SUPREME COURT OF APPEALS
STATE OF WEST VIRGINIA

JUVENILE JUSTICE COMMITTEE

E-400 STATE CAPITOL
CHARLESTON 25305
304/348-3649

TO: ALL SHERIFFS AND COUNTY COMMISSIONERS

FROM: JUVENILE JUSTICE COMMITTEE

DATE: DECEMBER 1982

Last fall when you received a copy of the Jail Standards, we indicated that a medical appendix would be forthcoming to aid in implementing the health care standards. Medical care guidelines have since been designed and are enclosed. The development of these standards was undertaken by the Marshall University School of Community Medicine in consultation with Virginia University Medical School and the West Virginia Health Department.

se guidelines are felt to satisfy legal and health requirements. The use of a health authority is suggested er to alleviate the burden upon non-medical jail personnel e responsible for medical procedures. Pages one through ncompass the medical guidelines, the remaining material appendix and training information.

other matters relating to jail operations see: Boone Jail Inspection Committee v. Vernon Harless; State of irginia v. Boone County Commission; State of West Virginia orable Jerry W. Cooke; No. 81-C-8384 the interim order g forth conditions permitting the re-opening of the Boone Jail; and Kim Hickson and Verlon Jones v. Dotty Kellison, 533, regarding the Pocahotas County Jail. Also of interest t the Department of Corrections is offering a training m on jail officers. The first of such training will occur ember. For more information on this training contact ing at the Department of Corrections (348-2037). For copies above mentioned court orders contact the clerk's office ose courts. Hopefully the enclosed information will be helpful to you.

Special appreciation is extended to Dr. David Heydinger whose dedication led him to coordinate the efforts of this project. The work of the many other persons who also volunteered their time in research or review is also gratefully acknowledged.

Sincerely,

Lauren Young

Lauren Young, Counsel

LY/bj

93039

MINIMAL HEALTH CARE GUIDELINES FOR WEST VIRGINIA JAILS

JUVENILE JUSTICE COMMITTEE
West Virginia Supreme Court of Appeals

In conjunction with

DEPARTMENT OF COMMUNITY MEDICINE
Marshall University School of Medicine

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I. Administrative

A. Responsible Physician

Each West Virginia jail shall designate a responsible physician to approve health care policies, procedures and agreements which can include use of hospital emergency rooms. Each jail shall have agreements for 24 hour on call physician coverage.

The responsible physician may be a County Health Officer, a private practitioner, or a physician may be obtained voluntarily through the County Medical Society.

All physicians and dentists examining or treating inmates must be licensed to practice in the State of West Virginia.

B. On-site Health Authority

Each West Virginia jail shall have designated on-site health authorities who shall be responsible for arranging making available all health care services. There will be a health authority on site twenty-four hours per day.

The health authority may be a physician, physician's assistant, registered or licensed practical nurse, nurse practitioner, paramedic, emergency medical technician, or a health-trained staff member.

Health-trained staff are those non medical personnel whose duties are set out in Section E.5 on page 3.

C. Medical Autonomy and Jail Administration

Medical decisions shall be made only by the responsible physician or designee(s).

It will be made clear to the health authorities and physicians that security regulations which apply to the non medical jail staff also apply to them. They will be provided with a list of these regulations and an orientation to the jail system.

D. Administrative Meetings and Reports

There shall be meetings between the health authority and/or responsible physician and the facility administrator to discuss jail health care at least quarterly. Notes of these meetings shall be kept by the administrator.

There shall also be an Annual Statistical Report which will include the number and nature of sick call visits, diagnostic studies performed, emergency services rendered, specialty referral visits, hospitalizations, special procedures performed, ambulance transfers, communicable diseases reported, and deaths.

Annual Statistical Reports shall be submitted, to the County Commission. (See Appendix, page 1, for sample Annual Statistical Report Form). The responsible physician will submit an annual appraisal of the jail's health care delivery to the County Commission.

E. Policies and Procedures

The responsible physician shall write or approve pre-written health policies and procedures for the following aspects of jail health care:

1. Decision making: Special Problem Patients
2. Notification of next of kin
3. Post-mortem examination
4. Minimal staff training requirements
5. Emergency services
6. Receiving screening and health appraisal
7. Alcohol and drug detoxification
8. Access to treatment and sick call
9. Use of restraints or isolation relative to out of control residents
10. Standing orders
11. Health promotion and disease prevention
12. Dental care
13. Personal hygiene
14. Management of pharmaceuticals
15. Health records
16. Facilities and equipment

These key areas are defined as stated below. More definitive guidelines for use by a physician are included in appendix pp. 8 - 13.

1. Decision-making: Special Problem Patients

Before inmates with diagnosed psychiatric or significant medical illnesses are given housing assignments, work assignments, disciplinary measures, or transfers, consultation between the facility administrator and responsible physician or their designees must take place to decide on any special precautions or preparations. A list of frequent illnesses which require special handling could be developed special diets must be provided when ordered by health personnel.

2. Notification of Next of Kin

Any inmate having any serious illness or injury or who dies while incarcerated shall have his next of kin or legal guardian notified by the facility administrator or the responsible physician.

3. Post-mortem Examination

In the event of an inmate death, the medical examiner shall be notified immediately.

4. Minimal Staff Training Requirements

Health-trained staff is defined as jail personnel who have the equivalent of EMT training and also have received information regarding the symptoms of physical and mental illnesses common to the inmate population (including depression and chemical dependence), basic management of seizures, medication administration, health record maintenance, and recognition of potential suicides.

Training may be effected through a local hospital Emergency Room, County Health Department, County Medical Society, Red Cross Chapter, or any other program approved by the responsible physician. 1/

Each shift must include at least one member who has become health-trained as described above. Ideally these persons shall be from the health care profession but may be trained jail personnel.

5. Emergency Services

There shall be twenty-four hour emergency medical care available. By definition, a medical emergency is an acute illness or unexpected health need that must be attended to immediately and cannot be delayed until the next scheduled sick call.

The responsible physician shall approve a plan providing for: use of emergency transportation, use of a local hospital emergency department or appropriate health facility with emergency on-call physician services, procedures for the transfer of inmates to other medical facilities.

1/ Development of a specialized training course was estimated to be possible at 60-80 hours. Perhaps video tapes with local personnel used to answer questions or demonstrate techniques, would be most efficient. Also available as a beginning point for training are monographs published by the Jail Health Care Accreditation. These pamphlets are available at a small handling and postage fee from; American Health Care Consultants, Inc.;McClurg Court Center; Tower B. Suite 29028; 333 E. Ontario Street; Chicago, Illinois 60611; Phone: (312) 440-1574. These pamphlets include: "The Recognition of Jail Inmates with Mental Illness: Their Special Problems and Needs for Care", "Management of Common Medical Problems in Correctional Institution: Epilepsy and Tuberculosis", "Guide for the Care and Treatment of Chemically Dependent Inmates", and "Common Health Problems of Juvenile Correctional Facilities".

6. Receiving Screening and Health Appraisal

A receiving screening appraisal to elicit information pertinent to the inmate's health shall be performed on every inmate at the time of admission (or as soon thereafter as conditions permit). The screening shall be recorded on a form which has been approved by the responsible physician. Screening is a means to discover and prevent health and safety threats to residents and staff. The goal of receiving screening shall be to detect any communicable diseases, chemical dependence, suicide potential, or other medical or psychiatric problems before the inmate is placed within the jail population. (See Appendix p.2)

When the inmate has been transferred from another facility and is accompanied by a previous completed screening form, the form shall be reviewed and verified.

Receiving screening shall be conducted by the health authority on duty or by a health-trained staff member.

Inmates who are in need of immediate medical attention at time of admission shall be referred immediately for emergency care after the physician on call has been notified.

Within 30 days of admission, each inmate held longer than 30 days with inmate's concurrence, a health appraisal which will include a history and examination, recorded on a form approved by the responsible physician. This will not be required if the inmate has received an adequate health appraisal within the previous 90 days. Although a physician physician's assistant, or nurse practitioner must perform the physical examination, the health history may be collected by any health-trained staff member. (See Appendix p.3 and 4.)

7. Care for Persons Under the Influence of Drugs

The responsible physician shall approve policies and procedures for the identification of alcohol and drug dependence as well as subsequent management and/or transfer for the care of persons under a drug influence. Unless the jail has special facilities and constant medical supervision to perform detoxification, the process shall not be performed on site; the inmate shall be transferred to a hospital or community detoxification center designated by the responsible physician. Procedures for adequate care of persons under the influence of drugs include policies and training governing medical screening, observation, referral evaluations, and safety protections.

8. Access to Treatment and Sick Call

It shall be required that each inmate, at time of admission, be given orally and in writing, information concerning the right to medical treatment. The information sheet should be approved by the responsible physician, and should include procedures for registering complaints and the jail's sick call schedule.

Sick call shall be performed by a licensed physician, physician's assistant, registered nurse, or other person designated by the responsible physician. Sick call is a designated time to see non-emergency problems. Minimum frequency of sick call should be as follows:

Average daily inmate population	
Greater than 100 inmates	thrice per week
50 - 100	twice per week
10 - 49	once per week
Less than 10	as needed

Inmates will have daily access to sick call forms which will be reviewed that day by the health authority or other person designated by the responsible physician. All complaint forms will become part of the inmate's health record. (See Appendix p.6.)

9. Use of Restraints or Isolation for Out of Control Residents

The responsible physician shall approve a plan guiding the use of restraints, or isolation and providing for mental health personnel to evaluate residents who are repeatedly out of control or remain out of control for more than a short amount of time. 2/

10. Standing Orders

A set of standing orders will be developed by the responsible physician for any on-site treatment to be performed by the health-trained staff. This may include orders pertaining to the care of inmates being transported to other health facilities or transported to other jail/prison facilities. (See Appendix p.5.)

11. Health Promotion and Disease Prevention

The responsible physician should consider plans providing inmates with health education, preventive medical services, and shall review inmate's opportunities to engage in exercise.

Jails shall consider establishing a holding bed area for use by inmates having medical problems requiring separation or close observation. Residents shall be allowed to participate in some form of exercise involving large muscle activity for a minimum of one hour daily. Structured programs should be offered.

2/ See Jail Standards, Standard 18, Juvenile Justice Committee, West Virginia Supreme Court of Appeals, November, 1981.

12. Dental Care

The responsible physician must arrange for 24-hour coverage by licensed dentists to provide emergency dental services.

13. Personal Hygiene

Inmates who are expected to be incarcerated for more than 24 hours must be provided with bathing or showering facilities with hot and cold running water. Showering or bathing will be permitted daily. Inmates will be provided with soap, toothbrush, toothpaste, toilet paper, and towel. Sanitary napkins will be provided. The facility must provide laundry services at least weekly.

14. Management of Pharmaceuticals

Procedures for prescribing, dispensing, and administration of drugs must be in compliance with applicable state and federal laws and regulations.

The responsible physician will approve written procedures for distribution, administration, accounting, and disposal of medications.

A written medication log must be approved by the responsible physician and maintained for each inmate receiving medication. (See Appendix p.7.)

Facilities should maintain a list of medications stocked by the facility.

The facility must provide a locked storage area for medications.

15. Health Records

A separate health file will be established on every inmate at the time of his/her receiving screening. The record will contain documentation of all health encounters, sick call complaints, the receiving screening form and, if the inmate has been incarcerated at least 30 days, the health appraisal.

The health record should be sufficiently detailed to enable any practitioner to give continuing care and enable them to determine what the inmate's condition was at a specific time and what procedures were done and to enable consultants to give an opinion after examination of the inmate. Entries must be written in ink and be legible, signed and dated.

Access to the health record file will be confidential, allowed to the responsible physician and designee, the inmate, consultants, or inspectors and the facility administrator and, your request, the county commission. Written authorization by the inmate must precede any transfer of health record information excepting emergency situations.

Health records must be maintained for a minimum of 7 years after the inmate's last incarceration.

16. Facilities and Equipment

If health services are delivered on-site, the jail must have a private examination/treatment area. Basic items provided should include: stethoscope, blood pressure cuff, thermometer, tongue blades, flashlight.

Other equipment which should be available includes: ophthalmoscope, otoscope and ear specula, percussion hammer, weight scales, examination gloves, vaginal specula.

Each jail must have one or more first aid kits containing such items as bandages, gauze, sling, adhesive tape, band-aids.

The responsible physician shall designate the number, location, and contents of first aid kits.

The health authority must periodically inspect all equipment and first aid kits.

II. Personnel

A. Job Descriptions

The responsible physician shall approve the duties and responsibilities of those personnel providing health care within the jail facility.

B. Staff Development and Training

Health-trained staff should be provided with the opportunity for continued health education (i.e. recertification in EMT and first aid classes).

III. Pharmaceuticals

The responsible physician shall approve a written plan regarding the procedures for medication dispensing, distribution, administration, accounting, and disposal.

1. Procedures for prescribing, dispensing, and administration of drugs must be in compliance with applicable state and federal laws and regulations.

2. The facility must have a locked area for storage of pharmaceuticals. Medications must be refrigerated if necessary.

3. A medication administration log form approved by the responsible physician must be kept for each inmate receiving medications and must include the date, time, name of drug and dosage. Each entry must be initialed by the person administering the drug. Any inmate refusing medication must sign a statement to that effect, which will be filed in the health record (staff must also sign). See Appendix, page 7, for sample medication log and page 26 for sample medication distribution guidelines.

4. Medications will be administered only by a physician or nurse, or, after written approval by the responsible physician, by the health authority or health-trained staff members; exception to this requirement may be made in that insulin injections may be self-administered by the inmate with supervision by the health authority or health-trained staff member. The physician shall inform jail personnel of possible side effects of medication on residents.

5. When medications are taken by mouth, the person administering the drug will observe the inmate swallow the drug and have him speak after swallowing to ensure ingestion of the medication.

6. Facilities should maintain a list of medications stocked by the facility.

7. Controlled substances must not be stocked by the facility. The responsible physician must design a procedure for the dispensing and administration of a controlled substance in the event that an inmates' medical condition necessitates its use.

IV. Health Records

1. A health record will be established on every inmate at the time of his/her first health encounter after the initial receiving screening.

2. The health record will contain the following items:
   - The completed receiving screening form.
   - Health appraisal data (if inmate has been incarcerated for at least 30 days).
   - All findings, diagnoses, orders, and treatments.
   - Medication log sheet.
   - Results of any laboratory, x-ray, and diagnostic studies.
   - Completed medical complaint forms.
   - Place, date, and time of health encounters.
   - Dental, psychiatric or other consultation reports.
   - Consent and refusal forms.
   - Release of information forms.

3. All entries will be made in ink and should be clearly legible. Each entry must be dated and signed.

APPENDIX

(HEALTH CARE STANDARDS)

SAMPLE

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

Receiving Screening Form

DATE _____

NAME _____ SEX _____ D.O.B _____ TIME _____

INMATE NO. _____ OFFICER OR PHYSICIAN _____

Booking Officers Visual Opinion

	YES	NO
1. Does the new inmate have obvious pain or bleeding or other symptoms suggesting need for Emergency Service?	YES	NO
2. Are there visible signs of trauma or illness requiring immediate Emergency or Doctor's care?	YES	NO
3. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection which might spread through the jail?	YES	NO
4. Is the skin in good condition and free of vermin?	YES	NO
5. Does the inmate appear to be under the influence of alcohol?	YES	NO
6. Does the inmate appear to be under the influence of barbiturates, heroin or any other drugs?	YES	NO
7. Are there any visible signs of Alcohol/Drug withdrawal symptoms?	YES	NO
8. Does the inmate's behavior suggest the risk of suicide?	YES	NO
9. Does the inmate's behavior suggest the risk of assault to staff or other inmates?	YES	NO
10. Is the inmate carrying medication or does the inmate report being on medication which should be continuously administered or available?	YES	NO

Officer-Inmate Questionnaire

11. Are you presently taking medication for diabetes, heart disease, seizures, arthritis, asthma, ulcers, high blood pressure, or psychiatric disorder? Circle Condition.	YES	NO
12. Do you have a special diet prescribed by a physician **or by religious belief?** Type_____	YES	NO
13. Do you have history of venereal disease or abnormal discharge?	YES	NO
14. Have you *recently* been hospitalized or recently seen a medical or psychiatric doctor for any illness?	YES	NO
15. Are you allergic to any medication?	YES	NO
16. Have you fainted recently or had a recent head injury?	YES	NO
17. Do you have epilepsy?	YES	NO
18. Do you have a history of tuberculosis?	YES	NO
19. Do you have diabetes?	YES	NO
20. Do you have hepatitis?	YES	NO
21. If female, are you pregnant?	YES	NO
22. If female, are you currently on birth control pills?	YES	NO
23. If female, have you recently delivered?	YES	NO
24. Do you have a painful dental condition?	YES	NO
25. Do you have any other medical problem we should know about?	YES	NO
26. Have you previously been arrested for public intoxication?	YES	NO
27. Have you mixed alcohol with any medication or other drugs?	YES	NO
28. Do you currently have feelings tending towards suicide?	YES	NO

29. What drug/alcohol have you consumed and approximately how much?_____

30. Is there an adult (friend, parent, relative) who the jail can contact to help you? NAME:_____; NUMBER:_____

Any comments of person contacted relative to inmates health needs:

*Any Additional Remarks (over)

Name & Number _____

Date: _____

Medical Confidential

Health History

HAVE YOU EVER?	YES	NO	DO YOU?	YES	NO
Lived with anyone who had TB			Wear glasses or contact lenses		
Coughed up blood			Have vision in both eyes		
Bled excessively after injury			Wear a brace or back support		
Attempted suicide					

HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW	HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW
Asthma				Night Sweats			
Tuberculosis				Tumors, Cysts, or Growths			
Cancer or Tumor				Cramps in your Legs			
Diabetes				Rupture or Hernia			
Emphysema				Recent gain or loss of Weight			
Ear, Nose, or Throat Trouble				Frequent Indigestion			
Hearing Loss				Stomach Trouble or Ulcer			
Chronic or Frequent Colds				Hepatitis or Jaundice			
Hay Fever				Gall Bladder Trouble			
Severe Tooth or Gum Trouble				Hemorrhoids or Rectal Trouble			
Shortness of Breath				Head Injuries			
High Blood Pressure				Epilepsy or Seizures			
Pain or Pressure in Heart				Frequent or Severe Headaches			
Pounding Heart				Loss of Memory or Amnesia			
Arthritis or Bursitis				Periods of Unconsciousness			
Fractures (Broken Bones)				Paralysis, Numbness, Weakness			
Bone, Joint, or Other Deformity				Dizziness, Fainting Spells			
Painful or Trick Shoulder				Nervous Problem of Any Type			
Foot Trouble				Alcoholism			
Recurrent Back Trouble				Syphilis, Gonorrhea			
Swollen or Painful Joints				Drug Allergies			
Kidney Trouble				Lumps, Pain, Discharge on Breast			
Frequent or Painful Urination				Change in Menstrual Pattern			
Blood in Urine				Pregnancy/Abortion/Miscarriage			
Recurrent Infections				Treated for Female Disorder			
Rheumatic Fever				Thyroid Trouble			

YOUR PRESENT DOCTOR'S NAME (Address, Phone)	Have you ever been a patient or received treatment in a hospital? (surgery/injuries); state where, when, why & address
Have you ever been treated for a mental condition? (If yes, state reason and give details)	Have you ever taken narcotics? (If yes, state what kind, when you last took it, and if you are in a treatment program)
Highest level of education (years)	Additional Remarks: (use reverse side)
Have you ever been incarcerated in this jail before? (if so, when?)	

Medical Confidential

Physical Examination

Name & Number _____

Date: _____

Blood Pressure:	Pulse Rate:	Pulse Rhythm.	Respir. Rate:	Respir. Rhythm
Height:	Weight:	Temp:	Visual Acuity.	Ocular Tension.

General appearance ☐ Healthy ☐ Unhealthy

PARTS OF THE BODY		OBSERVATION
1 Head, face, scalp		
2. Skin	(a) lesions, ulcers, jaundice	
	(b) lacerations, tracks	
3. Eyes	(a) pupils	
	(b) conjunctiva, sclera	
4. Ears	(a) pinnae, canals, drums	
	(b) gross hearing	
5. Nose		
6. Mouth	(a) teeth:dentures	
	(b) throat	
7. Neck	(a) lymph nodes	
	(b) masses	
8. Chest Wall		
9. Breasts		
10. Lungs		
11. Heart	(a) rate	
	(b) murmurs	
12. Abdomen (appearance)		
13. Liver	(a) size (cm)	
	(b) tenderness	
	(c) edge	
14 Spleen		
15. Groin	(a) nodes	
	(b) lesions	
	(c) hernias	
16 Back	(a) pain	
	(b) range of motion	
17. Extremities	(a) clubbing	
	(b) tracks	
18 Flanks		
19. Joints	(a) deformity	
	(b) range of motion	
20. Neurologic	(a) reflexes	
	(b) gross touch	
	(c) gait	
	(d) oriented	
	(e) speech	
21 Rectal		
22 MALES Penis, scrotum, testes		
23. FEMALES.	(a) vulva, vagina	
	(b) cervix	
	(c) uterus, adnexae	

Laboratory Results PPD or tine	RPR or VDRL	SGPT	U.A.

Disposition/Referral

_____

Signature of Examiner

SAMPLE

Doctors Orders to the Jailer

Patient's Name _____ I.D. # _____

Date _____ Time _____

Treatment Prescribed _____

_____

Medication Prescribed & medication administration instructions _____

_____

Special instructions (restrictions of diet, activity, work assignment, observation orders, etc.) _____

Referral/Return appointment

_____

_____

Physician/Dentist

_____

Date

_______________ County Jail

Request Slip for Medical Care

Date _______________ Time _______________

Name _______________

Cell _______________

Complaint _______________

____

For how long _______________

TO BE FILLED OUT BY SHIFT COMMANDER:

Disposition and Instructions:

____

____

____

____

____

Date _______________ Time _______________ Initials _______________

MEDICAL CONFIDENTIAL

Medication Log Sheet

Name _______________ I.D. # _______________

Date	Medication	Time dispensed and initials (giver & inmate)															
		Time	Given by: Init.	Inmate Init.	Time	Given by: Init.	Inmate Init.	Time	Given by: Init.	Inmate Init.	Time	Given by: Init.	Inmate Init.				

(after completion—file with the medical record)

CARE AND TREATMENT APPENDIX FOR RESPONSIBLE PHYSICIAN

The following section is written to guide the duties of the responsible physician. The responsible physician should write or approve existing health care plans following the guidelines below.

The following topics are included:

A. Emergency services
B. Receiving screening and health appraisal
C. Alcohol and drug detoxification
D. Access to treatment and sick call
E. Direct and standing orders
F. Holding bed area
G. Treatment philosophy
H. Use of restraints or isolation for out-of-control residents
I. Health promotion and disease prevention
J. Dental care
K. Special medical problems

A. Emergency Services

The responsible physician shall approve a plan for emergency services, including:

1. Recognition of an emergency (signs and symptoms which require immediate attention, such as acute chest or abdominal pain, change in mental status or level of consciousness, shortness of breath, severe bleeding uncontrolled by first aid efforts, protracted vomiting or diarrhea, sever trauma, continual seizure activity, actual or potential suicide attempt, etc.) (See Appendix, page 19, for sample guidelines for management of a seizure and pages 8 thru 18 for guidelines for handling mentally ill, suicidal, alcohol, and drug dependent inmates).

2. Designation of a local hospital emergency department or other appropriate off-site facilities.

3. Provision of 24-hour physician and dentist coverage (on site or on-call).

4. Procedure for notifying physician on call.

   In the event of an emergency, the on-site health authority shall be notified immediately and will contact the physician on call.

   Names, phone numbers, and monthly call schedules of physicians and/or names, addresses, and phone numbers of designated off-site emergency facilities shall be easily accessible to the health authority.

5. Access to emergency transportation.

6. Transfer procedures.

7. Health record documentation procedure.

B. Receiving Screening and Health Appraisal

Upon admittance a receiving screening shall be performed on each inmate and recorded on proper forms which have been approved by the responsible physician. Inquiry should include, but not be limited to:

Current health problems, including hypertension, diabetes, heart problems, seizures, dental problems.
Current medications, including dosage and duration of use.
Alcohol and drug use, including quantity and duration of usage and history of withdrawal.
Allergies to medications, foods, etc.
Name of physician, place or agency consulted previously.
History of mental illness, including psychiatric hospitalizations and prior suicide attempts.
History of recent hospitalization, illness, or trauma.
Obstetric history, including date of last menstrual period, and possibility of pregnancy.
History of tuberculosis or venereal disease.
Special diets prescribed by a physician prior to admission.
Religious affiliation which might prohibit certain forms of medical treatment.

Screening shall be done by the on-site health authority or a health-trained staff member. (See Appendix, page 2.)

Inmates needing emergency care at time of admission shall be handled according to the emergency services plan.

Within 30 days of admission, each inmate will have a health appraisal performed, unless the inmate has in his/her health record an adequate health appraisal that was conducted within the previous 90 days.

The health appraisal shall include:

Review of the receiving screening form and completion of any omitted items.
Collection of additional history.
Review of systems symptoms.
Physical examination, including vital signs; mental status; head, eyes, ears (including otoscopic exam), nose, throat; teeth and gums; auscultation of heart and lungs; abdomen, including liver percussion or palpation; external genitalia, including hernia check; breast palpation (male and female); lymph nodes; skin; spine and extremities, including ease of motion; anus and rectum. Pelvic examination should be made available to females.
A general assessment of inmate's overall condition.

Ordering of any laboratory or diagnostic tests as deemed necessary by the responsible physician (such as TB skin testing, sickle cell testing, venereal disease testing, EKG, chest or other x-ray, urine analysis, hemoglobin/hematocrit, CBC, etc.). If desired by the inmate, females must have a Pap smear obtained during the physical exam.
Initiation of therapy when indicated.

Health history information may be collected by health-trained staff; physical examination must be performed by a physician, physician's assistant, or nurse practitioner.

The health appraisal forms shall be approved by the responsible physician. Upon completion, it shall be signed and dated and placed in the inmate's health record.

(See Appendix, pages 3 - 5, for sample Health History, Physical Examination, and Physicians Order Forms.)

C. Care for Persons Under the Influence of Drugs

The responsible physician shall approve a written plan providing for the care of persons under the influence of drugs (including alcohol). Such plan shall address the following:

Adequate receiving information. The screening shall include attempts to contact family, relative or other responsible adult and inquiry into use of drugs, possible complicating medical factors and suicidal tendencies.
Notification of responsible physician or designee when persons with a known or acknowledged history of drug use are admitted to the jail.
Safety procedues, including removing potential hazards from inmates and placing resident in a safe environment.
Observation procedures for staff, including periodic verbal exchanges and continuous observation for the first 24 hours of incarceration with continued appropriate observation thereafter and recordation of such.
Recognition of alcohol, and other drug use symptoms and suicide tendencies.
Documentation in the inmate's health record.
Designation of community mental, medical, or social services personnel for evaluation and treatment referrals.
Designation of a hospital or community detoxification center, including transfer procedures.

See Appendix, pages 13 through 18 for guidelines.

D. Access to Treatment and Sick Call

The responsible physician shall approve a written plan outlining the procedure for seeking and receiving medical care, including:

Daily ability to register, in writing, medical complaints on forms approved by the responsible physician. The form must include the nature and duration of the complaint. Assistance by jail personnel must be offered to illiterate inmates. See Appendix, page 6, for sample Medical Complaint Form.

Daily review of medical complaint forms by the health authority or other person designated by the responsible physician.

Documentation of action taken regarding complaints (placing forms in inmate's health record, maintaining a log, etc.)

Arrangement for sick call to be conducted by a physician, physician's assistant, registered nurse, or other person designated by the responsible physician, with the following minimum frequency:

Average inmate daily population	
Greater than 100 inmates	thrice per week
50 - 100	twice per week
10 - 49	once per week
less than 10	as needed

Arrangement for off-site services (such as private specialists' offices, laboratory or x-ray facility, etc.)

E. Direct and Standing Orders

The responsible physician may write a set of standing orders for treatment of common conditions arising or existing among inmates, for which on-site treatment by health-trained staff is reasonable.

If written, standing orders must be signed by the responsible physician.

Each order must specify the duration of treatment.

Common conditions for which standing orders may be written include, but are not limited to:

Pharyngitis, upper respiratory infection ("common cold"), allergic rhinitis, toothache, ear wax accumulation, indigestion, mild viral gastroenteritis, mild diarrhea, mild constipation, headache, insomnia, acne, seborrhea, minor burns, contusions and abrasions.

See Appendix, pages 20 through 25 for sample standing orders.

F. Holding Bed Area

All jails, shall consider establishing a holding bed area, which is a room containing bed(s) for use by inmates having medical problems not requiring hospitalization but that do require close observation.

G. Treatment Philosophy

The responsible physician shall approve a written treatment philosophy which will ensure the following:

Medical procedures shall be performed in privacy with appropriate chaperoning.

Verbal consent will be obtained from the inmate before rectal or pelvic examinations are performed.

Medical care of inmates will comply with acceptable community standards.

Inmates will be treated with respect, in a manner which preserves confidentiality and dignity.

H. Use of restraints

The responsible physician shall approve a written plan guiding the use of restraints, for residents who are out of control including:

Indications for use (such as when an inmate is a physical threat to himself or others).

Type of restraints which may be used.

Duration of restraint

Authorization required.

Documentation of restraint procedure in the inmate's health record.

I. Health Promotion and Disease Prevention

The responsible physician should consider plans for health education, preventive medical services such as immunizations and pap smears.

J. Dental Care

The responsible physician shall approve a written plan providing 24-hour emergency dental care by a dentist licensed in the State of West Virginia, including:

Designation of dentist on call to provide 24-hour emergency coverage.

Notification of dentist on call by the health authority.

Documentation in inmate's health record.

K. Special Medical Problems

The responsible physician, in conjuction with the facility administrator, shall outline in a written plan any special

procedures for inmates who have been diagnosed as having significant medical or psychiatric illnesses or conditions, including:

1. A list of conditions or illnesses which might necessitate special handling (such as pregnancy, diabetes mellitus, depression, psychosis, sickle cell disease, physical deformity or musculoskeletal disorders, hemophilia).

2. Requirement for consultation between the facility administrator and the responsible physician or their designee before housing assignments, work assignments, disciplinary measures, or transfers are made.

3. Special transport procedures, including:

   - suitability for travel.
   - type of vehicle required for transport.
   - provision of a health summary or copy of the inmate's medical record prior to transport.
   - medication or other therapy required en route.
   - instruction to transport personnel regarding medication or other therapy or precautions.

GUIDE TO CARE OF MENTALLY ILL

Recognition: Mental conditions may show a variety of signs to be alert for. Many of these signs are not evident on casual observation (i.e., during receiving screening) but may become evident during the incarceration period. Some signs to be alert for include the following:

1. The individual thinks people are plotting against him/her.
2. They have grand ideas about themselves.
3. They talk to themselves or hear voices. They see visions, or smell strange odors, or have peculiar tastes.
4. They think people are watching or talking about them.
5. They have bodily ailments that are not possible.
6. They are extremely frightened or in a state of panic.
7. They behave in a way which is dangerous to themselves or others.
8. They are depressed and slowed down.
9. They are very confused or disoriented.
10. They are withdrawn and avoid human contact.

These symptoms may be present when mental illness is not. Some legitimate medications produce side effects causing the patient to feel drowsy, listless, shaky, or restless.

Various medical conditions can produce confusion and simulate mental illness. Diabetics are frequently thought to be mentally ill when in fact they are in diabetic coma. Diabetics who are sweating profusely, jerking and twitching are apt to need immediate hospital care. Epileptics are also frequently misdiagnosed. Epileptics may wander about for hours in a confused state. Some types of epilepsy may have periods of violence. (See Appendix p. 19 for management of epilepsy). Persons with head injuries who exhibit any of the above signs should be seen by a physician even if there is little visible injury. All persons who have received head injuries should be kept under careful observation over a period of several hours.

Persons with high blood pressure, severe infections or brain tumors sometimes become dazed, delirious, or irrational.

Detecting symptoms will enable staff to make appropriate referrals and aid the health personnel making the diagnosis.

Management. It is important to identify potentially seriously ill individuals. Following are guides for handling such persons, particularly when they are quite disturbed and potentially violent.

1. Take time to look the situation over and to give the individual some time to quiet down. Often the excited stage will last only a short time if the individual is properly handled and not threatened. Keep reassuring them that they will be well taken care of and that you are there to help them.

2. Do not abuse or threaten the individual. Disturbed persons are already badly frightened. They may be threatened by the voices they hear. If you further frighten them they may think you are just another person who is against them and want to punish or kill them. As a result they may turn against you, call you names, and accuse you of being against them. Never threaten a disturbed or violent person. Do not strike them; do not call them names. Never try to bully them. These things do not work. They only make your job harder, longer and more dangerous.

3. Don't let them "get your goat". People who are mentally disturbed are often clever in picking out weaknesses and points of irritability in those around them. If a disturbed person tries this tactic, remain calm and kind, though firm, and he/she may begin to quiet down.

4. Do not deceive. It is sometimes tempting to deceive the disturbed person but this is so harmful to them that it must be avoided at almost any cost. Lying to a disturbed person at the time they are taken into custody or while they are in custody may delay their recovery. Individuals sometimes trick the sick person and tell them they are being taken to a hospital; then when they believe them and find themselves later locked in a cell, they lose more faith.

To sum up these suggestions, remember:

*Stop, Look and Listen.
*Move slowly.
*Be understanding, kind and firm.
*Above all, don't threaten or strike and don't lie.

There are times, of course, when mentally ill persons are so disturbed, so excited, so violent, that they must for their own safety and for the safety of others, be restrained. When you see that this is the situation, do not try to handle things alone, unless it is absolutely necessary.

If reasonable effort has been made to give the individual opportunity to comply with the procedures and he/she does not comply, then call for a "show of force". Tell the person firmly that you are there to help and that you are not going to hurt him/her. Moving together, circle the patient and grasp him/her. Never let go of a patient once you have hold of them and together lift up the patient and carry them to a place where they may be properly restrained.

If the combative individual has a non-lethal weapon, again call for a show of force with one person assuming the leadership role. Do not move until all know their roles. A mattress is a good defense in this situation and two carrying the mattress should move toward the individual with it held up so it can receive the weight of the blow from the weapon. At the same time two other individuals should converge towards the individual and grasp him/her immediately after he/she has thrown or struck with the weapon. An individual must be secured the moment after they throw or strike the mattress.

The individual should be isolated in a cell of his/her own, in restraints. The doctor should be summoned. Individuals should not be left in a cell alone because they may thrash about, strike their head or attempt to destroy themselves. All articles that individuals might use to hurt themselves should be removed and if possible someone should be with such individuals until they have had medical attention.

Previous arrangements for medical attention for such emergencies are a must. Likewise plans for removing disturbed individuals who are truly mentally ill to a hospital which is adequate for taking care of mentally disturbed patients should be made.

Referral Plan: Designated local mental health professionals shall be used to diagnose and treat mentally ill residents. Treatment may involve group, family or individual counseling. Provisions for release from jail to attend these sessions will be authorized by the chief administrator or designee. A hospital, adequate to care for mentally disturbed patients shall be identified and a working arrangment regarding transfers of patients will be retained in writing between the jail and the hospital and shall be made known to all jail staff.

GUIDE TO THE CARE OF POTENTIALLY MENTALLY ILL

Suicide is a danger when persons are depressed or self-destructive. Often individuals who attempt suicide give warning in advance. Signs of depression can include weeping a great deal or remaining silent for long periods, feeling very hopeless, guilty and unworthy. Suicides cannot always be prevented but recognizing the dangers can save numerous lives. A health professional should decide whether persons are a likely danger to themselves or others. If the person poses such a danger they need to have a hearing to determine whether transfer to a mental health hospital is appropriate. W.Va. Code §27-5-2 governs such proceedings when a person is mentally ill, mentally retarded or addicted.

Management of persons who have been identified as potentially mentally ill:

1. Inmates may remain in general population and need not be admitted to hospital or placed in an observation room unless it is determined that they are a danger to themselves or others or in need of special protection.

2. The designated inmate should be considered to be unpredictable and as such should not be placed in a position of risk. Examples are:

   a) An assignment which would place him in a high position, from which he might jump, i.e., ladders, third or fourth cellblock tiers.
   b) Kitchen jobs with access to knives.

3. Visual checks should be made and recorded regularly to insure presence and well-being of the inmate.

4. The inmate's special status should be reviewed by the health authority and his staff at the beginning of their tour of duty.

5. Each shift shall make an entry into the jail record as to the inmate's general behavior, personal grooming, appetite, relations with staff and other prisoners as well as any unusual or bizarre behavior.

6. Any observation which suggests a sudden change in behavior, or, that may be harmful to the individual or others, should be immediately reported to the health authority who may then order increased precautions until the medical/mental health staff can be notified and evaluate the inmate.

Specifications for Psychiatric/Suicidal Observation Room

1. Should be located as near as possible to control or nursing station to allow for good visual and audio monitoring.

2. Should be of a size meeting minimum jail cell requirements.

3. Should have a secured solid slab bed, no springs, slats, ropes, etc.

4. Should have a fireproof, heavy duty mattress.

5. Should have no glass fixtures, mirrors, etc. - window glass to be of a security type.

6. Should have tamper-proof electrical fixtures with controls on outside of cell.

7. Should have low-intensity night light.

8. Should have no electrical outlets.

9. Should be devoid of structures which would provide an opportunity for hanging, i.e., overhead pipes, cell bars, light fixtures, etc.

10. Door should preferably be solid but with adequate glassed-in port hole for observation.

11. Security screening should be provided on insides of windows.

Suicidal Precautions

1. Inmates should be immediately placed in room designated for suicidal inmates.

2. Any items with which an inmate could hang himself should be removed, i.e., belts, shoe laces, electrical cords, etc.

3. Matches and flammable materials should be removed; patient may smoke out of the room under supervision.

4. All sharp objects are to be removed, i.e., pens, pencils, knives, scissors, nail files, forks, as well as any glass items such as mirrors, glasses, jars, etc. Locked razor to be issued for shaving and returned immediately.

5. Inmate should be visually checked and the results recorded every 15 minutes.

6. If proper housing, as outlined above, is not available the potentially suicidal inmate should not be isolated in an ordinary cell. Such individuals should be housed with one or two other inmates who can help keep them alive.

GENERAL RULES FOR HANDLING ALCOHOL ABUSERS IN THE JAIL

Not all intoxicated inmates who are admitted to the jail pose serious medical problems. Many new inmates have simply had too much to drink and will suffer no more than some vomiting and a hangover. However, whether the situation appears serious or not, officers must follow these rules. A national study showed that jail suicides have been closely connected in 60% of the cases with being placed in the jail when intoxicated. In West Virginia 60% of jail deaths in the past four years were found to be of persons under use or influence of alcohol.

1. Screening: Each jail should have admissions procedures which include basic psychological and medical screening. Part of the screening must be completed when the resident is aware. The screening is designed to bring to the attention of the officers the key elements which indicate a suicide risk. During the screening process, officers should seek information on how much the inmate has had to drink, whether he/she has taken any drugs, and whether he/she has any suicidal feelings. If inmates indicate they have been taking alcohol and barbiturates, officers should obtain medical assistance immediately, since this combination can be fatal. By the time severe reactions set in, it may be too late. Officers who perform the screening and discover a pattern of alcohol and drug abuse must contact parents, spouse, relative, or friend to gain information relating to the habits of the inmate, his pattern of drug or alcohol abuse and his psychological state.

2. Paranoia: When some people are very drunk or in a great deal of discomfort from alcohol withdrawal, they may feel extremely threatened and paranoid. A person who has these feelings will probably distrust the jail officer. The officer should try to act in a non-threatening manner and be reassuring to the inmates.

3. Level of Consciousness: A booking officer should never admit an unconscious person to the jail even if it is believed the person has merely passed out from drinking. Anyone who faints or collapses in the jail and who does not recover consciousness almost immediately should be sent to the hospital. The level of consciousness of an admitted inmate should always improve while he/she is in the jail. If the level of consciousness deteriorates, then the inmate may be in danger of falling into a coma; medical personnel should be notified immediately. Officers should wake an inmate who is sleeping off a "drunk" every 3 or 4 hours. If an officer cannot wake an inmate or if the level of consciousness seems to be getting worse, the officer should request an immediate medical evaluation. During the booking process and again every few hours, officers can give inmates this simple test to evaluate their level of consciousness:

   a. Who are you? Who am I?

   b. Where are you?

   c. What is the present year, date, day, and approximate time of day?

   d. Count backwards from 29 by 3's.

   e. What does the expression "don't cry over spilt milk" mean?

The answers to these questions should improve as the effects of the alcohol wear off. If the inmate's responses do not improve, the officer should request both a medical and psychological evaluation for the inmate. Complete documentation should be made of every circumstance surrounding such an inmate.

4. Observation: officers must observe all alcohol abuse admissions closely to detect medical symptoms and to prevent suicides. Residents receive continual observation for the first 24 hours of incarceration with continual appropriate observation thereafter and recordation of the observations throughout.

5. Contact with Physician: The officer must notify responsible physician (or designee).

   a. the level of consciousness of a resident fails to improve;
   b. medical complications associated with alcohol or drug abuse occur;
   c. it becomes clear to authorities that detoxification services are required or withdraw symtoms appear;
   d. it is known, or the resident acknowledges, that the resident has a history of drug use.

6. Depression and Suicide: Often an intoxicated inmate is "high" or hostile when admitted to the jail. But as the blood alcohol level drops, he/she may become depressed to the point of suicide. All alcohol abuse admissions should be considered potential suicide risks until they are completely withdrawn from alcohol (which may take three or four days).

7. Housing of Intoxicated Residents: Because of the danger of suicide and other harm an inmate may cause to him or herself, the environment in which residents are housed must be made safe. The room in which they are placed must be free from pipes, ledges or other places from which an inmate may attempt strangulation. Belts, shoe laces, and other personal items must be removed which can be used in strangulation. Sheets should also be removed.

8. Vomiting and Staggering: The intoxicated inmate should be protected from harming himself and encouraged to rest and lie down to prevent head injuries. A semi-conscious, vomiting inmate should be turned face down with the head to the side to prevent choking on vomitus. If there are any signs of head injuries, such as bruises, bumps, stitches, vomiting, or, weakness of an arm or leg developes, officers should seek an immediate medical evaluation even if the inmate must be transferred to a hospital.

9. Antabuse Reaction: Antabuse is a drug given to alcoholics to prevent them from drinking alcohol. Those who drink while on antabuse will have these symptoms:

   a. Very red face;
   b. Pain;
   c. Fast heart rate;
   d. Vomiting; and
   e. Cold sweats.

   If the inmate has been taking both antabuse and alcohol and has these symptoms, officers should transfer him/her to a medical facility immediately

10. After Admission: An inmate who has adjusted to the jail environment after alcohol withdrawal still has special needs. Often the doctor will recommend a special diet to repair the alcoholic's poor physical health. The inmate must also be watched carefully: alcoholics sometimes try to drink various poisonous cleaners, paint thinners, and other fluids containing alcohol in an attempt to become intoxicated. Jail staff members should be alert to this possibility.

11. Referral to Community Resources: The jail's physician must be notified immediately of any new admittee who because of drug or alcohol dependency is likely to need detoxification services. The physician will develop and monitor a plan for the detoxification of the resident. A resident who has abused drugs or alcohol or who for other reasons indicates a need for counseling or other psychological assistance must be afforded the opportunity to contact the responsible physician or the mental health center for services. The jail shall contact mental health personnel whenever a person exhibits suicidal threats, gestures or tendencies/i.e. crying, despondence, loss of appetite.

GUIDE TO CARE OF ALCOHOL AND DRUG DEPENDENT INMATES

Drug Overdose and Abuse Require Specific Care

Detoxification from some drugs (e.g., amphetamines, cocaine and alcohol) may require the use of drugs or medical procedures. So-called "cold-turkey" detoxification is inconsistent with the practice of medicine, and can be lethal. If drug or alcohol abuse is indicated upon admission screening, a medical professional shall be notified and given all pertinent information.

A physician or designee must be responsible for the development and implementation of a medical detoxification plan. The clinical aspects of the treatment plan should be implemented only by qualified personnel.

The plan should document a physician's decision regarding the following:

1) Access to a range of supportive and rehabilitation services.

2) Proper medications; and,

3) Referral to community resources.

The facility must provide for referral to community resources for use during inmate's incarceration and upon the inmate's release. A documented list of approved community resources must be available for staff. The facility and existing community resources should have a contract or letter of agreement, updated on at least a biennial basis, describing their relationship.

The medical record should reflect by documentation a physician's monitoring and responsibility for the case.

If a health professional determines that a person is addicted and poses a danger to themselves or others, transfer to a hospital may be initiated under W. Va. Code §27-5-2.

Alcohol Withdrawal Syndromes

An intoxicated person who is admitted to the jail often requires medical treatment. Heavy, long-time drinkers withdrawing from alcohol may suffer from the DT's (delirium tremens). The mortality rate for persons suffering from the DT's who do not receive proper medical treatment ranges from five to fifteen percent. Alcohol withdrawal can be more serious than withdrawal from many dangerous narcotics.

There are four alcohol withdrawal syndromes: tremulousness and hallucinations, seizures, auditory hallucinosis, and delirium tremens.

Tremulousness and Hallucinations

A tremulousness and hallucinations reaction usually begins from seven to eight hours after the inmate has had his last drink and attains maximum severity within 24 hours. The withdrawing inmate is overly alert, nervous, shaky, weak, has a flushed face, suffers a loss of appetite, and often has a rapid heart beat. Disordered perceptions, hallucinations, and delusions may be present. The inmate should be housed in a well lighted, individual cell away from noise and activity. Officers should watch such inmates carefully.

Treatment. The inmate may be disoriented; this can sometimes be overcome by talking to him/her or leaving a personal item in the cell, such as a picture from his/her wallet. The officer should explain to the inmate that he/she is a correctional officer carrying out normal duties and is there to help the inmates. It is best to contact the infirmary staff or a local doctor for advice on how to handle this inmate. The doctor may prescribe food or medication or recommend that the inmate be moved to a detoxification center or hospital.

Seizures

Seizures may occur within a 7 to 48 hour period after the inmate has stopped drinking. They are essentially grand mal, epileptic-like seizures and should be treated as such. Only from two to six seizures should occur during the 7 to 48 hour period and each seizure should not last more than five minutes.

Treatment. Surprisingly, a series of these seizures may not pose a serious medical threat. As each seizure occurs, the officer should treat it as a grand mal epilepsy attack. He should not restrain the inmate. However, the officer should observe the inmate carefully and make a complete written report to the jail medical staff or to local medical authorities. The officer should become concerned if the inmate seems to have one seizure after another without regaining consciousness or if each seizure lasts more than five minutes. If either of these conditions occurs, the inmate should be transferred to a hospital. Officers should also consider the situation to be a medical emergency if the seizures occur in conjunction with a high fever or with the DT's.

Auditory Hallucinosis

Between 12 and 48 hours after stopping drinking the inmate may have auditory hallucinations. When this occurs, the inmate usually will complain that he/she hears accusing voices which are persecuting him/her, but otherwise he/she may appear to be rational and alert.

Treatment. Officers should keep the inmate in a well-lighted cell, away from noise and activity. Since the inmate may be paranoid, officers might try to convince him/her that they mean no harm, that they are concerned, and that the voices he/she hears are the result of drinking and will eventually go away.

DT's (Delirium Tremens)

This is an extremely dangerous medical condition with a mortality rate of from 5 to 15 percent. DT's usually occur within 72 to 96 hours after the inmate has had his/her last drink.

The symptoms of delirium tremens are:

- Profound confusion and disorientation;
- Delusions;
- Vivid hallucinations;
- Tremor;
- Agitation;
- Autonomic overactivity (increased pulse and breathing);

- Pallor;
- Sweating;
- Possible terror or confusion;
- High fever with possible convulsions; and
- Vomiting.

Treatment. Transfer the inmate to a hospital immediately. While the officers are waiting for an ambulance to arrive at the jail, a hospital or jail physician may advise them to give the inmate emergency medical aid for high fever and convulsions if necessary; however, officers should not restrain an inmate who is suffering from convulsions. If the inmate is admitted to a jail infirmary, the infirmary staff should administer multivitamin pills and fluids within two hours from the time of admission. They should also keep the inmate well-hydrated.

Hard Narcotic Withdrawal Symptoms

Persons who are addicted to hard narcotics should reveal withdrawal symptoms such as vomiting and profuse sweating. Death is a potential if the habit has been severe and the withdrawal sudden. Medical advice must be sought.

Common heroin or opiate withdrawal symptoms which the jail officer should develop an ability to recognize are:

1. Mild Withdrawal (when only these signs are present)

   - Yawning
   - Eyes water
   - Nose runs
   - Sneezing
   - Excessive perspiration

2. Moderate Withdrawal (when these signs are added)

   - Loss of appetite
   - Dilated pupils
   - Tremor
   - Goose flesh

3. Marked Withdrawal (when these signs are added)

   - Deep breathing
   - Fever
   - Insomnia
   - Restlessness
   - Rise in blood pressure

4. Severe Withdrawal (when these signs are added)

   - Vomiting
   - Diarrhea
   - Weight loss
   - Convulsions

MANAGEMENT OF SEIZURES

First Aid for an Epileptic Seizure

1. Keep calm. The epileptic seizure itself is not dangerous. However, injuries may result from the fall. Do not attempt to stop the attack or revive the patient. Let the seizure run its course, usually a few minutes.

2. Ease the person to the floor, loosen tight clothing but do not restrain movements.

3. Turn the patient's face to the side to permit release of saliva and make certain that breathing is not obstructed. A folded coat, blanket, or pillow may be placed under the head.

4. Do not force open the clenched jaws. Do not force anything between the patient's teeth. Never place a finger in the mouth. Do not give the person anything to drink.

5. When the person falls to, or is helped to the floor, the tonic phase has started and will be seen as a rigidity or stiffness of the muscles. After a few seconds the seizure passes into the clonic phase. Rigidity is replaced by jerking movements involving the whole body. The lips and face may turn bluish, excessive salivary flow may occur.

6. The seizure is followed by fatigue, possibly a state of reduced awareness, or deep sleep. Do not leave the patient unattended, provide supportive reassurance, and allow the patient to rest in an appropriate place until he/she feels better.

7. Carefully observe the duration and details of the seizure so that this can be reported accurately to the medical staff.

8. Notify medical personnel and follow their instructions.

9. Immediate medical assistance is required if a physical injury is suffered, if the seizure is prolonged, or if more than one seizure occurs.

PROBLEM EVALUATION AND MANAGEMENT

The list of problems below is based on a two year long study of medical problems encountered at the St. Paul-Ramsey County Workhouse. These problems are those that were most frequently encountered and for which a variable degree of evaluation and/or management by the on-site health authority is considered appropriate. This was written in 1978 and is only meant as a guide for responsible physicians.

In developing the recommendations for evaluation and management, several factors were considered. These include the demonstrated roles of depression and over concern with bodily image in health-seeking behavior of incarcerated individuals, increased accessibility to health care personnel, and barriers to "over-the-counter" treatment of minor symptoms and problems.

Judgements regarding inmate's ability to return to work detail are not included in these recommendations. This decision must be made on a case by case basis, rather than on the basis of necessarily general guidelines.

Problem Designation	Evaluation and/or Management
Acne	If pustular and diffuse, schedule for physician visit. If mild or localized, prescribe phisohex washings b.i.d. (twice daily) for three weeks, recheck, schedule for physician visit if no better or worse.
Dermatoses (minor and localized skin problems of unknown cause)	Prescribe Neutra-derm to affected areas b.i.d. for one week, recheck, and refer to physician if no better or worse.
Sleep Disturbance	Advise inmate regarding the causative role of stress and tension and the benign nature of the disturbance. Suggest that he/she avoid daytime naps, participate in physical exercise, and/or reading a book before attempting to fall asleep. Recheck in three weeks. If no better or worse, prescribe such as Chloral Hydrate 30 cc. h.s. 3 x weekly for one week. Recheck in one week, if no better or worse, schedule for physican visit.
Common Cold	Take inmate's temperature and check throat. If throat is injected (with or without exudate), do a throat culture. If inmate is febrile, schedule for physician visit. If nasal congestion severe or bothersome, prescribe according to responsible physicians standing orders.

Sore Throat	Take inmate's temperature, check his throat for injection and the presence or absence of exudate, and check for cervical adenopathy. Do throat culture. Prescribe throat lozenges or throat spray p.r.n. (as necessary). 1. If inmate is febrile, schedule for physician visit. 2. For exudative pharyngitis/tonsillitis start penicillin by mouth (Pen Vee 400,000 units q.i.d.), if the patient is not allergic to penicillin and while awaiting the results of the throat culture. a. If throat culture is positive, continue oral penicillin for 10 days total. 3. If throat culture is positive and has not been started on penicillin, initiate a 10 day course of oral penicillin as noted above, or administer 1.2 million units of benzathine penicillin (if the patient is not allergic to penicillin). 4. Antibiotic alternative for penicillin-allergic inmates with positive throat cultures is erythromycin 250 mg. q.i.d. for 10 days. 5. Do post-treatment throat culture 1 week after completing oral antibiotics or 1 month after administering benzathine penicillin.
Injury to Upper Extremity	1. For injuries to fingers, hand, wrist, forearm, elbow. a. If accompanied by localized, tender swelling, obtain x-ray (at least 2 views) 1) Patients with positive x-rays will routinely be referred to the Emergency Room for management. 2) If x-ray is negative, prescribe aspirin 2 tab. every 6 hrs. as needed for pain for one week. 3) Recheck in one week and schedule for physician visit if no better or worse. b. If not accompanied by localized, tender swelling, and if

	pain is not severe, prescribe aspirin 2 tab. every 6 hrs. as needed for pain. Recheck in one week and schedule for physician visit if no better or worse. 2. For arm and shoulder. a. Unless the injury is severe and accompanied by definite swelling of the affected part, schedule for physician visit; otherwise, prompt consultation or referral to physician.
Injury to Knee	1. If pain and disability are marked, or swelling present, promptly consult with or refer to physician. 2. If pain and disability are mild, and no swelling present, prescribe Ace wrap during the day only for 5 days. Then recheck and schedule for physician visit if no better or worse.
Injury to Foot and Ankle	1. If accompanied by localized, tender swelling, obtain x-ray (at least 2 views). a. Inmates with positive x-rays are routinely referred to the Emergency Room for management. b. If x-rays are negative, prescribe Ace wrap, give aspirin 2 tab. every 6 hrs. as needed for pain, and schedule for physician visit. 2. If not accompanied by localized, tender swelling, and if pain is not severe, prescribe aspirin 2 tab. every 6 hrs. as needed for pain, and an Ace wrap. Recheck in one week and schedule for physician visit if no better or worse.
Injury to Extremities not covered above (hip, thigh, leg)	1. If pain and disability are marked, give aspirin 2 tab. every 6 hrs. as needed for pain and schedule for physician visit. 2. If pain and disability are mild, give aspirin 2 tab. every 6 hrs. as needed for pain, recheck in 1 week and schedule for physician visit if no better or worse.

Injury to Head or Neck	Inmates with any of the following warning symptoms or signs* will be promptly referred to or consult with a physician. 1. Loss of consciousness 2. Mental confusion or disorientation 3. Inappropriate behavior 4. Severe headache or severe pain at the site of injury 5. Open wound 6. Acute visual disturbance 7. Acute hearing loss 8. Blood noted in auditory canal(s) 9. Signs suggestive of nasal, maxillary, or mandibular fracture 10. Obvious swelling of the neck 11. Hoarseness or change in voice
Minor Injuries to Head or Neck	Review warning symptoms and signs (see above) with inmate. Prescribe aspirin 2 tab. every 6 hrs. as needed for pain and recheck in 24 hrs. Promptly refer to or consult with physician if any of the warning symptoms and signs are present. If warning signs and symptoms not present but inmate is no better or worse, schedule for physician visit.
Pain of Head, Neck, Trunk, and Extremities	For pain with the following characteristics: 1. Of apparent musculoskeletal origin. 2. Not of acute onset. 3. Mild to moderate in severity. 4. Not disabling. 5. Not related to recent trauma. 6. Not accompanied by associated physical findings (swelling, new deformity, etc.), Prescribe aspirin 2 tab. every 6 hrs. as needed for pain. Recheck in 1 week, schedule for physician visit if no better or worse.

*This list is not intended to be all inclusive. Other less common and more serious head and neck injuries may occur. The seriousness of such injuries and the need for prompt physician or hospital referral are usually obvious.

Non-specific eye complaints	For eye complaints with the following characteristics: 1. "Burning" or "tired" 2. Not of acute onset 3. Not associated with visual disturbance 4. Not related to recent trauma or foreign bodies 5. Not accompanied by pain 6. Not accompanied by obvious physical findings (inflammation, discharge, localized lesions, etc.) Prescribe methylcellulose, 2 drops in each eye 4 times a day for 5 days.
Headache	For headaches with the following characteristics: 1. Not severe 2. Not of acute or recent onset 3. Not unilateral 4. Not preceeded by an aura 5. Not related to recent trauma 6. Not associated with visual disturbance, tearing of the eyes, nausea, vomiting, or mental confusion or disorientation. Prescribe aspirin 2 tab. every 6 hrs. as needed. Recheck in 1 week, schedule for physician visit if no better or worse.
Abdominal Pain	For abdominal pain with the following characteristics: 1. Not of acute or recent onset 2. Not severe 3. Not localized to the periumbilical area or right lower quadrant 4. Not accompanied by fever, chills, jaundice, nausea, vomiting, diarrhea, or abdominal distension 5. Not related to recent trauma 6. Not distinctly and consistently related to meals or time of day Prescribe acetaminophen (Tylenol®) 2 tab. every 6 hrs. as needed for pain for 1 day. Recheck within 24 hrs. If any of the characteristics noted above are present, promptly refer to or consult with physician. If none of these characteristics have developed, schedule for routine physician visit.

Impacted Cerumen	1. If wax is soft and moderate in amount, irrigate gently with ear syringe. 2. If wax is hard and large in amount, prescribe Debrox, 2 drops in each ear B.I.D. for 1 week, and then irrigate gently with ear syringe. 3. Check hearing and tympanic membranes after wax has been removed. Schedule for physician visit if findings are abnormal or equivocal.
Depression	1. If inmate appears moderately or severely depressed, inquire about the presence of suicidal thoughts. If patient responds affirmatively, alert appropriate correctional personnel, and schedule for physician visit. 2. If inmate appears mildly depressed, schedule for physician visit.

GUIDE TO MEDICATION DISTRIBUTION

Staff shall administer medications only after receiving approval from the responsible physician. Medications shall be stored in a secure place and refrigerated when necessary. Medication must be taken in the presence of jail staff. (Exceptions are made for oral contraceptives which, after verification of the medication, may be given to the resident to keep in her cell for self-administration).

When medications are taken by mouth, staff shall observe swallowing and have resident speak after swallowing and watch for several minutes to assure ingestion of medication.

Any resident who refuses medication will sign a statement to that effect, which will be filed in the health file. The health professional who prescribed the medication shall be consulted and their instructions followed, recorded and kept in the health file.

Prescription medications: Distribution of prescribed medication shall be according to directions printed on the medication container. The medication log shall be filled out by staff after all distributions. The log will be kept in the residents health file.

Non-prescription medications: Shall be administered for the following symptoms and times specified.

Simple headache:	2 aspirin or ( ) every four hours, NOT TO EXCEED 8 PER A 24 HOUR PERIOD.
Simple cough:	2 teaspoons ( ) every four hours, NOT TO EXCEED 6 DOSES PER A 24 HOUR PERIOD.
Athlete's foot:	( ) powder as needed.
Superficial cuts:	1 bandage (band-aid) every 12 hours, NOT TO EXCEED A 36 HOUR PERIOD.

If symptoms persist after these designated periods the responsible physician will be called. Documentation of the administration of non-prescription medications will be completed in the same manner as for prescription medications.

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