in use; makes problem more acute. AMA standards clearly disallow inmates to perform 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

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

IV. MEDICAL RECORDS AND THE RIGHT TO REFUSE MEDICAL CARE

A. Inmates' Medical Records

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

1. Confidentiality, not always to same degree, holds true for inmate medical records as in the community:

   a. Needs of facility, if clear enough, can outweigh privilege of confidentiality.

   b. Jail doctor and custody staff have same obligations to preserve confidentiality.

   c. Statutes in nearly all states support above.

   d. Welfare of patient, welfare of community or dictates of law can outweigh need of confidentiality; however, unauthorized release of information is legally actionable.9/

2. Adequate medical records must be kept.

   a. Poor record can cause grievous harm..

   b. In Burks v. Teasdale (492 F. Supp. 650, 1980), court rejected contention of insignficant relationship between proper medical records and adequate medical care.

B. 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 is 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.

V. DEVELOPING NEED FOR STANDARDS

A. Standards development one form of correctional reform.

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

B. "Standard" means goal, model or example - something set up on authoratative basis to measure quantity and quality.

C. History of criminal justice standards including reference to health care:10/

   1. American Correctional Association Manual of Correctional Standards, 1966;

   2. National Advisory Commission on Criminal Justice Standards and Goals, 1973;

   3. National Sheriffs' Association, 1974;

   4. Some states enacted jail inspection legislation, including mention of health care;11/

   5. General Accounting Office (GAO) in 1976 report cited lack of standards to measure adequacy of physical conditions and health care.12/

D. American Medical Association's "Standards":

   1. Primary focus of AMA Standards for Health Services in Jails is accreditation of jail health care systems.

   2. AMA Standards developed over five years with help of:

      a. AMA National Advisory Committee and its special task forces

      b. Hundreds of sheriffs, facility administrators and health care providers across the country.

E. How Severe/Exacting Should Standards Be?

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

11 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).

12 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, footnote1/, supra, at p. 49.

1. Early attempts at standards development resulted in too general terms/standards; were really not measurable; allowed too much latitude in interpretation.

2. AMA approach/standards:

   a. Standards are "minimal";

   b. Health care equivalent to that provided in community;

   c. Tough enough to be meaningful;

   d. Clear proof of adequacy of health care;

   e. Not so idealistic only a few could attain them.

F. Current AMA Standards reflect changes based on experience of two earlier editions; they cover:

1. Administrative Matters

2. Personnel

3. Care and Treatment

4. Pharmaceuticals

5. Health Records

6. Medical-Legal Issues

G. In addition to the AMA Standards For Health Services In Jails (revised September, 1981), other organizations/agencies have developed jail health care standards:

1. American Correctional Association, in cooperation with the Commission on Accreditation For Corrections (adopted for most part from AMA): Standards For Adult Local Detention Facilities (second edition, 1981);

2. American Public Health Association (APHA): Standards For Health Services In Correctional Institutions (1976);

3. National Sheriffs' Association: The Manual on Jail Administration (1974) and Jail Officers' Training Manual, 1980.

4. National Advisory Commission on Criminal Justice Standards and Goals: The Report on Corrections (1973);

5. U.S. Justice Department: Federal Standards For Prisons and Jails (1980); and

6. A number of states have incorporated AMA standards in their jail inspection standards.

STUDENT'S MANUAL

UNIT III

PART A

REVIEW OF THE AMERICAN MEDICAL ASSOCIATION'S

STANDARDS FOR HEALTH SERVICES IN JAILS

STUDENT'S MANUAL

UNIT III

REVIEW OF THE AMERICAN MEDICAL ASSOCIATION'S STANDARDS FOR HEALTH SERVICES IN JAILS

STUDENT MANUAL

UNIT TITLE: 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:
      i. essential
      ii. important

NOTE: This unit is in two parts. Part "A" is a published edition of the American Medical Association's Standards for Health Services in Jails. Part "B" is a listing, by standard, of who should be interviewed and what should be documented by a jail inspector in order to determine whether or not a jail is in compliance with each standard. During this section of the training program, you should use both parts "A" and "B" together.

AMERICAN MEDICAL ASSOCIATION STANDARDS

FOR HEALTH SERVICES IN JAILS

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AMERICAN MEDICAL ASSOCIATION STANDARDS

FOR HEALTH SERVICES IN JAILS

Preface

A. INTRODUCTION

The standards in this document 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. Equally important, several hundred sheriffs, facility administrators and health care providers in jails across the country contributed substantially to the standards. The development, printing, distribution and revision of Standards for Health Services in Jails were made possible through grants from the Law Enforcement Assistance Administration to the American Medical Association.

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's House of Delegates. 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.

Many jails have been or are under legal action for failure to provide adequate health care. A number of court decisions involving pre-trial 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. 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.

The AMA's standards reflect the viewpoint of organized medicine regarding its definition of adequate medical care and health services for correctional institutions. They are considered minimal. 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.

Standards are acknowledged criteria for qualitative and/or quantitative measurement of health care delivery systems. The AMA's standards form the basis of a program to accredit jail health care

systems. As of July 1981, there were 96 facilities which were AMA accredited under earlier editions of the Standards. Interestingly, 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.

Accreditation means professional and public recognition of good performance. Accreditation through standards implementation is the foundation for professionalization of and public support for criminal justice medicine. As demonstrated in the AMA's Jail Program, implementation of these standards can result in (1) increased efficiency of health care delivery, (2) greater cost effectiveness and (3) better overall health protection for inmates, staff and the community.

B. CONTENTS

These standards address the following aspects of medical, psychiatric and dental care and overall health services: (1) Administrative Matters, (2) Personnel Matters, (3) Care and Treatment, (4) Pharmaceuticals, (5) Health Records and (6) Medical Legal Issues. 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 this document as a special section.

The health care of women inmates is also not addressed in a special section. For the most part, the basic health care needs of incarcerated individuals will be the same regardless of sex. Where differences exist on the basis of sex, the special needs of women are identified within the standards themselves. The AMA's standards are meant to apply equally to male and female inmates. A facility cannot meet compliance if the required services are available to only one sex and not the other.

The medical program must function as part of the overall institutional program. The implementation of standards calls for close cooperation between the medical staff, other health professionals, correctional personnel and the facility's administration. Facility administrators and clinicians will find the standards helpful in providing services to inmates. The standards also provide information useful to administrators in program planning and budgeting. The Standards document will also assist clinicians to establish priorities, determine services, allocate resources and train staff.

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

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.

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.

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.

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.

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 help to promote the proper diagnosis and referral of these inmates to services appropriate to their needs.

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. Correctional facilities function best as part of the human services system of the surrounding community. The emphasis of the standards is to bring medical resources into the facility for routine care and transfer out inmates with extraordinary needs.

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. 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.

Finally, various health providers report that a number of inmates on sick call come there because of social problems which have not been addressed. Some jails employ social workers/counselors to handle these problems. Others use volunteers who are properly screened, oriented/trained and supervised. Please refer to the AMA's monograph "The Use of Volunteers in Jails," for guidance concerning the development of such a program.

C. HOW TO USE THIS DOCUMENT

There are fifty-six standards included in this document. They are arranged numerically within specific topic areas (e.g., Administrative, Personnel, etc.), with the title of each preceding the standard. Essential standards are listed first in each topic area, followed by the Important standards. For accreditation, all applicable essential standards must be met. In addition, 70% of the applicable important standards must be achieved for one year accreditation and 85% for two years.

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. In addition, definitions of key terms will be found in the Discussion sections. 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. Further, a Glossary of terms is provided in the Appendix and key words are listed alphabetically in the Index.

TABLE OF CONTENTS

A. ADMINISTRATIVE

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

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.

Discussion: 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.

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.

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.

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.

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."

102 - 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.

Discussion: 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. The health authority arranges for the availability of health care services; the official responsible for the facility provides the administrative support for accessibility of health services to inmates.

Health personnel have been called upon to provide non-medical services to inmates: "talking to trouble-makers," providing special housing for homosexuals or scapegoats in the infirmary, medicating unruly inmates, conducting body cavity searches for contraband and taking blood alcohol samples for the possible purpose of prosecution. These are examples of inappropriate use of medical personnel. 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 result;

   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.

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.

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

Regular staff meetings which involve the health authority and the official legally responsible for the facility and include discussions of health care services, meet compliance if documentation exists.

If administrative and regular staff meetings are held but neither is documented, the health authority needs to submit a quarterly report to the facility administrator 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 actions. Health environment factors which are of the greatest concern are those in which there are life-threatening situations, i.e., a high incidence of suicides and/or physical assaults and severe overcrowding which affects inmates' physical and mental health.

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.).

Reports done more frequently than quarterly or annually satisfy compliance.

104 - Policies and Procedures

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

Liaison Staff (106)
Peer Review (107)
Public Advisory Committee (108)

Decision-Making -- Special Problem Patients (109)
Special Handling: Patients With Acute Illnesses (110)
Monitoring of Services/Internal Quality Assurance (111)
Access to Diagnostic Services (113)
Notification of Next of Kin (114)
Postmortem Examination (115)
Disaster Plan (116)
Basic Training of Correctional Officers/Jailers (120)
Medication Administration Training (121)
Inmate Workers (122)
Food Service Workers - Health and Hygiene Requirements (123)
Utilization of Volunteers (124)
Emergency Services (125)
Receiving Screening (126)
Detoxification (127)
Access to Treatment (128)
Daily Triaging of Complaints (129)
Sick Call (130)
Health Appraisal (131)
Skilled Nursing/Infirmary Care (133)
Use of Restraints (136)
Special Medical Program (137)
Standing Orders (138)
Continuity of Care (139)
Health Evaluation - Inmates in Segregation (140)
Health Promotion and Disease Prevention (141)
Chemically Dependent Inmates (142)
Pregnant Inmates (143)
Dental Care (144)
Delousing (145)
Exercising (146)
Personal Hygiene (147)
Prostheses (148)
Food Service (149)
Management of Pharmaceuticals (150)
Health Record Format and Contents (151)
Confidentiality of the Health Record (152)
Transfer of Health Records and Information (153)
Records Retention (154)

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.

Discussion: The facility need not develop policies and procedures for the following standards when the processes, programs and/or services do not exist:

Standard 106 - Liaison Staff
Standard 108 - Public Advisory Committee
Standard 124 - Utilization of Volunteers
Standard 133 - Skilled Nursing/Infirmary Care
Standard 138 - Standing Orders
Standard 143 - Pregnant Inmates

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

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.

2. IMPORTANT STANDARDS

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.

Discussion: 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. In all facilities, space should be provided where the inmate can be examined and treated in private.

Basic items generally include:

- 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.

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

Private interviewing space;
Desk;
Two chairs; and
Lockable file.

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.

Discussion: Invaluable service can be rendered by a health trained corrections officer or 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.

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 license, certification or registration.

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.

107 - Peer Review

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

Discussion: Quality assurance programs are methods of insuring the quality of medical care. Funding sources sometimes mandate quality assurance review as a condition for funding medical care.

The American Medical Association 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."

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."

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. 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.

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.

Discussion: Correctional facilities are public trusts, but are often removed from public awareness. 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 support or facilitation of medical peer review processes which are carried out by the medical society or other peer review agencies.

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.

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.

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."

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.

Discussion: 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 management. Medications may have to be adjusted for safety at the work assignment or prior to transfer.

Significant aspects of medical or psychiatric illness may include:

1) Suitability for travel based on medical evaluation;

2) Preparation of a summary or copy of pertinent health record information (please refer to Standard 151 for guidelines);

3) Medication or other therapy required enroute; and

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

Please refer to the AMA monographs "The Recognition of Jail Inmates with Mental Illness: Their Special Problems and Need for Care" and "Management of Common Medical Problems In Correctional Institutions."

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.

Discussion: Psychiatric and other acute medical problems identified either at receiving screening or after admission must be followed up by medical staff. The urgency of the problems determines the responses. 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.

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

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

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

111 - Monitoring of Services/Internal Quality Assurance

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.

Discussion: The responsible health authority must be aware that patients are receiving appropriate care and that all written instructions and procedures are properly carried out. Except in unusual circumstances, it is felt that this process of internal quality assurance can be accomplished only by on-site monitoring.

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

112 - 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.

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

Kits can be either purchased or assembled from improvised materials. All kits, whether purchased or assembled, meet compliance if the following points are observed in their selections:

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.

113 - Access to Diagnostic Services

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

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.

114 - 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.

115 - Postmortem Examination

Written policy and defined procedures require that in the event of an inmate 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.

Discussion: 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.

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.

Discussion: 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) disaster must be incorporated in the correctional system plan and made known to all facility personnel.

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.

B. PERSONNEL

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

1. ESSENTIAL STANDARDS

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.

Discussion: When applicable laws are ignored, the quality of health care is compromised.

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

118 - Job Descriptions

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.

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.

Discussion: 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.

All levels of the 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 "burn-out" of health providers and help to re-emphasize the goals and philosophy of the health care system.

Please refer to the following AMA monographs:

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

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

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

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.

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

Current first aid certification must be from an approved body, such as 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 ARC instructor's certificate.

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.

Please refer to the following AMA monographs which can be used to help train correctional officers in the above subjects:

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."

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.

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.

Discussion: Training from the responsible physician encompasses the medical aspects of the administration of medications. Training from the facility administrator encompasses security matters inherent in the administration of medications in a correctional facility.

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

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

122 - 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.

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

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. IMPORTANT STANDARDS

123 - 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.

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

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.

Discussion: 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.

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.

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

Please refer to the AMA monograph on "The Use of Volunteers in Jails."

C. CARE AND TREATMENT

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

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;

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.

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

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, jaundice, 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.

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

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.

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

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

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.

Discussion: 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. The detoxification of certain patients (e.g., psychotics, seizure-prone, pregnant, juveniles or geriatrics) may pose special risks and thus, require special attention. Detoxification from alcohol should not include decreasing doses of alcohol; further, supervised "drying out" may not necessarily involve the use of drugs.

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

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.

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

Please refer to the AMA monograph "Guide for the Care and Treatment of Chemically Dependent Inmates" for further information on the subject.

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.

Discussion: The facility should follow the policy of explaining access procedures orally to all inmates, especially those unable to read. Where the facility frequently has non-English speaking inmates, procedures should be explained and written in their language. Signs posted in the dayroom/living area do satisfy compliance; signs posted in the booking area do not.

129 - 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.

Discussion: 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.

130 - 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.

Discussion: Some people refer to sick call as a "clinic visit." Clinic care or "sick call" is care for an ambulatory inmate with health care complaints which are evaluated and treated at a particular place in time. It is the system through which each inmate reports for and receives appropriate medical services for non-emergency illness or injury.

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

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.

Discussion: 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 for an alcohol or drug abuse problem such as disulfiram, methadone hydrochloride or others;

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.

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 assessment will be done by a general practitioner or family practitioner.

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

Please refer to Standard 106 for definitions of the different levels of health personnel.

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.

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.

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.

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.

Discussion: 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.

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.

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

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

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

2. IMPORTANT STANDARDS

134 - Hospital Care

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

Discussion: 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. Where conditions in the facility are inadequate to meet state standards, the quality of care is compromised.

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.

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

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

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.

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

Medical monitoring of the health status of inmates held under disciplinary restraints should be carried out on a periodic basis by qualified or health trained personnel.

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.

Discussion: The special medical program services a broad range of health problems (e.g., seizure disorders, diabetes, potential suicide, chemical dependency and psychosis). These are some of the special medical conditions which dictate close medical supervision. In these cases, the facility must respond appropriately by providing a program directed to individual needs.

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). 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.

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

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

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

Please 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."

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.

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.

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.

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

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.

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

Carrying out this policy may help to prevent suicide or serious illness.

141 - Health Promotion and Disease Prevention

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

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

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.

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.

Discussion: Existing community resources should be utilized if possible.

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 depressants.

Please refer to the AMA monograph "Guide For The Care and Treatment of Chemically Dependent Inmates."

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.

Discussion: 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.

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

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.

Discussion: While dental hygiene by standard definition 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.

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 on an appropriate uniform dental record utilizing a number system such as the Federation Dentaire Internationale System.

Please refer to the AMA monograph "Dental Care for Jail Inmates."

145 - Delousing

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

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.

Discussion: Examples of large muscle activity include walking, jogging in place, basketball, ping pong and isometrics.

Facilities meet compliance of 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.

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.

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.

Discussion: Prostheses are artificial devices to replace missing body parts or compensate for defective bodily functions.

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.

Discussion: Adequate diets frequently are based on those developed by other agencies which utilize the recommended national allowances/guidelines. Equivalent nutritional guidelines containing the four basic groups, satisfy compliance. 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.

The adequate diet referred to in the standard applies to inmates in segregation/isolation as well as all others.

D. PHARMACEUTICALS

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.

ESSENTIAL 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.

Discussion: 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.

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.

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.

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

Accounting is the system of recording, summarizing, analyzing, verifying and reporting the results of medication usage.

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. The latter procedure is preferred. Further, when a facility uses the sealed, pre-packaged unit dose system, the unused portion can be returned to the pharmacy.

A controlled substance is a drug or other substance that is subject to special controls due to its abuse potential.

E. HEALTH RECORDS

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

151 - Health Record Format and Contents

At a minimum, the health record file contains:

- The completed receiving screening form;
- Health appraisal data forms;
- All findings, diagnoses, treatments and dispositions;
- Prescribed medications and their administration;
- Laboratory, X-ray and diagnostic studies;
- Signature and title of each documenter;
- Consent and refusal forms;
- Release of information forms;
- Place, date and time of health encounters;
- Discharge summary of hospitalizations;
- Health service reports (e.g., dental, psychiatric and other consultations); and
- Specialized treatment plan (if such exists).

The method of recording entries in the record and the form and format of the record are approved by the health authority.

Discussion: The problem-oriented medical record structure is suggested. However, whatever the record structure, every effort should be made to establish uniformity of record forms and content throughout the correctional system. The record is to be completed and all findings recorded including notations concerning psychiatric, dental and other consultative services.

A health record file is not necessarily established on every inmate. However, any health intervention after the initial screening requires the initiation of a record. The receiving screening form becomes a part of the record at the time of the first health encounter. If an inmate is incarcerated more than once, existing medical records should be re-activated.

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.

Please refer to the AMA monograph "Health Care in Jails: Inmates' Medical Records and Jail Inmates' Right to Refuse Medical Treatment."

2. IMPORTANT STANDARDS

152 - 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.

Discussion: The principle of confidentiality protects the patient from disclosure of confidences entrusted to a physician during the course of treatment.

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.)

The health authority should share information with the facility administrator regarding an inmate's medical management and security. The confidential relationship of doctor and patient extends to inmate patients and their physician. Thus, it is necessary to maintain active health record files under security, completely separate from the patient's confinement record.

153 - 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 transfering 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.

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.

154 - Records Retention

Written policy and defined procedures require that inactive health record files are retained according to legal requirements of the jurisdiction.

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.

F. MEDICAL-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.

IMPORTANT STANDARDS

155 - 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.

Discussion: Informed consent is the agreement by the patient to a treatment, examination or procedure after the patient receives the material facts regarding the nature, consequences, risks and alternatives concerning the proposed treatment, examination or procedure. 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.

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.

Physicians must exercise their best medical judgment in all such cases. It is advisable that the physician document the medical record for all aspects of the patient's condition and the reasons for medical intervention. Such documentation facilitates review and provides a defense from charges of battery. In certain exceptional cases, a court order for treatment may be sought, just as it might in the free community.

The law regarding consent to medical treatment by juveniles and their right to refuse treatment, varies greatly from state to state. Some states allow juveniles to consent to treatment without parental consent, as long as they are mature enough to comprehend the consequences of their

decision; others require parental consent until majority, but the age of majority varies among the states. The law of the jurisdiction within which the facility is located should be reviewed by legal counsel, and based upon counsel's written opinion, a facility policy regarding informed consent should be developed. In all cases, however, consent of the person to be treated is of importance.

156 - Medical Research

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

Discussion: This standard recognizes past abuses in the area of research on involuntarily confined individuals and stresses the protective measures and prisoner/patient autonomy interests that must be considered in a decision to include such persons in clinical research.

There should be adequate assurance of safety to the subject, the research should meet standards of design and control and the inmate must have given his/her informed consent.

G. APPENDIX

Glossary and Subject Index

GLOSSARY

Accounting (Medications) ..... Accounting is the system of recording, summarizing, analyzing, verifying and reporting the results of medication usage.

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.

Alcohol Detoxification ..... (See "Detoxification")

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.).

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.

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).

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.

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.

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

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 on an appropriate uniform dental record utilizing a number system such as the Federation Dentaire Internationale System.

Dental Hygiene ..... While dental hygiene by standard definition 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.

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.

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.

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.

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.

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

Documented Inmates' Health Complaints ..... Examples of health complaints being documented are:

1. Some jails note on the complaint slip the action taken regarding triaging and file such slips in the inmate's medical record; and

2. Others use a log and record the complaint and its disposition.

Drug Detoxification ..... (See "Detoxification")

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.

Formulary ..... A formulary is a written list of prescribed and non-prescribed medications used within the facility.

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.

Health Administrator ..... A health administrator is a person who by education (e.g., RN, MPH, MHA or 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.

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.

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.

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.

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.

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.

Hospital Care ..... Hospital care is inpatient care for an illness or diagnosis which requires optimal observation and/or management in a licensed hospital.

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.

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.

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.

Large Muscle Activity ..... Examples of large muscle activity include walking, jogging in place, basketball, ping pong and isometrics.

Medical Preventive Maintenance ..... (See "Preventive Maintenance")

Medical Restraints ..... (See "Restraints")

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.

Medication Accounting ..... (See "Accounting")

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

Medication Dispensing ..... (See "Dispensing, Medication")

Medication Disposal ..... (See "Disposal, Medication")

Medication Distribution ..... (See "Distribution, Medication")

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).

Opioids ..... Opioids refer to derivatives of opium, (e.g., morphine and codeine and synthetic drugs with morphine-like properties).

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 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."

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.

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.

Prostheses ..... Prostheses are artificial devices to replace missing body parts or compensate for defective bodily functions.

Psychiatric Personnel ..... Psychiatric services staff are psychiatrists, general family physicians with psychiatric orientation, psychologists, psychiatric nurses, social workers and trained correctional counselors.

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.

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.

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.

Responsible Physician ..... The responsible physician is the individual physician who is responsible for the final decisions regarding matters of medical judgement.

CONTINUED

1 OF 3

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 are likewise to be used for the medically restrained incarcerated individual (e.g., leather or canvas hand and leg restraints, chemical restraints and straight jackets).
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.
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."
Skilled Nursing Care	(See "Infirmary Care")
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, chemical dependency and psychosis).
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.
Supervision	Supervision is defined as overseeing the accomplishment of a function or activity.
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.

SUBJECT INDEX

STUDENT'S MANUAL

UNIT III

PART B

VERIFYING A JAIL'S COMPLIANCE

WITH THE AMA STANDARDS

Unit III, Part B - VERIFYING COMPLIANCE WITH THE STANDARDS

A. Administrative Standards

1. Essential Standards

Standard 101 - Responsible Health Authority

Interview:

Health authority
Responsible physician

Document:

Written agreement, contract or
job description

Standard 102 - Medical Autonomy

Interview:

Responsible physician
Dentist
Other health providers

Standard 103 - Administrative Meetings and Reports

Interview:

Health authority
Person legally responsible for the facility

Document:

Minutes of administrative meetings
Quarterly report on health care system and health environment
Statistical summaries

Standard 104 - Policies and Procedures

Interview:

Health authority
Other health providers

Document:
Policy and Procedure Manual

2. Important Standards:

Standard 105 - Support Services

Interview:

Health authority
Other health providers

Document:

Space
Equipment
Supplies
Materials
Publications

Standard 106 - Liaison Staff

Interview:

Responsible physician
Person legally responsible for the facility

Document:

Written policy and defined procedure if no full-time qualified health personnel (See Standard 104)

Standard 107 - Peer Review

Interview:

Responsible physician
Health authority

Document:

Written policy statement (See Standard 104)

Standard 108 - Public Advisory Committee

Interview:

Officer legally responsible for the facility

Document:

Written policy statement if committee exists (See Standard 104)

Standard 109 - Decision Making - Special Problem Patients

Interview:

Health authority
Other health providers
Person legally responsible for the facility

Document:

Written policy statement (See Standard 104)

Standard 110 - Special Handling: Patients with Acute Illnesses

Interview:

Health authority
Booking officer
Correctional officer

Document:

Written policy and defined procedure (See Standard 104)
Written list of referral services
Inmates within sight or sound of at least one health trained corrections officer

Standard 111 - Monitoring of Services/Internal Quality Assurance

Interview:

Responsible physician

Document:

Written policy statement (See Standard 104)

Standard 112 - First Aid Kits

Interview:

Health authority
Booking officers
Correctional officer

Document:

Location of first aid kits
Procedures for monthly inspection of first aid kits

Standard 113 - Access to Diagnostic Services

Interview:

Health providers

Document:

Written policy and defined procedures (See Standard 104)
Written document outlining access to those services

Standard 114 - Notification of Next of Kin

Interview:

Person legally responsible for the facility
Health authority
Other health providers

Document:

Written policy and defined procedures (See Standard 104)

Standard 115 - Postmortem Examination

Interview:

Person legally responsible for the facility

Document:

Written policy and procedures (See Standard 104)

Standard 116 - Disaster Plan

Interview:

Person legally responsible for the facility
Health authority

Document:

Written policy and defined procedure

NOTE: This completes the "Administrative Standards" section. Turn to Appendix A for situational exercises dealing with those standards.

B. Personnel Standards

1. Essential Standards:

Standard 117 - Licensure

Interview:

Health providers

Document:

Copies of current credentials or letters from state licensing body

Standard 118 - Job Description

Interview:

Health authority
Health providers

Document:

Written job classification

Standard 119 - Staff Development and Training

Interview:

Health providers

Document:

Written training plan

Standard 120 - Basic Training of Correctional Officers/Jailers

Interview:

Person legally responsible for facility
Health authority
Booking officers
Correctional officers

Document:

Written policy and procedures (See Standard 104)
Written training plan
Schedule of training
How many officers have been trained

Standard 121 - Medication Administration Training

Interview:

Responsible physician
Person legally responsible for the facility
Persons who administer medications .

Document:

Written policy and procedures (See Standard 104)
Accountability for administering medications
Recording the administration of medications

Standard 122 - Inmate Workers

Interview:

Person legally responsible for the facility
Health authority
Health providers
Pharmacists
Health records person

Document:

Written policy and procedures (See Standard 104)

2. Important Standards:

Standard 123 - Food Service Workers - Health and Hygiene Requirements

Interview:

Person legally responsible
Director of food service

Document:

Written policy and procedure (See Standard 104)

Standard 124 - Utilization of Volunteers

Interview:

Person legally responsible
Health authority

Document:

Written policy and procedures, if the facility utilizes volunteers (See Standard 104)

NOTE: This completes the "Personnel Standards" section. Turn to Appendix A for situational exercises dealing with those standards.

C. Care and Treatment Standards

1. Essential Standards:

Standard 125 - Emergency Services

Interview:

Person legally responsible
Health authority
Dentist
Booking officers
Correctional officers

Document:

Written policy and procedures
Written security procedures

Standard 126 - Receiving Screening

Interview:

Booking officers
Health providers
Inmates

Document:

Written policy and defined procedures (See Standard 104)
Receiving screening form
Inmate medical records

Standard 127 - Detoxification

Interview:

Health providers

Document:

Written policy and defined procedures (See Standard 104)

Standard 128 - Access to Treatment

Interview:

Booking officers
Correctional officers
Inmates

Document:

Written policy and procedure (See Standard 104)

Standard 129 - Daily Triaging of Complaints

Interview:

Health providers
Booking officers
Correctional officers

Document:

Written policy and defined procedures (See Standard 104)
Documentation of inmate health complaints

Standard 130 - Sick Call

Interview:

Health providers
Booking officers
Correctional officers
Inmates

Document:

Written policy and defined procedures (See Standard 104)

Standard 131 - Health Appraisal

Interview:

Health authority
Responsible physician
Health providers
Inmates

Document:

Written policy and defined procedures (See Standard 104)
Health record files

Standard 132 - Direct Orders

Interview:

Health providers

Document:

Health record files

Standard 133 - Skilled Nursing/Infirmary Care

Interview:

Health providers

Document (if the facility operates an infirmary):

Written policy and defined procedures (See Standard 104)
Manual of nursing procedures
Defined list of scope of infirmary care services
Medical records

2. Important Standards:

Standard 134 - Hospital Care

Interview:

Health authority
Pharmacist
Health records person

Standard 135 - Treatment Philosophy

Interview:

Health providers
Inmates

Standard 136 - Use of Restraints

Interview:

Health providers

Document:

Written policy and defined procedures (See Standard 104)

Standard 137 - Special Medical Program

Interview:

Health providers

Document:

Written policy and defined procedures (See Standard 104)
Written individualized treatment plans
Health records

Standard 138 - Standing Orders

Interview:

Responsible physicians
Health providers

Document (if they exist):

Written policy and defined procedures (See Standard 104)
Health records

Standard 139 - Continuity of Care

Interview:

Health authority
Responsible physician
Health providers

Document:

Written policy and defined procedures (See Standard 104)

Standard 140 - Health Evaluation - Inmates in Segregation

Interview:

Health authority
Health providers
Booking officers
Correctional officers
Inmates

Document:

Written policy and defined procedures
Health records

Standard 141 - Health Promotion and Disease Prevention

Interview:

Health providers

Document:

Written policy and defined procedures (See Standard 104)
Health records

Standard 142 - Chemically Dependent Inmates

Interview:

Health providers

Document:

Written policy and defined procedures (See Standard 104)
Health records

Standard 143 - Pregnant Inmates

Interview:

Health providers
Pregnant inmates (if any)

Document:

Written policy and defined procedures (See Standard 104)

Standard 144 - Dental Care

Interview:

Dentists
Inmates

Document:

Written policy and defined procedures (See Standard 104)
Health records

Standard 145 - Delousing

Interview:

Responsible physician

Document:

Written policy and defined procedures (See Standard 104)

Standard 146 - Exercising

Interview:

Booking officers
Correctional officers
Inmates

Document:

Written policy and defined procedures (See Standard 104)

Standard 147 - Personal Hygiene

Interview:

Person legally responsible for the facility
Booking officers
Correctional officers
Inmates

Document:

Written policy and defined procedures (See Standard 104)
Bathing facilities

Standard 148 - Prostheses

Interview:

Responsible physician
Dentist
Health providers

Document:

Written policy and defined procedures (See Standard 104)
Health records

Standard 149 - Food Service

Interview:

Health authority
Director of food service

Document:

Written policy and defined procedures (See Standard 104)
Recent menus

NOTE: This completes the "Care and Treatment Standards" section. Turn to Appendix A for situational exercises dealing with those standards.

D. Pharmaceutical Standard

1. Essential Standard:

Standard 150 - Management of Pharmaceuticals

Interview:

Health provider
Pharmacist

Document:

Written policy and defined procedures (See Standard 104)
Formulary
Maximum security storage
Weekly inventories

2. Important Standards:

None

NOTE: This completes the "Pharmaceutical Standard" section. Turn to Appendix A for situational exercises dealing with this standard.

E. Health Records Standards

1. Essential Standard:

Standard 151 - Health Record Format and Content

Interview:

Health authority
Dentist
Health providers
Health records person

Document:

Written policy and defined procedures (See Standard 104)
Health records

2. Important Standards:

Standard 152 - Confidentiality of Health Record

Interview:

Health authority
Health providers
Health records person
Booking officer
Correctional officer

Document:

Written policy and defined procedures (See Standard 104)

Standard 153 - Transfer of Health Records and Information

Interview:

Health authority
Health providers
Health records person

Document:

Written policy and defined procedures (See Standard 104)

Standard 154 - Records Retention

Interview:

Health authority
Health records person

Document:

Written policy and defined procedures (See Standard 104)
Inactive health record file retention

NOTE: This completes the "Health Records Standards" section. Turn to Appendix A for situational exercises dealing with those standards.

F. Medical Legal Issues

1. Essential Standards:

None

2. Important Standards:

Standard 155 - Informed Consent

Interview:

Health authority
Responsible physician
Health providers

Document:

Health records files
Consent and refusal forms

Standard 156 - Medical Research

Interview:

Person legally responsible for the facility
Health authority
Health providers

NOTE: This completes the "Medical Legal Issues" section. Turn to Appendix A for situational exercises dealing with those standards.

STUDENT'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, you will be aware of:

1. Who should be interviewed
2. How to resolve conflicting information
3. Documents to be reviewed
4. Sample inspection form to be used and where AMA Standards fit into it
5. End results of systematic inspection

INTRODUCTION

Prior to inspecting a jail the inspector should:

A. Thoroughly review inspection form and cross-index with AMA Standards

B. Review AMA Standards for requirements of each standard

C. For questions on meanings, read "Discussions" following standards or in Glossary

CONTENT OUTLINE: I. SELECTION OF INTERVIEWEE BY INSTRUCTOR

A. Interview variety of people

B. Interview jail administrator first

1. Should be told he/she first in series
2. Interviews independent of administrator and health authority essential for widest perspective

C. Interview various levels of health care and jailer staff and inmates

1. On one-to-one basis
2. Inmates perceptive about deficiencies and improvements

D. Carry out interviews on patterned approach

1. Interview sufficient number
2. Knowing importance of information and confidentiality of provider essential for frankness
3. Never single out one person in one subject area
4. Number of staff and inmate interviews based on size of jail and setup of health care system

E. Selection of Interviewees

Ask administrative and professional staff who best to interview regarding health care system

a. Select health and jailer staff and inmates from different housing units/cellblocks

b. If staff don't rotate shifts, "catch" each shift for varying practices.

II. HOW TO RESOLVE CONFLICTING INFORMATION

A. Conflicting information not uncommon

B. Discuss with administrator and/or health authority preponderance of conflicting information for possible resolution

C. If not readily resolved, inspector must decide what is "true" situation

1. Most conflicts resolved by majority response of staff and/or inmates

2. Exceptions would be negative responses from administrator and/or health authority regarding compliance

III. REVIEW OF DOCUMENTATION

A/B. Essential documents to be reviewed to help determine compliance with standards:

1. Written agreement, contract or job description of health authority (Standard 101)

2. Copies of:

a. minutes of meetings between administrator and health authority or

b. quarterly reports on progress and problems of health care system and

c. annual statistical reports outlining services (Standard 103)

3. Manual of policies and procedures (Standard 104)

4. List of referral sources for patients with acute illnesses (Standard 110)

5. Current credentials of health care providers (Standard 117)

6. Job descriptions, health care providers (Standard 118)

7. Written plan for orientation and training of health care personnel (Standard 119)

8. Receiving screening form (Standard 126)

9. Access to treatment information (Standard 128)

10. Health appraisal form (Standard 131)

11. Written and signed direct orders (Standard 132)

12. Manual of nursing care procedures - infirmary, if applicable (Standard 133)

13. Standing medical orders, if applicable (Standard 138)

14. Recent menus (Standard 149)

15. Drug formulary (Standard 150)

16. Inmate health records (Standard 151)

C. Documentation may <u>not</u> mean <u>operational</u> practices

1. Practices started but dropped

2. New administrator effected changes verbally

3. <u>Operational</u> practices must be verified

<u>EXERCISE</u>: You should now refer to Appendix F, pertaining to the above three sections, and discuss "Response Situations Regarding 'Inspection of Health Services'."

IV. FORMS TO BE USED - U.S. Marshals Service (USMS) Audit Format* As Sample

A. Form used will vary, with agency doing inspection

B. Health care only one aspect of inspector's job

*See Appendix G for USMS Audit Form.

1. Inspectors' training not as exhaustive as for accreditation survey

2. Inspector able to evaluate jail's compliance with any standard

C. Typed number in parentheses under USMS inspection item refers to specific AMA standard

No second number means no applicable AMA standard

D. Comparison of items on audit form with indicated AMA standards reflects compliance requirements:

1. USMS inspection form item 253-H-NA corresponds with AMA Standard 147 (if laundry services are provided at least weekly, check "confirmed")

2. USMS item 255 requires bathing at least three times weekly and prevails over AMA Standard 147 - at least twice

3. USMS item 300 and AMA's 101 require a physician "health authority," defined by contract, written agreement or job description. If authority is non-physician, a designated physician must make final medical judgements

4. USMS 301/AMA 102 require medical people to make medical judgements, e.g.:

   a. access to sick call

   b. medical classification for work assignments

   c. medical diets

   Standard not met if security staff interviewed overrule on above.

5. USMS 304, 309, 315 and 316 found in AMA 110/120

   Requirements for "inmates within sight or sound of health-trained correctional officer":

   a. at least 75% are currently trained in six required areas

   b. balance scheduled for training within reasonable time

   c. administration and preponderance of officers verify sufficient number of officers to assure sight or sound supervision to inhibit suicides and assaults

   d. officers and inmates verify: enough CPR-trained officers exist to respond to all emergencies within four minutes

   Final verification with "man down" call to check response time

   At least one officer per shift must be trained in symptoms of common illnesses - to do receiving screening

E. Exercise

You are now ready to select one or more inspection items, not included above, and outline procedures for determining compliance

V. THE END RESULTS

A. If a careful job is done, the inspector will have credibility

B. Unless systematic approach is taken, process and inspector will lose credibility

C. An open system of inspection, clearly laid out beforehand to key persons involved, supports strong credibility and validity.

UNIT V

STUDENT'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 you 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

CONTENT OUTLINE: I. MAJOR FACTORS INFLUENCING GREATER USE OF COMMUNITY RESOURCES

A. Improved communications between jail administrators and health care providers

1. When they learn each others' roles, problems and services offered, working relationships improve.
2. Positive attitudes result in greater use of resources.
3. Sheriffs/jail administrators who inform and involve the public usually receive better support/ resources.

B. Why adequate medical care?

1. Early detection/treatment provide better protection for public, jail staff and inmates.
2. Early attention is more effective and economical in the long run, particularly avoiding hospitalization.

   Sparing wage-earner and family from welfare rolls due to resolving medical problems in jail.
3. Numerous costly lawsuits result from inadequate medical care, in violation of Eighth Amendment to U.S. Constitution (e.g., see Estelle v. Gamble 429 U.S. 97, 1976).
4. Improved inmate and staff morale stem from improved health care.

C. Improved health care more a matter of changing attitudes and philsophy than obtaining bigger budgets

D. The jail, as part of community, should be viewed as component of community's health care delivery system.

1. Jail holds mainly local residents who return to community shortly.
2. Use of community resources to detect and treat inmate health problems,especially communicable diseases, is true community disease prevention.

E. Training jailers/correctional officers in recognition of symptoms of common illnesses frequently results in earlier referrals to in-jail qualified health care providers, often avoiding "man down" situations, expensive ambulance and emergency room costs and lost officer time.

II. THE ROLE OF STATE AND LOCAL MEDICAL SOCIETIES

Coordinator, catalyst and information provider:

1. Each county or district and state have medical societies, independent of each other and AMA.

2. Involvement of societies in jail medicine is essential for its development.

3. Some societies are self-starters and voluntarily assist in upgrading health care services in jails.

4. Others need to be encouraged and requested by sheriffs/jail administrators to assist with developing health care, e.g.:

   a. recruiting physicians

   b. encouraging health departments to do communicable disease screening

   c. involving mental health agencies

5. Some state and local societies have standing committees on jail health care - an important resource.

III. JAIL ADVISORY COMMITTEES

Jail advisory committees representing geographical, political, ethnic, economic, occupational and other interests can be significant factors in advancing jail systems, including health care. For details on organizing jail advisory committees, please refer to the AMA monograph "Organizing and Staffing Citizen Advisory Committees To Upgrade Jail Medical Programs." (see Appendix C)

A. Representatives of established groups, most with criminal justice platforms, are particularly good.

members to join with the medical society representative. For example:

1. Local and state bar associations
2. Chambers of commerce
3. Councils of churches
4. Leagues of Women Voters
5. Junior Leagues
6. Jaycees
7. National Councils of Jewish Women
8. Various labor organizations

B. In addition, professional and official representatives should be recruited from:

1. County commissioners
2. County/state health departments
3. Mental health agencies
4. Jail inspection agencies
5. Local/regional/state planning committees.

C. What can advisory committees do?

1. Get job done - act as the eyes, ears and voice of the community.
2. Do survey of jail for sake of <u>action</u> - not research.
3. Help determine health care needs and action priorities.
4. Inform public on problems and solutions.
5. Serve as coordinator for unified action.

D. Formula for advisory group's success

1. Action-oriented members
2. Working around common cause

3. Periodic open discussion meetings

4. Sharing of experiences

5. Concerted efforts bring strength and accomplishments.

IV. OTHER SOURCES OF ASSISTANCE IN COMMUNITY

A. Gaps in jail health care can be filled by existing resources, readily available in many communities.

1. Health department most successful model, especially for smaller jails.

2. Depending on locale, they can provide communicable disease screening, primary medical/dental care, nutritional counseling and training for staff.

3. Financed by same source, many health departments can provide services without charge to jail.

4. Close working relationships and recognition of services performed can quickly, economically change non-existent health care system into viable one.

B. Other potential resources offering variety of services:

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).

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. Lack of information breeds fear and prejudice

Untapped resources go to waste because:

1. Agency administrators don't talk with each other.

2. Information on problems, needs and services available remains unknown to various administrators.

3. Agencies usually don't volunteer their services.

*CPR = Cardiopulmonary resuscitation
EMT = Emergency Medical Technician

D. Please do exercise in small groups, developing list of agencies providing services in your communities

(See Appendix G - Sample "Linkages With The Community".)

1. Exercise will better familiarize you with health care resources in your community.

2. More thorough understanding of available resources enables you to do better job of providing technical assistance.

V. ADVANTAGES OF IN-JAIL HEALTH CARE

A. Most costly model of jail health care is use of hospital emergency rooms and/or downtown physicians' offices.

B. Providing In-jail regular/primary health care most important factor in upgrading jail health care systems.

C. Special Ten Jail Case Study and Analysis[1] showed two of three jails can meet AMA Standards, with little more or less money than previously.

D. Above accomplished in part by using untapped resources.

E. Health care services increased 70% in AMA project jails in two years with very little over-all expenditure of monies.[2]

F. With $7,500 of demonstration monies to spend on eight jails, some pilot states did not even spend all monies.[3]

G. Summary

1. Two-way communications and cooperation result in better use of community resources.

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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).

2. Greater efficiency and use of tax dollars result.

3. Community, staff and inmates each benefit from better health care protection.

STUDENT'S MANUAL

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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"?

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?

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?

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?

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?

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?"

T. Standard 116 - Disaster Plan

In reviewing the documents during the inspection, what factors do you look for in determining whether there is compliance?

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:

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?

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?

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"?

E. Standard 120 - Basic Training of Correctional Officers/Jailers

What are the minimum requirements in a jail for compliance with this standard?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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.

G. Standard 130 - Sick Call

Are the following sick call approaches in compliance?

1. 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."

2. 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.

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

S. Standard 141 - Health Promotion and Disease Prevention

What is meant by preventive maintenance?

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?

U. Standard 143 - Pregnant Inmates

What types of services must be provided under this standared?

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?

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?

X. Standard 146 - Exercising

What are the minimum requirements for a jail to meet compliance with this standard?

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?

Z. Standard 148 - Prostheses

Must a jail always, provide medical and dental prostheses to inmates?

AA. Standard 149 - Food Service

What is considered an adequate diet?

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.

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?

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?

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?

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?

E. Standard 154 - Records Retention

What factors do you look for during the inspection, from the standpoint of compliance:

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?

B. Standard 156 - Medical Research

Can biomedical or behavioral research involving inmates be done?

APPENDIX B

AWARDS OF ACCREDITATION

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATIO	
ALABAMA (1)						
1. Mobile Co.	L	260	VI-A	2 yr	6/81	E
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	

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

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	
. 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	

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATION	
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	

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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	

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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	
76. 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	
99. 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	
107. 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	

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATION
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
123. 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

AMERICAN HEALTH CARE CONSULTANTS, INC.
AWARDS OF ACCREDITATION

FACILITY & STATE	SIZE (S,M,L)	ADP	ROUND ACCREDITED	LENGTH OF ACCREDITATION	DATE OF EXPIRATION	
VIRGINIA (Cont.)						
126. Newport News	M	142	VIII-B	2 yr	10/83	
127. Virginia Beach	L	264	VI-B	2 yr	4/83	
WASHINGTON (3)						
128. Okanogan Co. (RESCINDED 6/78)	S	30	I-A	1 yr	8/78	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	
139. 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.

American Health Care Consultants, Inc.
MC CLURG COURT CENTER • TOWER B, SUITE 29028 • 333 E. ONTARIO STREET, CHICAGO, ILLINOIS 60611 • TELEPHONE (312) 440-1574

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 1978)

(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

Requests for publications should be made on the accompanying order form. Send the order form along with a check for postage and handling charges to:

American Health Care Consultants, Inc.
McClurg Court Center
Tower B, Suite 2902-B
333 East Ontario Street
Chicago, Illinois 60611

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

	Postage and handling charge	Quantity	Total
I Monographs			
Set A (Numbers 1-5)	$1.50	_____	_____
Set B (Numbers 6-11)	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¢	_____	_____
4. Organizing and Staffing Citizen Advisory Committees to Upgrade Jail Medical Programs	50¢	_____	_____
5. The Use of Volunteers in Jails	50¢	_____	_____
6. Orienting Health Providers to the Jail Culture	75¢	_____	_____
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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		Postage and handling charge	Quantity	Total
16.	Profile Study of Selected Juvenile Health Care Facilities	75¢	_____	_____
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¢	_____	_____
	Spanish versions:			
20.	The Recognition of Jail Inmates with Mental Illness: Their Special Problems and Needs for Care	1.00	_____	_____
21.	Guide for the Care and Treatment of Chemically Dependent Inmates	1.00	_____	_____
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	Juvenile Standards	2.50	_____	_____
	Exercising Manual	2.50	_____	_____
	Practical Guide	2.00	_____	_____
IV	Conference Proceedings			
	2nd National Conference Proceedings	2.00	_____	_____
	3rd National Conference Proceedings	3.00	_____	_____
	Both Proceedings	4.00	_____	_____
V	CHCF Manuals			
	Complete set of 19 publications	15.00	_____	_____
		TOTAL AMOUNT OF ORDER		$_____

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333 E. Ontario Street, Chicago, Illinois 60611
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

I. Ambulatory Clinical Services (patients treated)	MD	PA	RN	Total
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
_____ Arthritis
_____ Asthma
_____ Delirium Tremens(DT's)
_____ Dental Condition
_____ Diabetes
_____ Epilepsy
_____ Fainting
_____ Heart Condition
_____ Hepatitis
_____ High Blood Pressure
_____ Physician Prescribed Diet
_____ Psychiatric Disorder
_____ Tuberculosis
_____ Ulcers
_____ Urinary Tract Problems
_____ Venereal Disease (VD) (Which)?
_____ 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

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.

STUDENT'S MANUAL

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?

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?

3. What are your preferences for the selection of staff to interview during the inspection?.

4. What are your preferences for the selection of inmates to interview during the inspection?

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?

6. What value do you place on written documentation?

7. During an inspection what are your feelings on interviewing staff persons from only one shift?

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?

APPENDIX G

UNITED STATES MARSHALS SERVICE (USMS) AUDIT FORMAT

CONTINUED

2 OF 3

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 H-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 in compliance	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				

MEDICAL AND HEALTH CARE SERVICES			In compliance	Not in compliance	Exceptions Noted	Staff Information Confirmed
326 (contd) (133)		staff person?				
		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*

AGES WITH
THE COMMUNITY

Agency/Organization	Health education materials	Professional publications	Medication administration, training and documentation	Medical-Legal situations	Clothing	Volunteers	Counseling	Mental health/retardation assessment	Receiving screening training	EMT - A training	First aid training - Basic/Advanced	CPR training-Basic/instructor	Drug addiction services	Detoxification	Lab & diagnostic tests for disease	EMT - A services	Mental health services	Hospital services	Dental services/consultation	Nursing services/consultation	On cases, programs, policies, forms	Physician services/consultation
City/County Health Dept.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Local Hospital	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Local Nursing Home		X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
County Nurse	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
School Nurse				X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
County Medical Society		X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Local Physicians/Clinics	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Local Dentists/Clinics	X	X	X		X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medical School	X	X	X		X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nursing (RN/LPN) School	X	X	X		X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental School	X	X	X		X	X				X	X	X	X	X	X	X	X	X	X	X	X	X
Dental Hygienists School	X	X	X		X	X					X	X	X	X	X	X	X	X	X	X	X	X
Community College/University (Interns in criminal justice)	X	X	X		X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
Ambulance Company/Rescue Squad			X		X	X				X	X	X	X	X	X	X	X	X	X	X	X	X
Fire/Police Dept.		X	X		X	X				X	X	X	X	X	X	X	X	X	X	X	X	X
County Coroner's Office			X		X	X				X	X	X	X	X	X	X	X	X	X	X	X	X
Military Base/VA Hospital	X	X	X		X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
HMOs/IPAs	X	X	X		X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Heart Assoc.	X	X			X	X					X	X	X	X	X	X	X	X	X	X	X	X
American Cancer Society	X				X	X					X	X	X	X	X	X	X	X	X	X	X	X
American Red Cross	X	X	X		X	X					X	X	X	X	X	X	X	X	X	X	X	X
Civil Defense					X	X					X	X	X	X	X	X	X	X	X	X	X	X
Epilepsy Foundation	X	X	X		X	X					X	X	X	X	X	X	X	X	X	X	X	X
Cooperative Extension Service	X	X	X		X	X					X	X	X	X	X	X	X	X	X	X	X	X
Local Mental Health Center	X	X	X		X	X					X	X	X	X	X	X	X	X	X	X	X	X
Local Drug Abuse Agencies	X	X	X		X	X					X	X	X	X	X	X	X	X	X	X	X	X
Detoxification Programs	X	X	X		X	X					X	X	X	X	X	X	X	X	X	X	X	X
Alcoholics Anonymous	X				X	X					X	X	X	X	X	X	X	X	X	X	X	X
Regional Criminal Justice Planning Agency		X	X		X						X	X	X	X	X	X	X	X	X	X	X	X
Church Groups						X																
Auxiliaries						X																
Civic Groups						X																
Salvation Army						X																
Family Planning Groups	X		X			X																

* Developed by Illinois State Medical Society Jail Project, Larry S. Boress, Director

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