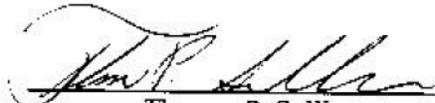


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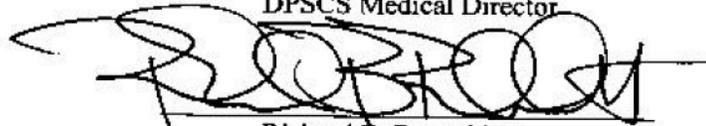


INFIRMARY CARE MANUAL

Date Issued:	01/07/2008
Dates Reviewed:	07/15/2008
	09/29/2009


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All Policies and Procedures will be reviewed, at a minimum, annually by Office of Inmate Health Services Staff

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

INFIRMARY CARE MANUAL

Chapter 1
INFIRMARY CARE GENERAL

I. Policy:

All inmates in DPSCS regional infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures.

II. Procedure:

- A. Any inmate housed as a patient in the infirmary for treatment, observation or other medical care shall be placed on medical hold.
- B. All DPSCS infirmaries shall be licensed by the State of Maryland and maintain DHMH certification of bed capacity.
- C. All respiratory isolation beds will be maintained, inspected, and certified by the Department of Public Safety and Correctional Services industrial hygienist and contracted consultants as referenced under the institutional and facility directives that govern this equipment. The State Medical Director or a designated health professional will determine the clinical indications for admission as referenced in the Office of Inmate Health Services Manual, DPSCS Medical contract, guidelines established by the Center of Disease Control, National Institute of Occupational Safety and Health (NIOSH, and Occupational Safety and Health Administration (OSHA), etc.
- D. All DPSCS infirmary operations shall be promulgated in accordance with the following guidelines:

Patient Acuity Determination Process.

- 1. A specific index shall be used to determine nursing staffing of the infirmary. The index is used to determine nursing staffing needs and to allocate necessary resources to match patient care needs. Every DPSCS Infirmary operation will include this analysis, as a daily routine procedure, in a log format available for DPSCS review.

2. Levels of Inmate Acuity include:

- Level 1:
 - Inmates requiring minimal assistance with their Activities of Daily Living (ADL).
 - Inmates whose blood condition is stable as well as inmates requiring standard IV lines and solutions.
 - Inmates requiring minimal teaching and psychosocial support.

- Level 2:
 - Inmates requiring routine dressing changes every two (2) hours and vital sign readings.
 - Inmates requiring moderate assistance with ADL.

- Level 3:
 - Inmates receiving blood transfusions, chemotherapy, on-going tube feedings, and continuous use of oxygen.
 - Inmates whose conditions warrant complex medication administration, conditions that include the first 24 hour observation of a post-operative period, extensive assistance with ADL, and; discharge planning and assistance.

- Level 4:
 - Inmates who are medically unstable and require total assistance with ADL.
 - Inmates housed in respiratory isolation units requiring special procedures and precautions.
 - Inmates requiring chest tubes, those inmates that have behavioral challenges, and those requiring the use of restraints.

3. A patient classification form is used to determine patient acuity (See Infirmery Care Acuity Tool)

- a. The patient classification form is placed on each infirmery patient chart; and is checked each shift with changes noted and is transferred to the staffing form. Staffing needs are determined from acuity calculations. Management will be notified if additional staffing is needed for any shift.

- b. Day shift: (8am-4pm) will determine acuity and shall plan staffing for the oncoming shift by 2:00 pm.
- c. Night shift: (12 mid-8am) will determine acuity and plan staffing for the oncoming shift by 6:00 am
- d. Point system – Acuity Tool: Patient Assessment

<u>Classification/Acuity</u>	<u>Points</u>
Confused/Disoriented Retarded/Unconscious	15
Vital Signs oftener than four (4) hours	12
Special Teaching Needs	12
Special Education Needs	12
Continuous Observation	12
Incontinent/Diaphoretic	12
Sensory Deficits	8
Mobility Assistance	6
Respiratory Therapy (Oxygen)	6
Wound Skin Care	6
Provide Total Bath	5
Provide nourishment	5
Intravenous fluids/lines	5 (each)
Tubes/Drains	3 (each)
Total Points	_____

4. Patient Classification Summary

Type I	0-2	Points
Type II	21-40	Points
Type III	41-70	Points
Type IV	71+	Points

- 5. Consideration for additional staff will be advised if one RN has to care for more than two “Level 4” inmates (See Levels of Acuity Section A Infirmary Care-General) for defining Level 4 inmates); and must be supported by the evaluation of need. The level of the additional inmate services required, and evaluation of needs, will determine the level of additional providers to be considered.

- 6. Patient Classification For a Level Increase Additional Staff Consideration includes:

- a. Consideration of an additional CMA for Levels 1-2. Maximum of four (4) admissions.
 - b. Consideration of an additional LPN for Level 3. Maximum of two (2) admissions
 - c. Consideration of an additional RN for Level 4. Maximum of 2 admissions.
 - d. One RN and one LPN will staff each shift
7. An infirmary log shall be maintained at each infirmary. It will include the following:
- a. The name, Identification number, admission and discharge diagnosis, disposition date and time of each infirmary admission, discharge and community emergency room transfer and release.
 - b. Identification of all pregnant women on the infirmary listing;
 - c. A census report shall be made available, via e-mail, to a Utilization Management designee daily (no later than 4 pm copying the Director of Inmate Health and the ACOM.)
 - d. A census report of all pregnant women shall be submitted to the Office of Inmate Health Services (OIHS) on a monthly basis. The report shall include the name, identification number, last menstrual period (LMP) trimester of gestation and estimated date of confinement, Rapid Plasma regain (RPR), HIV status, high risk complications and methadone maintenance.
8. The infirmary audits will be conducted by the contractor as referenced by the (Continuous Quality Improvement (CQI) calendar.

III. References:

- A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
- B. NCCHC – Standards for Health Services in Prisons -2003
- C. NCCHC –Standards for Health Services in Jails -2003
(*J-G-03/P-G-03 Infirmary Care*)
- D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al – 1999
- E. DPSCSD 130-100, Section 160 – Do Not Resuscitate

- F. ACA Standards for Adult Correctional Institutions – 4th Edition and ACA 2006 Standards Supplement
 - G. DPSCS Infectious Disease Manual
 - H. Advanced Directive/Living Will
 - I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227 aR)
 - J. Appendix 2 DPSCS Infirmary Discharge Form (130-21aR)
 - K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)
 - L. Appendix 4 Infirmary Care Acuity Tool
- IV. Rescissions: DCD 130-100 Section 120, March 1, 1994
- V. Date Issued: July 15, 2007
- VI. Date Reviewed: September 17, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

INFIRMARY CARE MANUAL

Chapter 2
ADMISSIONS PROCEDURE

I. Policy:

All inmates in DPSCS infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures.

II. Procedure:

- A. Inmates for whom off-site hospital care is not medically necessary but who require skilled nursing care and daily evaluation of their medical condition by a clinician will be placed in the infirmary for comprehensive care. These inmates will have vital signs measured as ordered by a clinician but at least every shift and shall be weighed at least weekly.
- B. Inmates shall be evaluated for admission to the infirmary by a licensed clinician. An order, verbal or written by a provider must be completed before an inmate receives treatment in an infirmary setting. A midlevel provider shall have any admission order co-signed within twenty-four (24) hours by a provider.
- C. Prior to transferring an inmate to the infirmary documentation of a discussion of the case with the chief medical officer by the clinician referring the inmate for admission shall be done.
- D. Within twenty-four (24) hours of notification of an admission into a mental health infirmary a medical consultation shall be completed and will include the following documentation:
 - 1. Suspected diagnosis
 - 2. Stability /condition
 - 3. Diet; activity
 - 4. Vital signs

5. Admitting laboratory tests if indicated
 6. Chronic care medications
 7. Problem list
 8. Other physician orders pertinent to the admitting diagnosis
 9. History and physical examination shall be documented on the medical record by a clinician within twenty-four (24) hours of admission to the infirmary utilizing the DPSCS Infirmary Admission History and Physical Form.
 10. Discharge summary of an inmate from the infirmary will be completed by a physician by using the DPSCS Infirmary Discharge form within twenty-four (24) hours of discharge.
- E. A physician's evaluation including an individualized treatment plan shall be documented in the infirmary medical record within twenty four (24) hours of the infirmary admission.
- F. Daily progress notes by the provider shall be done and any abnormal laboratory tests or X-rays shall be addressed in the progress notes and the documentation signed with the provider's title, date and time of day.
- G. A nursing care plan shall be developed and documented in the infirmary medical record within twenty-four (24) hours of the infirmary admission,
- H. Inmates who require monitoring or care by a licensed nurse for less than twenty-four (24) hours are eligible for observation status. Such inmates include but are not limited to:
1. Pre-operative or pre-procedure inmates requiring NPO (nothing by mouth) status or preparation of post hospital discharge inmates who require evaluation prior to return to housing
 2. Inmates recovering from a clinical condition that rendered them temporarily unstable or altered state of consciousness (seizure or an insulin reaction, or other conditions). These inmates will be monitored and evaluated for stability with vital signs measured until considered out of risk by the admitting clinician
- I. Inmates who cannot independently complete their activities of daily living due to chronic medical condition or advanced age are eligible for sheltered housing status. Nursing staff will provide necessary assistance

with activities of daily living. These inmates will be evaluated at least monthly by a clinician and have a documented progress note along with vital sign measurement to include weight.

- J. Inmates refusing to eat or who have an acute exacerbation of a chronic mental illness are eligible for infirmary admission at the direction of a psychiatrist or somatic clinician. These inmates will be seen daily by a mental health professional and a somatic clinician and have vital sign measurement and nursing assessment on each shift.

III. References:

- A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
 - B. NCCHC – Standards for Health Services in Prisons -2003
 - C. NCCHC –Standards for Health Services in Jails -2003
(*J-G-03/P-G-03 Infirmary Care*)
 - D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al – 1999
 - E. DPSCSD 130-100, Section 160 – Do Not Resuscitate
 - F. ACA Standards for Adult Correctional Institutions – 4th Edition and ACA 2006 Standards Supplement
 - G. DPSCS Infectious Disease Manual
 - H. Advanced Directive/Living Will
 - I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227 aR)
 - J. Appendix 2 DPSCS Infirmary Discharge Form (130-21aR)
 - K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)
 - L. Appendix 4 Infirmary Care Acuity Tool
- IV. Rescissions: DCD 130-100 Section 120, March 1, 1994
- V. Date Issued: July 15, 2007
- VI. Date Reviewed: September 17, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

INFIRMARY CARE MANUAL

Chapter 3
MEDICAL MANAGEMENT OF INFIRMARY PATIENTS

I. Policy:

All inmates in DPSCS regional infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures.

II. Procedure:

A. Infirmary patients shall be medically managed in accordance with the following guidelines; dependent upon the level of infirmary care.

B. All DPSCS infirmaries shall have a licensed physician assigned the responsibility of the medical management of infirmary patients who will ensure compliance with the Office of Inmate Health Services Manual and the DPSCS medical contract.

C. All DPSCS infirmaries shall have twenty-four (24) hour physician on-call coverage daily except whereby contract or circumstances on-site provider services are available 24/7. At a minimum, the infirmary medical director shall be on-site within the infirmary area in accordance with the DPSCS medical contract designated hours.

D. All DPSCS infirmaries shall have twenty-four (24) hour on-site nursing coverage daily by a registered nurse within the infirmary area. If there is more than one (1) floor of infirmary beds in the facility, an RN specifically assigned to that floor will cover a designated infirmary area.

E. All inmates housed in the infirmary for comprehensive care shall have a nursing assessment once every shift documented in the medical record to include: (S) subjective data, (O) objective data, (A) assessment, and (P) treatment care plan.

F. All inmates housed in the infirmary, except those who are in “sheltered housing”, shall have a clinician assessment documented daily in the progress notes.

- G. Progress notes shall include patient education and specific instructions as to disease process referenced. They shall include documentation of review of all laboratory testing, X-rays, and consultations that are abnormal with a plan of action or recommendation. The date and time of the note will be documented and signed by the writer/provider.
- H. Nursing staff shall conduct safety and sanitation inspections on a daily basis to ensure a safe infirmary environment.
- I. Inmates shall be admitted and discharged to infirmary isolation units and medically managed in accordance with the Office of Inmate Health Services Manual.
- J. The attending physician shall discuss medical treatment options with all terminally ill inmates admitted to the infirmary in accordance with the Office of Inmate Health Services Manual (Do Not Resuscitate).

III. References:

- A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
- B. NCCHC – Standards for Health Services in Prisons -2003
- C. NCCHC –Standards for Health Services in Jails -2003
(*J-G-03/P-G-03 Infirmary Care*)
- D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al – 1999
- E. DPSCSD 130-100, Section 160 – Do Not Resuscitate
- F. ACA Standards for Adult Correctional Institutions – 4th Edition and ACA 2006 Standards Supplement
- G. DPSCS Infectious Disease Manual
- H. Advanced Directive/Living Will
- I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227 aR)
- J. Appendix 2 DPSCS Infirmary Discharge Form (130-21aR)
- K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)
- L. Appendix 4 Infirmary Care Acuity Tool

- IV. Rescissions: DCD 130-100, Section 120, March 1, 1994
- V. Date Issued: July 15, 2007
- VI. Date Reviewed: September 16, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

INFIRMARY CARE MANUAL

Chapter 4
TRANSFERS

Section 1
Somatic Infirmary

I. Policy:

All inmates in DPSCS regional infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures.

II. Procedure:

A. Inmates admitted to the infirmary who develop problems that cannot/should not be managed in the infirmary setting, shall be immediately transferred to an appropriate hospital for care.

B. A transfer note summarizing the medical indications for hospitalization shall be documented in the progress notes by a clinician and appropriate information regarding the inmate's condition including a copy of an advanced directive may accompany the inmate.

C. All inmates discharged from a community hospital for inpatient services shall be transferred to a DPSCS infirmary for evaluation in accordance with the following guidelines:

1. All inmates shall be evaluated by a physician upon transfer from the community hospital. (Patients returning from an emergency room visit who were admitted will be managed under the OIHS Manual Emergency Services).

2. The physician shall determine if infirmary admission is medically indicated or if the inmate can be housed in the general population. The indication not to admit the inmate to the infirmary must be documented in the medical record. Any inmate who returns to a site where no clinician is available, to assess the inmate for infirmary admission, must be evaluated by the infirmary nurse who will contact the on-call physician, review the case and document the decision not

to admit the inmate or take a verbal admission order. The provider must follow-up and sign the order within twelve (12) to twenty-four (24) hours and see the inmate at the first available time period.

3. A review of the treatment recommendations by the discharging physician of the community hospital should be documented in the medical record in the form of a progress note, for all inmates who are admitted to the infirmary upon return. Failure to comply with any recommended treatment should be documented in the medical record with the alternative treatment considerations.

D. All inmates admitted to the infirmary shall be placed on “Medical Hold” by the regional medical director or his/her designee through a written order on the medical record. Case Management shall be notified using the designated forms.

E. Inmates may be transferred from one DPSCS infirmary to another only with the pre-approval of the DPSCS medical director or his/her designee. Phone permission/e-mail by the DPSCS Medical Director/Designee should be followed by written documentation and placed in the infirmary medical record. The regional Agency Contract Operations Manager (ACOM) should be made aware of the transfer. The medical provider shall follow the “Notification Cascade” to include the following:

1. Security
2. Case Management
3. Warden’s Office
4. Agency Contract Operations Manager

F. Tuberculosis isolation cell transfers must include the Infectious Disease Director and the Infectious Disease coordinators for the regions. Any inmate occupying a respiratory isolation bed who is not a “rule out TB” case will be removed if the need for a respiratory bed arises in that region before transfers to alternative regions will be done.

G. Non TB observation patients who are temporarily housed in respiratory isolation units must be reported to the DPSCS TB Coordinator as soon as possible by cell phone, pager, voice mail as we move inmates twenty-four (24) hours a day, seven (7) days a week including holidays and weekends. It is the responsibility of the medical provider, who made the decision, to make certain the facility Infection Control Administrator is informed of the admission to the respiratory isolation unit who in turn shall alert DPSCS of the admission to the respiratory isolation unit.

- H. Documentation shall be provided to the Agency Contract Operations Manager of Hand Washing, Universal Precautions for Nursing, and Custody and inmate worker staff training on a scheduled quarterly basis through in-service training shall be made available to the Agency Contract Operations Manager.
- I. Telemedical infirmary patients (TB, HIV etc.) who are admitted to an infirmary who are HIV positive and have not been presented for HIV telemedicine consultation will be incorporated into the next scheduled telemedical conferencing through coordination with the Regional Infectious Disease Coordinator. The attending physician will present the clinical information without the inmate in attendance if circumstances prevent it. The provider will make sure that all the information required by the HIV directive (laboratory tests, medications, old medical record information, etc) has been provided to the Infectious Disease Consultant at least one week prior to the presentation of CD4 count, viral load, primary diagnosis, medication regime, scans, and liver function.

III. References:

- A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
- B. NCCHC – Standards for Health Services in Prisons -2003
- C. NCCHC –Standards for Health Services in Jails -2003
(*J-G-03/P-G-03 Infirmary Care*)
- D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al – 1999
- E. DPSCSD 130-100, Section 160 – Do Not Resuscitate
- F. ACA Standards for Adult Correctional Institutions – 4th Edition and ACA 2006 Standards Supplement
- G. DPSCS Infectious Disease Manual
- H. Advanced Directive/Living Will
- I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227 aR)
- J. Appendix 2 DPSCS Infirmary Discharge Form (130-21aR)
- K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)
- L. Appendix 4 Infirmary Care Acuity Tool

- IV. Rescissions: DCD 130-100 Section 120, March 1, 1994
- V. Date Issued: July 15, 2007
- VI. Date Reviewed; September 22, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

INFIRMARY CARE MANUAL

Chapter 4
TRANSFERS

Section 2
Mental Health Infirmary

I. Policy:

All inmates in DPSCS mental health infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures.

II. Procedure:

A. Inmates admitted to an infirmary who develop problems that cannot/should not be managed in the infirmary setting, shall be immediately transferred to an appropriate hospital for care.

B. A physician shall determine if a mental health infirmary admission is medically indicated or if the inmate can be housed in the general population or has other special housing needs. The indication not to admit the inmate to a mental health infirmary must be documented in the medical record. Any inmate who returns to a site where no clinician is available, to assess the inmate for infirmary admission, must be evaluated by the infirmary nurse who will contact the on-call physician, review the case and document the decision not to admit the inmate or take a verbal admission order. The provider must follow-up and sign the order within twelve (12) to twenty-four (24) hours and see the inmate at the first available time period.

C. Inmates may be transferred from one DPSCS infirmary to another only with the pre-approval of the DPSCS medical director or his/her designee. Phone permission/e-mail by the DPSCS Medical Director/Designee should be followed by written documentation and placed in the infirmary medical record. The regional Agency Contract Operations Manager (ACOM) should be made aware of the transfer. The medical provider shall follow the "Notification Cascade" to include the following:

1. Security

2. Case Management
3. Warden's Office
4. Agency Contract Operations Manager

D. Procedures specific to persons transferring to a mental health setting primarily for mental health services include the following:

1. Understanding that these patients may not be known to medical personnel serving the facility, and may have unknown medical or psychiatric illness, the examining clinician will perform an in depth medical evaluation and/or refer to emergency room (ER) to rule out medical causes of altered mental status changes such as intoxication or intracranial lesions if the examination suggests an indication for such a referral within twelve (12) hours prior to transfer.
2. Known medical problem will be evaluated during the medical evaluation to ensure that care can be adequately managed in the inpatient mental health unit or other mental health area.
3. An intoxicated or confused patient will require a medical evaluation appropriate to their current medical condition.
 - a. Intoxicated patients shall not be transferred to a mental health inpatient unit until the condition is resolved or diagnosed.
 - b. The intoxicated patient shall be stabilized for a minimum of twenty-four (24) hours or until an alternative disposition has been agreed upon by medical and mental health clinicians.
4. Much of the necessary information will already be in the medical record of a known patient, but the information will need to be included in the transfer summary using the form described above. The medical clearance examination should include the following at a minimum:
 - a. History of presenting illness
 - b. Review of systems

- c. History of allergy with the clinical result of contact with those allergens, past medical history and family history
 - d. Physical examination sufficient to screen for major medical problems
 - e. Mental status examination
 - f. Lab- dependent on medical condition or clinical presentation
- E. The medical clearance shall be completed by a medical provider if available onsite.
- F. In the event that a provider is not onsite an alternative process may be employed allowing the on-site registered nurse to provide medical clearance only once all of the steps below are completed.
- 1. This alternate process shall include completion of the Transfer Screening Form from information in the patient medical record.
 - 2. This alternative process shall occur only after the nurse has consulted by telephone with the on-call physician and shared the following:
 - a. A complete description of the events regarding the patient's condition leading up to the call,
 - b. A report of the patient's vital signs to include blood pressure, temperature, pulse, respirations, and oxygen saturation,
 - c. A report of any chronic, substance abuse, or mental health problems noted in the patient's problem list,
 - d. What behaviors prevent the care of the patient in his or her usual setting until a physician arrives for his or her scheduled assignment.
 - e. The date of the most recent assessment by a medical provider,
 - f. Who from the Mental Health staff has been apprised of the pending transfer including the source for the suggestion to make the transfer.

- g. The nurse will document the conversation in the patient's EMR and will include the date and time of the conversation along with any orders received by the physician via the telephone call. Orders to make the transfer will be transcribed as verbal orders and the clinician will seek the record the next time he or she is on site and countersign those orders following EMR processes.
3. The alternate process shall require that the on call medical provider complete the following before arrangements are made for the transfer:
 - a. The on call provider will contact the designated psychiatrist on call and advise him or her of any known medical concerns about the patient to be transferred.
 - b. Refer any conflict regarding the need for the transfer that cannot be resolved by the discussion (medical to psychiatry) to the regional medical director and the chief psychiatrist who will resolve the issue.
 4. In the event of an absence of bed availability, the patient shall be sent to the IMHU where five beds have been designated for observation, or to a safe cell in the distant SDAs (ECI, Hagerstown, and Western facilities)
- G. Medical and Psychiatric providers will discuss the case prior to the transfer, regardless of the time of day or the day of the week. That conversation will include at a minimum:
1. Any concerns by the receiving facility that may not have been covered on the transfer form.
 2. Any projections that may be available upon initial examination at the receiving site regarding a return to the sending facility.
 3. Patuxent transfers that have been medically cleared must have prior approval from the medical director for that facility or his/her designee. No transfer shall occur until this is done.

III. References:

- A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
- B. NCCHC – Standards for Health Services in Prisons -2003

C. NCCHC –Standards for Health Services in Jails -2003
(*J-G-03/P-G-03 Infirmary Care*)

D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al – 1999

E..ACA Standards for Adult Correctional Institutions – 4th Edition and ACA 2006
Standards Supplement

IV. Rescissions: None

V. Date Issued: September 29, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

INFIRMARY CARE MANUAL

Chapter 5
INFIRMARY CARE DISCHARGES

I. Policy:

All inmates in DPSCS regional infirmaries shall have standardized indications for admission and discharge and shall be monitored by nursing and medical providers in accordance with the requirement of health care contracts, law, and regulation and established procedures.

II. Procedure:

A. Infirmary Discharges

1. An inmate may be discharged only if ordered by a licensed physician.
2. A physician will summarize the patient's treatment plan and need for scheduled follow up in a discharge note documented on the discharge summary within 24 hours of inmate's discharge from the infirmary. (Discharge Summary form).
3. The infirmary physician will communicate the discharge plan to the receiving physician before the discharge.

B. Infirmary to Infirmary transfers

1. A Regional Medical Director, after consultation with DPSCS Medical Director, can request transfer of an infirmary patient to another region. At a minimum, prior to the transfer, the following needs to be completed.
2. Both regional medical directors need to document the request via e-mail and summarize the points supporting the need for transfer and copy the Office of Case Management at Reisterstown Road Plaza after a verbal request to the DPSCS medical director/designee. The following information required may be faxed to the receiving infirmary and the office of the DPSCS Medical Director.

- a. Problem list
- b. Admission history and physical
- c. Most recent progress notes
- d. Short discharge transfer note
- e. Most recent Medication Administration Record (MAR)
- f. Any medical consultations pending or special requests, such as durable medical equipment

III. References:

- A. DHMH COMAR 10.07.12 Health Care Facilities within Correctional Institutions
- B. NCCHC – Standards for Health Services in Prisons -2003
- C. NCCHC –Standards for Health Services in Jails -2003
(*J-G-03/P-G-03 Infirmary Care*)
- D. Clinical Practice in Correctional Medicine; Michael Puisis D.O. et al – 1999
- E. DPSCSD 130-100, Section 160 – Do Not Resuscitate
- F. ACA Standards for Adult Correctional Institutions – 4th Edition and ACA 2006 Standards Supplement
- G. DPSCS Infectious Disease Manual
- H. Advanced Directive/Living Will
- I. Appendix 1 DPSCS Infirmary Admission History and Physical Form (130-227 aR)
- J. Appendix 2 DPSCS Infirmary Discharge Form (130-21aR)
- K. Appendix 3 DPSCS Infirmary, Short Stay Form (130-230a)
- L. Appendix 4 Infirmary Care Acuity Tool

IV. Rescissions: DCD 130-100, Section 120, March 1, 1994

V. Date Issued: July 15, 2007

VI. Date Reviewed: September 22, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

INFIRMARY CARE MANUAL

Chapter 6
Reports

Mandatory State Report On Infirmary Bed Days and Infirmary Admissions

I. Policy:

All reports to DPSCS (the Department of Public Safety and Corrections) from all of its vendors/contractors regarding regional infirmaries shall have standardized practices and employ consistent definitions regarding those reports.

II. Procedure:

A. Maryland Department of Public Safety and Corrections recognizes that the contract with vendors to provide medical care to its detainees and inmates identifies beds in the Service Delivery Areas (SDAs) as follows:

1. Baltimore has

- a. 48 infirmary beds at MTC
- b. 12 infirmary beds (shared with mental health) at BCDC for females
- c. An additional 6 respiratory isolation beds at MTC

2. Eastern has

- a. 22 infirmary beds
- b. An additional 4 respiratory isolation beds that can be expanded to 24 in an emergency

3. Jessup has

- a. 24 infirmary beds at MCI-W
- b. 22 Infirmary beds at JRH

- c. 6 infirmary beds at JCI
- d. An additional 6 respiratory isolation beds at MCIW
- e. An additional 6 respiratory isolation beds at MHCX

4. Western has

- a. 17 infirmary beds at MCIH
- b. 28 beds at WCI
- c. An additional 5 respiratory isolation beds in Hagerstown
- d. And 12 respiratory isolation beds in Cumberland

- B. There are an additional 262 beds for mental health infirmaries, and reports on the use of these beds shall replicate that described for the beds enumerated above.
- C. All vendors will use the same reporting time period, a calendar month specifically dates 1 through 28, 29, 30 or 31 (dependent upon the number of days in a specific month) for each month. "Hybrid" months (those beginning in one calendar month and cycling through the next) will not be accepted.
- D. An infirmary bed day will occur from 12:01 A.M. through Midnight of a stated day.
- E. Infirmary bed days will be defined as one bed equals one day, regardless of the number of hours occupied or the number of persons that used the same bed within a twenty-four hour period.
- F. Infirmary admissions will be defined as the individuals admitted to the infirmary for any of the acceptable reasons for infirmary admissions. There may be multiple admissions to one bed within any given day, and this number will address that issue.
- G. Specific steps that the vendors will take to ensure that all numbers are accurately recorded and retrievable for future reference include:
 - 1. The medical and mental health vendors will maintain all infirmary occupancy in electronic format. That electronic log will include at a minimum for each inmate patient:

- a. The Inmate/Detainee's name and DOC (Department of Corrections) number, and date of birth,
 - b. The date and time of admission to the infirmary,
 - c. The admitting clinician,
 - d. The Inmate's admitting diagnosis,
 - e. Other known diagnoses of the inmate,
 - f. A notation of any infectious processes,
 - g. The designated acuity level of each infirmary patient using approved acuity scale developed by the Department and updated daily which can be found in Chapter One of this manual (General Infirmary Procedures), and
 - h. Date of discharge once known.
2. Medical and mental health vendors will transmit their electronic logs to the utilization management vendor daily by 9:00 a.m. for the previous day. This will occur Monday through Thursday. The Friday, Saturday, and Sunday reports will be submitted by 9:00 a.m. on the following Monday each week.
 3. Vendors will include in the submission to the utilization management company a statement of occupancy and vacancy regarding infirmary beds to include the number of beds in each infirmary, the number occupied, and the number vacant each day. Any beds that are considered to be out of service for any reason must be named and the reason described.
 3. The utilization management vendor will collate the material and develop a report for DPSCS from those logs and will submit that report to DPSCS by the fifth day of the month following the month that reflects the information in that report.
 4. Electronic logs will be stored on dedicated "flash drives" or at the vendors' headquarters that will be produced upon demand by DPSCS Office of Inmate Health for the purposes

of auditing, inquiries by oversight bodies, or any other reason for which they may be needed.

H. Medical and mental health staff maintaining logs will receive additional training and oversight to assure that the accepted transfer of information is made to the UM vendor on a daily basis.

- III. References: Maryland State Stat Discussions/Recommendations
- IV. Rescissions: None
- V. Issued: September 17, 2008
- VI. Reviewed: September 22, 2009