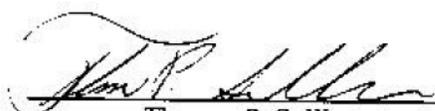


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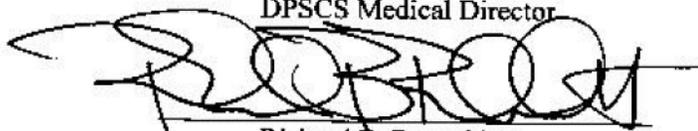


MEDICAL EVALUATIONS MANUAL

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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

MEDICAL EVALUATIONS MANUAL

Chapter 1
MEDICAL INTAKE

Section 1A
Medical Intake Process Part I: The IMMS

I. Policy:

All inmates newly admitted to DPSCS facilities shall receive a medical intake evaluation immediately upon an inmate's entrance from the community that will:

Identify and address any urgent medical/mental/dental health needs of those arrestees/detainees/inmates: *Admitted to any DPSCS facility and/or are transferred from a Pre-Trial facility to Patuxent Institution or a Division of Correction facility.*

Identify and triage arrestees/detainees/inmates with known or easily identifiable chronic health needs that require medical intervention.

Identify and isolate arrestees/detainees/inmates who appear potentially contagious or have communicable diseases.

Identify and facilitate intervention for arrestees/ detainees/inmates who may be at risk for suicide.

Identify and facilitate intervention for arrestees who have a history of acute or persistent and serious psychiatric illness.

Identify at an earlier time arrestees/detainees/ inmates who may be at risk for heat related health issues if placed in non-air conditioned environments

II. Procedures:

A. Initial Intake Processing:

1. Initial Intake screening shall be conducted by an RN or higher medical level staff in collaboration with correctional officers and remaining medical and mental health staff. The processing shall include the following:

- a. All arrestees shall have an initial observation screening by the RN before being accepted into Intake facilities.
 - i. The full screening as described below will not proceed unless the arrestee is deemed acceptable for continued detention secondary to an observed medical or mental health condition that would prohibit continuation of the process.
 - ii. Any inmate who presents to Intake sally port unconscious, semi-conscious, bleeding or otherwise obviously in need of immediate medical attention shall be identified prior to screening completion, rejected for admission, and referred to an Emergency Department for care.
- b. This process shall be completed upon arrival to the facility, prior to custody exchange, while the patient is still in the custody of Baltimore City Police to ensure that the arrestee is medically and mentally stable to complete the booking process.

B. Completion of the Intake Screening Process

1. The Intake Screening Process shall be completed by an RN or higher level of staff once it is determined that the arrestee/detainee can be admitted, i.e., has no medical condition that would prohibit admission.
 - a. Medical personnel will screen all arrestees for medical/mental illness using a form approved by the Office of Inmate Health Services. Information shall be entered into the Electronic Medical Record when possible and an OIHS approved paper form will be completed when EMR is not available
 - b. Intake Screening shall be conducted within 2 hours of admission for any inmate being admitted from the community or for any inmate being transferred from another facility who has not been so screened.
2. Intake Screening shall be conducted as an individual and confidential interview for both medical and mental health issues shall include the following:
 - a. Measurement and documentation of vital signs including:

- i. A blood pressure measurement using a wrist cuff in the event that handcuffs cannot be removed,
 - ii. Temperature,
 - iii. Pulse,
 - iv. Respirations,
 - v. A finger-stick glucose reading on all known or suspected persons with diabetes,
 - vi. A pulse-ox measurement and a peak flow rate measurement when there is an indication or suspicious of respiratory problems,
 - vii. A pregnancy test on all females of child-bearing age (ages 12 through 65) entering the facility.
- b. Nurse will question the arrestee/detainee regarding the presence of any known chronic or acute health conditions and will determine if any medications are currently being used.
- i. Nurse will document any report of disease, medical or mental health condition. Any accompanying records shall immediately be given to medical personnel conducting the intake processing and those records shall immediately be placed in the arrestee/detainee/inmate's medical record.
 - ii. Arrestee/detainee/inmate reporting or determined to have active acute, chronic medical, mental health, substance abuse, or other conditions requiring immediate medical care shall be referred to an appropriate clinician for physical examination and treatment or referred to community emergency medical services as medically indicated.
 - iii. Nurse will document any report of current medications whether prescriptive, over-the-counter, or street drugs.
 - iv. Medications brought into a facility may be turned over to custody to be placed in Property. Any medications disposed of shall be done so in accordance with the Pharmacy Services Manual and applicable State laws and regulations.

- v. Arrestees may be told that medications may be administered to inmates once they are seen by a clinician and medications are ordered, and that only current physician prescribed drugs can be offered. No drugs from containers brought by the inmate or arresting officers to the facility.
 - vi. Nurse will initiate the Continuity of Care form completing those sections regarding medical conditions and medications currently in use as well as any demographic information available.
3. Once the initial screening questionnaire is completed, the Intake team conditioning of the Nurse, the Mid-Level Provider/ Physician's observations, visual inspection and/ or patient response findings will be documented on appropriate forms electronically, if equipment is available, noting medical and mental health conditions, or on an OIHS approved form if the equipment is not available.
- a. Observations shall include, at a minimum:
 - i. Behavior, which includes state of consciousness, mental status, appearance, conduct, tremors and sweating etc.
 - ii. Body deformities, ease of movement, durable medical equipment needs, brace, prosthesis etc.
 - iii. Condition of visible skin, including trauma markings, bruises, sores, ulcerations, jaundice, rashes and infestations, needle marks or other indications of drug abuse.
 - b. Individuals requiring immediate attention or referral for more focused attention will be referred immediately (within the hour of admission) to the appropriate clinician or special care provider. These include, but are not limited to, individuals who have evidence of:
 - i. Potential withdrawal syndromes secondary to alcohol, substance abuse, use of barbiturates, or opiates,
 - ii. Suicide risk,
 - iii. Serious illness or injury previously un-noted that may require triage to community hospitals,

- iv. Acute or serious psychiatric conditions,
 - v. Communicable diseases,
 - vi. Urgent and emergent medical problems,
 - vii. Age group issues that may indicate the need for special treatment (i.e. juveniles and aged individuals),
 - viii. Education/DPSCS Student Information for Inmates must be completed for all inmates under the age of 22.
 - ix. Mental or physical disabilities requiring special attention.
- c. An opportunity for new arrestees, detainees and inmates to articulate their need for medical or mental health treatment will be provided.
 - d. Ectoparasite assessment shall be completed within the limits of discussion and visibility of hair and skin during this initial examination.
 - i. Those inmates appropriate for empiric treatment for lice infestation shall receive such treatment within the first 24 hours of admission. (Pregnant inmates will receive alternative treatment).
 - ii. Treatment supplies shall be obtained from the pharmacy vendor when treatment is ordered.
 - e. An examination of the mouth and teeth shall be done to determine if there are any dental problems requiring immediate referral.
 - f. Individuals eligible for methadone detoxification or methadone continuation shall be referred to substance abuse specialists and enrolled in those programs in accordance with established procedures
 - g. Individuals eligible for alcohol withdrawal shall be immediately referred for this treatment and appropriate placement.
 - h. PPD placement will be completed within 72 hours of acceptance into a facility, and will be read during the

Comprehensive Physical Examination that shall occur within seven days of that acceptance.

- i. A chest x ray for positive PPDs will be completed within five days of the positive reading and documented in the inmate health record.
- ii. Persons with positive readings shall be isolated until a clearance for the disease is verified.

4. Mental Health Screening

- a. Initial mental health screening shall be completed as part of IMMS. The nurse or higher level provider completing the IMMS process provides a brief screening using the approved questionnaire. Arrestee/detainee/ inmate who present with symptoms of psychosis, unstable mood, suicidal thought or behaviors, severe agitation considered not to be related to substance abuse or who exhibit other symptoms suggestive of danger to themselves or others shall be referred to a qualified mental health professional immediately for further evaluation and initiation of a treatment plan.
 - i. Mental Health personnel will provide training for medical personnel to assure that a consistent approach to these issues prior to any attempt to make observations regarding symptoms of psychosis, unstable mood, suicidal thought or behavior, or non substance abuse related agitation.
 - ii. All newly admitted inmates entering intake facilities from the community shall receive a suicide risk assessment by a qualified Mental Health Professional within 24 hours of admission.
- b. Individuals conducting mental health screening and suicide risk assessments shall follow the appropriate DPSCS protocol in doing so and in taking subsequent actions.
- c. All individuals conducting mental health screenings shall receive training, at least annually, on the conduct of such screening by a qualified mental health professional. Training shall include didactic information and standardized instructions for completing the screening form and suicide assessment.

- d. A complete mental health assessment will be completed for all arrestees/detainees/inmates within seven days of incarceration using an OIHS approved Intake Mental Health Screening Form.
- C. Medication Administration may be necessary to initiate or continue therapies begun prior to arrest.
 1. Nursing staff will collect all known data regarding prescription or other medications during the screening process including signed releases of information that may be used to verify current medication, as well as other health information required for making decisions regarding patient care management including any recent hospitalizations or treatments in progress prior to arrest.
 2. Arrestees with special medications related to organ transplant, HCV, HIV, Chemotherapy, dialysis etc will be allowed to continue those medications once verified by the medical staff.
 3. Arrestees will be maintained on pre-incarceration treatment regimens or a pharmacologically equivalent substitute for medical and mental health conditions whenever possible, i.e., the clinician can identify the need for those treatment regimens.
 - a. Persons requiring an evaluation for mental health medications will be referred to a Mental Health Specialist who will contact the psychiatrist assigned to the facility for bridge orders to enable immediate availability of mental health medications.
 - b. Once the psychiatrist has been apprised of the situation for persons with mental health conditions needing medication, the call shall be transferred to the mid-level or physician working in the Sallyport Area who will accept the verbal order and initiate the first dose of medication.
 - c. Somatic medications needs will be referred to the mid-level or physician responsible for the area for orders to enable immediate availability of those medications.
 4. Stock medication will be used to initiate dosing on the same day the detainee is admitted.
 - a. All medication administration from stock or non-stock shall be documented on the Medication Administration Record (MAR) following OIHS policy and procedure.

- b. All stock medication shall also be documented on the stock card to assure the medication can be refilled when necessary.
5. Formulary substitution maybe necessary and only with the facility physician's or psychiatrist's order and only after approval from the respective clinicians' Medical or Psychiatric Director.
6. The mid-level clinician or physician initiating the medication shall order the medication using the accepted ordering process for patient specific medications that will last for seven full days from the initial dose provided in the admission area. That medication shall be dispensed per dosing orders immediately upon receipt. (I.E., if the dose is to be at 10:a.m. and 10 p.m., the first ordered dose shall be given as close to the 12 hours following the initial dose as possible)

D. Disposition and Housing

1. Urgent onsite referrals to medical/mental health triage team for items on screening questionnaire that require immediate intervention include:
 - a. An onsite referral to the mental health triage team for mental health items on screening questionnaire that require immediate intervention
 - b. Isolation for arrestees with signs and symptoms of tuberculosis or any communicable disease suspected to prevent infection of others
 - c. Assurance that arrestees with alcohol withdrawal syndrome are housed in designated cells for monitoring and follows up.
2. Heat Stratification is required on all admissions to an Intake facility and periodically as conditions affecting any change in that status arises.
 - a. All arrestees, male and female will be assigned a heat risk category upon entry and at the Comprehensive Intake Physical Examination and housing assignment process, and throughout the year.
 - b. All male arrestees shall be designated for H1 housing by the receiving/screening nurse while at BCBIC (air conditioned housing) until they are reevaluated by a clinician and heat risk is reclassified based upon the initial

chronic medical conditions or medications prescribed as per DPSCS heat stratification policy.

- c. Clinical findings and medications prescribed at the intake examination will determine the final heat risk stratification.
- d. Any detainee who is prematurely moved prior to receiving a Comprehensive intake Physical or is placed into a non air-conditioned facility as part of the transfer screening process, prior to receipt of a final heat stratification assignment will receive an his or her Intake Comprehensive Intake Physical and a final heat stratification.
- e. The H-1 assignment will remain until the intake physical is completed and an alternative risk is assigned.
- f. Female arrestees will receive heat stratification upon entry to BCBIC and upon their Comprehensive Intake Physical at WDC per protocol.
- g. Final heat stratification shall be by medical doctor and shall be documented on the Electronic Medical Record (EMR) Patient Problem list as "Heat Risk Stratification" category H-1 H-2 or H-3 and in the Electronic Medical Record (EMR) classification template located on the home page.
- h. A weekly data report of H-1 and H-2 detainees will be maintained and submitted to classification and to the OIHS as an electronic file from May 1 through September 30th each calendar year from both medical and mental health contractors. Included in that file shall be, at a minimum:
 - i. The inmate's name ,
 - ii. Date of birth,
 - iii. DOC number,
 - iv. Heat stratification code
 - v. Facility and
 - vi. Any code changes.
- i. There shall be a notification on the individual problem lists for patients requiring a heat stratification code change, specifically, the original heat stratification on the problem

list will be recorded as resolved and the new Heat Stratification will be entered as the current “problem” on that list. This process will be repeated every time there is a Heat Stratification change.

3. If the clinician recommends housing other than general population related to heat such as infirmary or air-conditioned dormitory, staff will be responsible for coordinating the transfer of information regarding that order notifying custody of special housing needs or special needs and only by using the designated classification and housing form.
- E. Arrestee’s with positive response(s) to the Initial Medical/Mental Screening Questionnaire will have an orange wristband placed on the right wrist by the Triage team and a disposition made.
1. Arrestees /detainees identified as alcohol withdrawal problems will have a yellow wrist band placed on the left wrist by the triage team
 2. Arrestee’s who require immediate intervention will be directed/escorted to see the Medial Treatment Team and/ or Mental Health Team as soon as the IMMS disposition is completed.
 3. The Medical/Mental treatment team will perform a targeted patient evaluation focusing on the immediate medical/mental issue(s) and provide intervention(s) accordingly.
 - a. Arrestees with an Orange wristband and identified to have a medical condition and/or mental health problem, but are determined to be stable while being triaged, will be evaluated sequentially along with the booking process.
 - b. Arrestees with an orange wristband will be given priority during the booking process.
 - c. Arrestees with a yellow wristband will be monitored and evaluated for signs and symptoms of withdrawal and maybe given priority during the booking process
 - d. A daily log will be created and maintained to schedule medical evaluation of arrestees. The patient log created for the day will be communicated among the team leaders (Physician, Psychiatrists, Psychologist, PA, CRNP) of each shift to plan the follow-up and provision of services. A log of arrestee’s not seen/shift will be reconciled every 12 hours

to reflect completed screenings and submitted for review to the ACOM daily.

F. Inmate Transfers/Releases

1. Within 12 hours of being notified by custody that an inmate is to be released or transferred, the inmate's medical records shall be reviewed by nursing staff at the intake facility and a Transfer Screening Form shall be completed.
2. Inmates with risk stratification of M-1 and M-2 shall have their medical records envelopes labeled M-1 and M-2 as appropriate.

III. Rescission: DCD 130-100, Section 110 Medical Intake Evaluation, Dated March 1, 1996. OIHS Manual for Medical Evaluations Chapter One.

IV. Date Issued: July 15, 2007

V. Date Reviewed: July 1, 2008

Date Reviewed: April 1, 2009

Date Reviewed: September 28, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 1
MEDICAL INTAKE

Section 1B
Medical Intake Process: Part II

I. Procedure: PART TWO

A. Physical Examinations

1. All intake physical examinations shall be conducted by a clinician utilizing the DPSCS Intake History and Physical Examination Form found in the Electronic Medical Record (EMR).
2. All newly admitted inmates entering DPSCS facilities from the community shall receive a physical examination within seven (7) days of intake.
3. New Inmates or those called "Retakes" (such as parole violators) who have not received physical examinations within the past 12 months shall receive physical examinations.
 - a. Clinician will at a minimum, however review the physical examination that was completed within the last 12 months and comment upon any changes or updates and record that information in the EMR.
 - b. Clinician will ask the Inmate whether or not there have been changes in his or her medical/mental health since the time of that physical as each section is reviewed.
 - c. Clinician will follow the steps below (4) and do a new physical if the stated criteria above are unmet.
 - d. Regardless of whether a new physical is completed or the less than 12 month old physical is used, the clinician will enter a statement into the medical record regarding any changes and sign that entry.

4. Inmates who have a documented physical examination within the last 12 months need not have a new physical examination unless:
 - a. Abnormal vital signs are apparent
 - b. An acute medical problem or chronic medical condition by history is present, including but not limited to:
 - i. Hypertension (HTN)
 - ii. Coronary Artery Disease (CAD)
 - iii. Congestive Heart Failure (CHF)
 - iv. Chronic Obstructive Lung Disease (COPD)
 - v. Asthma
 - vi. Diabetes Types 1 and 2
 - vii. Seizures
 - viii. HIV infection
 - ix. Tuberculosis infection or disease (TBC)
 - x. CCC
 - xi. Cancer
 - xii. Recent surgery (past 12 months)
 - xiii. Recent physical trauma (past 12 months)
 - xiv. Other medical conditions requiring emergent or chronic care.
 - xv. Prescription medications he inmate is receiving.
 - xvi. Physical disability
 - xvii. Special needs
 - xviii. Medical screening identifies a new medical problem that requires evaluation.
 - c. The date of the last physical examination and the absence of active medical problems by history shall be documented on the Intake History and Physical Evaluation Form for all

inmates who have had a physical examination within the past 12 months and for whom the physical examination has been deferred.

5. All inmates receiving a history and physical examination shall be evaluated by a provider using the Intake History and Physical Examination Form documenting the following:
 - a. Medical history including but not limited to:
 - i. Allergies,
 - ii. Current medications,
 - iii. Chronic medical conditions,
 - iv. Hospitalizations,
 - v. Family history,
 - vi. Review of symptoms and
 - vii. Identification of disabilities.
 - viii. Last menstrual period.
 - b. Physical examination to include evaluation of the:
 - i. Head,
 - ii. Ears,
 - iii. Eyes,
 - iv. Nose,
 - v. Oropharynx,
 - vi. Neck,
 - vii. Lymphatics,
 - viii. Skin,
 - ix. Extremities,
 - x. Breasts,
 - xi. Lungs,

- xii. Heart,
 - xiii. Abdomen,
 - xiv. Genitalia,
 - xv. Pelvic (females)
 - xvi. Rectum, (includes stool guaiac for inmates 40 years of age and older),
 - xvii. Neurologic functioning
 - xviii. Mouth and teeth to determine if there are any apparent dental issues requiring referral and make referrals as appropriate
6. Time frames for conducting physical examinations for detainees and inmates entering DPSCS facilities may be expedited at the discretion of the DPSCS OIHS.
7. Diagnostic Screening Tests will be conducted and documented on the DPSCS Intake History and Physical Examination Form, as follows:
- a. Syphilis serologies (RPR with automatic FTA if RPR is positive). Blood will be drawn for the purpose of the necessary lab work at the time the PPD is planted enabling the results to be available at the time of the complete physical examination.
 - b. Education and voluntary HIV testing for all sentenced inmates in accordance with DPSCS protocol.
 - c. Pap smear and gonorrhea culture for all female inmates unless performed and documented within the last 12 months.
 - d. A review of the pregnancy test results and necessary referrals to obstetrical care following the OIHS Care of the Pregnant Inmate Manual if pregnant. If for any reason, the pregnancy test result cannot be located a repeat test shall be completed at this time and the clinician will proceed as already stated here.
 - e. Clinically indicated mammograms shall be performed for detainees and inmates in a time frame consonant with ABFF.

- f. Snellen Vision Test unless performed and documented within the past 12 months.
 - g. Audiometric screening in accordance with the following:
 - i. Bell-tone audiometry for all inmates under 21 years of age.
 - ii. Tuning Fork Test for all inmates 21 years of age and older unless performed and documented within the past 12 months
 - h. Electrocardiogram (ECG),
 - i. Blood chemistries,
 - j. PPD
 - k. Sickle cell screen and other diagnostic studies shall be ordered when medically indicated so that appropriate treatment may be provided.
8. All intake diagnostic lab tests shall be completed and documented in the patient health record within 48 hours of the order with the exception of RPR tests which must be reviewed and the review documented in the patient health record within 4 hours of receipt by the provider
9. All inmates identified with disabilities at the time of physical examination shall have documentation of the disabilities included in the medical record utilizing the DPSCS Disabilities Assessment Form.
- a. Disabilities shall be described in functional terms only, without disclosure of related medical problems such as hypertension, diabetes, cancer or HIVC infection.
 - b. A copy of the form shall be forwarded to the case management manager or supervisor of the intake facility.
10. The evaluating clinician shall determine the level of medically permissible activity and medically necessary housing assignments.
- a. The clinician's recommendation shall be documented using the Medical Clearance: Program and Work Assignment Form

- b. A copy of the form shall be forwarded to the case management manager or supervisor.

B. Treatment Plan/Risk Stratification

- 1. A physician shall review all inmates receiving physical examinations and shall develop and approve an individual treatment plan that is documented on the Intake History and Physical Examination Form. The treatment plan shall include, but not be limited to the following:
 - a. An assessment of active medical problems
 - b. An enumeration of all medically indicated diagnostic studies and treatments.
 - c. Recommendations for specialty referrals.
 - d. Chronic Care Clinic assignment as per DPSCS protocol including the placement of the clinic flow record sheet in the medical
 - e. Special housing assignment.
 - f. Risk stratification for chronic illnesses, as follows:
 - i. 0 – Healthy
 - ii. M-1 – Chronically ill – stable (hospitalization not anticipated during the next year)
 - iii. M-2 – Chronically ill – unstable (hospitalization anticipated during the next year. To include moderate to severe asthmatic individuals.
 - g. Final Heat Risk assignment which shall also be communicated to Custody Staff per procedure
 - h. Immunization assessment (see section II. C of this document)
 - i. Medical Alert Assessment (see Section II. D of this document)
 - j. Education/Special Needs Assessment and order referrals as appropriate.

2. The reviewing physician shall ensure that all identified medical, dental and mental health problems are documented on the DPSCS problem list.

C. Immunizations

1. All inmates shall receive immunization with tetanus/diphtheria toxoid when medically indicated. Immunization shall be documented in the inmate's medical record.
2. Inmates under the age of 18 will be assessed regarding immunization needs and authorization to update vaccinations by appropriate guardian will be documented in the medical record.

D. Medical Alert

1. All inmates shall be assigned medical alert badges if one of the following conditions applies:
 - a. Heart Disease (including pacemaker and internal defibrillators)
 - b. Diabetes (insulin dependent)
 - c. Seizure disorder (under treatment)
 - d. Asthma (moderate to severe)
 - e. Renal Disease (dialysis dependent)
 - f. Disabilities (blindness, deafness)
 - g. Allergies (life threatening only)
 - h. External medical devices (e.g. catheters, colostomy, etc.)
2. Inmates with psychiatric illnesses or infectious disease conditions shall be identified by a medical alert badge.
3. A physician shall secure a medical alert badge for an inmate by completing the Medical Alert Identification Request Form and submitting the form to the institution's Identification Unit unless otherwise specified by the Warden.
4. The same criteria and form shall be utilized for issuing alert badges in maintaining institutions for inmates newly identified with medical conditions requiring alert badges.

E. Education/Special Needs Referral.

II. References:

- A. Standards for Health Services in Prisons, National Commission on Correctional Health Services.
 - B. American Correctional Association: 3rd Edition with 2002 Supplements ALDF, 3-ALDF-4E-19 and 4-E-21
 - C. Clinical Practice In Correctional Medicine, Michael Puisis, D. O. 1999
 - D. American Public Health Association APHA Standards for Health Services In Correctional Institutions – 2003
 - E. Public Health Behind Bars from Prison to communities , Robert B.Greifigner ,2007
 - F. Department of Justice MOU
 - G. PDSD 185-4 Heat Stratification
 - H. DPSCS Receiving Screening
 - I. DPSCS Intake Mental Health Screening
 - J. DPSCS Intake History and Physical Evaluation Form
 - K. DPSCS Tuberculosis Testing Form
 - L. DPSCS Disabilities Assessment (DCD Form 130-100nR)
 - M. DPSCS Medical Clearance: Program and Work Assignment
 - N. Maryland State Department of Education/Correctional Education/DPSCS Student Information for Inmates Under 21 years of age.
 - O. OIHS Manual on Care of the Pregnant Inmate
- III. Rescission: DCD 130-100, Section 110 Medical Intake Evaluation, Dated March 1, 1996.
- IV. Date Issued: July 15, 2007
- V. Date Reviewed: July 1, 2008
- Date Reviewed: April 1, 2009
- Date Reviewed: September 1, 2009

OFFICE OF TREATMENT SERVICES
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MEDICAL EVALUATIONS MANUAL

Chapter 2
PERIODIC MEDICAL EVALUATIONS

I. Policy:

It is the policy of the Department of Public Safety and Correctional Services that periodic medical examinations are offered to all inmates in correctional institutions annually for inmates 50 years of age and older, and every four years for inmates under 50 years of age. In addition, age and gender appropriate preventive health screenings will be conducted as suggested by the American Academy of Family Physicians.

II. Procedure:

A. Periodic medical evaluations shall include:

1. Physical Examinations – Physical examinations shall be performed utilizing the DPSCS Periodic Physical Examination form and will include the following at a minimum:
 - a. Vital signs and weight
 - b. Right peak flow, pulse ox where indicated and random finger stick for glucose per policy
 - c. TB screening results
 - d. Examination of the head, ears, eyes, nose, throat
 - e. Examination and documentation for umbilical or inguinal hernias.
 - f. Neck, lymphatics, skin, extremities, breasts, lungs, heart, abdomen, genitalia, pelvic exam (females), PAP smear examination.
 - g. Rectum/prostate / and neurological systems. (Digital rectal prostate examination beginning at age 40)
2. Diagnostic tests, including, but not limited to:
 - a. Urinalysis dipstick for protein, red /white cells /glucose

- b. Complete Blood Count (CBC).
- c. Electrocardiogram at age 50 as a baseline study and at any age when medically indicated
- d. Snellen vision test
- e. Audiometric screening with tuning fork for inmates 25 years of age or older and with bell-tone audiometer for inmates 24 years of age or younger
- f. Random blood sugar test ,and
- g. Other diagnostic tests when clinically indicated
- h. Stool for occult blood x3 and an assessment for colorectal abnormality including digital rectal exam and consideration for colonoscopy per community standards.

3. Breast screenings include

- a. Breast examinations and mammograms shall be performed on female inmates beginning at the end of the inmate's first year of incarceration in accordance with the following guidelines and timetable:
- b. Breast examination annually for inmates 35 to 39 years of age and mammogram x 1 at age 39 unless exam is abnormal then as clinically warranted,
- c. Breast examination annually and mammogram every two years for females 40 to 49 years of age with a negative family history of breast cancer and negative breast exam,
- d. Breast examination and mammogram annually for females 40 to 49 years of age with a family history of breast cancer, or previously abnormal mammogram,
- e. Breast examination and mammogram annually for females 50 years of age or older regardless of family history
- f. Mammograms may be ordered at any time when medically indicated, e.g., symptoms of breast cancer, personal history of breast cancer or the breast exam is abnormal

4. Cervical/uterine cancer screening includes pelvic examinations and Pap smears to be performed with the following frequency from the date of intake:

- a. Every two years for females under 40 years of age unless otherwise clinically warranted.
 - b. Annually for females 40 years of age or older
 - c. Abnormal Pap smears are to be repeated and a referral made to a GYN specialist for evaluation for culposcopic exam when medically indicated
5. All inmates with a negative or unknown history of a positive PPD shall receive annual tuberculin skin testing with results documented in the inmate medical record, utilizing the DPSCS Tuberculosis Testing Form.
 6. All inmates seen for a periodic examination will be offered an opportunity to have a test for HIV/AIDS. The offer and resulting response of the inmate will be documented in the patient EMR.
- B. If an inmate refuses any part of the Annual or Quadrennial Periodic Physical then a Release of Responsibility form signed by the inmate listing sections refused must be faxed or emailed to OIHS.
- C. Any new diagnoses resulting from periodic medical evaluations shall be recorded on the DPSCS Problem List
1. Abnormal tests will be discussed with the inmate within 14 working days of the result and documented in the EMR that the inmate has been informed.
 2. A treatment plan will be developed and documented in the EMR and discussed with the inmate.
- D. Documentation of exams and testing results shall be done in the medical record and/or the EMR.

III. References:

- A. ACA Standard 3-4348, Periodic Examinations
- B. MCCS Standard .02, Periodic Health Examinations
- C. DPSCSD 130-110, Medical Intake Evaluation
- D. DPSCSD 130-207, Medical Management of Tuberculosis

IV. Rescissions: DCD 130-100, Section 112, Periodic Medical Evaluations

V. Date Issued: July 15, 2007

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Date Reviewed: June 1, 2009

Date Reviewed: September 1, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 3
ARRESTEE ENTRANCE/REFUSAL

I. Policy:

All arrestees presented at the Baltimore City Central Booking and Intake Center for admission will be subjected to a cursory triage to determine if the person suffers a condition which may prevent participation in the booking process. Arrestees who require urgent or emergent care shall not enter the facility to be booked, but shall instead be referred to an outside hospital.

II. Procedure:

A. An RN or higher shall conduct a cursory triage of each arrestee prior to the booking process and refuse admission to any arrestee whose condition the assessor determines is so serious that the arrestee should first be cleared at a hospital prior to being booked.

1. The Medical Services Contractor shall develop decision making guidelines for the Department's review and approval.

B. All pregnant arrestees shall be identified and triaged according to the DPSCS OB/GYN guidelines and those guidelines referred to in II.A.1. of this document.

C. The Contractor shall be responsible for all costs (medical, police transportation costs etc.) related to inmates who have been rejected but who are later determined by the Department's Medical Director to have been appropriate for admission. The decision of the Department's Medical Director shall be final.

D. The Contractor shall maintain an electronic record containing pertinent information of every individual refused admission.

E. If the individual is accepted for admission, the Contractor shall determine the appropriate housing classification for the inmate after conducting the appropriate reception screening process.

III. References: None

IV. Rescissions: None

V. Date Issued: July 15, 2007

VI. Date Reviewed: October 1, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 4
EMERGENCY SERVICES

Section 1
EMERGENCY SERVICES

I. Policy:

All DPSCS inmates and detainees requiring emergency health care shall receive timely treatment from appropriately trained personnel and emergency care organizations in accordance with established procedures and the DPSCS Utilization Management Procedure and Protocol Manual.

II. Procedure:

A. Emergency health care services shall be provided in DPSCS institutions in accordance with the following parameters:

1. All DPSCS institutions shall have 24-hour “on-call” somatic and psychiatric physician coverage documented on a monthly roster distributed and posted for the staff and facility personnel.
2. All DPSCS institutions shall have access to community emergency medical services (EMS) including, but not limited to:
 - a. Emergency Department/Community Hospital
 - b. Regional Trauma Center
 - c. Regional Burn Center
 - d. Poison Control Center
3. Listings of emergency resources shall be posted in medial areas designated by the Regional Medical Director and in administrative areas designated by the managing officer. These lists shall include emergency addresses and telephone numbers.
4. The Regional Medical Director/designee shall co-ordinate “911” emergency services with appropriate local emergency health care providers who provide ambulance “911” response operations. The

Utilization Management contractor policy and procedure regarding emergency notifications shall be followed. The process shall include the following:

- a. Expedient evacuation of inmates requiring emergency medical treatment, and
 - b. Uninhibited facility access for community emergency vehicles, equipment and personnel.
5. Any problems or delays in providing community "911" emergency service responses shall be reported to the contractor managing officer, the Regional Medical Director, ACOM and the DPSCS Medical Director.
 6. All DPSCS detainees who suffer medical emergencies shall be provided first-aid and Basic Life Support (BLS) services by trained medical staff. Visitors who experience medical emergencies shall be triaged and managed by contractor health staff until community emergency services arrive.
- B. All clinicians, nursing staff, dentists, mental health staff, medical administrators and correctional officers working in DPSCS institutions shall be certified in BLS or American Heart Association (AHA) emergency medical care and re-certified per perspective organizations in accordance with applicable directives. All medical healthcare personnel shall have Automatic External Defibrillator (AED) training and competency documented in their personnel record.

Documentation of BLS/ AHA/AED training and/or certification shall be readily available in the medical administrator's office. BLS certification includes familiarization with the operation of the AED.

1. No less than annually, the Regional Medical Director / designee shall ensure that designated clinicians and nursing staff in all DPSCS institutions receive in-service training on the provision of emergency medical care. Training shall include the following:
 - a. Review of the usage and location of stock emergency medications, supplies, and equipment, and
 - b. Basis first aid training,
- C. All DPSCS institutions (dispensaries and infirmaries) shall maintain emergency medications, supplies, and equipment according to established lists that have been approved and maintained by the Regional Medical Director.

1. All DPSCS dispensaries, and infirmaries, designated by the DPSCS Medical Director, shall maintain an automated external defibrillator (AED). This device will be tested weekly at a minimum, and testing results will be recorded on a log as part of “crash cart” checks. A monthly AED utilization report shall be submitted as part of the CQI monthly meeting agenda.
 2. The emergency “crash cart” and other emergency supplies shall be stocked, at a minimum, with the items listed in Appendix 1 found at the end of this Chapter.
 3. The emergency “crash cart” shall be sealed without compromising emergency access. Seals will be checked for breakage each shift by the nursing staff.
 4. Emergency “crash cart” contents, and other emergency supplies, shall be replaced as necessary. The emergency “crash cart” will be inventoried immediately following utilization. Weekly inspections shall be conducted by the medical contractor staff to ensure that supplies are available according to protocol and to ensure that no medications have expired.
- D. First Aid Kits shall be made available in all DPSCS institutions, and in designated DPSCS motor vehicles. They shall be contained in areas that provide security, yet allow ready accessibility to necessary emergency supplies.
1. Locations of first-aid kits shall be determined by the managing officer, in conjunction with the Regional Medical Director. First aid kits shall be maintained in accordance with the guidelines outlined in the Department’s approved pharmacy manual.
 2. First-aid kits shall contain, at a minimum, those emergency supplies listed on the First-Aid Kit Stock List as seen in Appendix II found at the end of this Chapter.
 3. First-aid kits shall be compact and manually transportable.
 4. An inventory of supplies shall be listed in all DPSCS facility first-aid kits. This inventory of institutional First-Aid kits shall be reviewed monthly by the Charge Nurse.
 - a. Outdated inventory shall be replaced and missing medication documented per pharmacy policy and procedure.
 - b. A summary of the outdated inventory shall be submitted as part of the contractor pharmacy audit report submission to DPSCS.

5. All supplies will be kept in an organized manner for ready accessibility, and individually wrapped and kept dry so that cleanliness is maintained.
 6. The inventory of First-Aid Kits in DPSCS motor vehicles shall be completed by designated officers and medical staff as appropriate to ensure that adequate supplies are maintained.
- E. Medical staff shall participate in all disaster drills conducted by DOC personnel.
 - F. Emergency drills – the Regional Medical Director / designee shall conduct emergency drills no less than semi-annually for all DPSCS facilities and maintain documentation of the drills and training components of the drills.

III. References:

- A. NCCHC – Correctional Health Care – Prison Standards, 2003
- B. DCD 110-24, Emergency Operations Plan
- C. DCD 130-100; Section 140 – Emergency Services Protocol – 140A Automatic External Defibrillator – Jan. 2002

IV. Rescissions: DPSCS 130-100-140 Emergency Services

V. Date Issued: July 15, 2007

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Appendix I

DPSCS Emergency Supplies, Equipment and Medications

List A

Eye Tray

Proparacaine ophthalmic solution 0.5% (2 ml)
Homatropine 2%
Pilocarpine solution 2%
Mydriacyl 0.5%
Sodium sulfacetamide – ointment, 10% solution
Fluorescein dye strips 1 mg
Ophthalmic irrigation solution (e.g. Dacriose)
Morgan lens
Eye spuds
Eye pads, adhesive tape, 2x2s, 4x4s
Sterile cotton swabs
Magnifying glasses on headband

Ear Tray

Carbamide peroxide otic solution 6.5% (Debrox)
Cotton Balls
Cortisporin otic suspension
Large syringe (pref. 60ml) + IV catheter for flushing
Acetasol otic solution (Vosol)
Sterile cotton swabs
Emesis basin
Small alligator forceps
Bulb syringe

Nasal Tray

4% Lidocaine solution
Epinephrine solution
Neosynephrine 1% solution
Lidocaine jelly
AgNO₃ applicators
Nasal specula
Bayonet forceps
Cotton balls
Vaseline gauze (1/2"x72")
Adhesive tape
Posterior nasal packing (e.g. Merocel)
Posterior nasal catheter (e.g. Epistat)
Emesis basin
Gauze 4x4s, 2x2s

GI Bleed

0.9% NS 100m. IV bags
Asepto syringes
Large basin
Saline pour bottles
Salem pump nasogastric tubes
Large bore IV catheters (14, 16, 18 gauge)
Suction source (wall, portable pump)

Orthopedic

Webroll
Plaster splints
Stockinette
Cast cutter
Cast spreader
Finger splints
Velcro wrist splints
Aircasts (inflatable ankle splints)
Knee immobilizers

Suturing, I&D

Arm board
Iodoform packing
Sutures -- Monofilament, nonabsorbable (e.g. Nylon)
-- Absorbable (e.g. Vicryl)
Scalpels (disposable) – blades #10, 11, 15
Steristrips – 1/8inch, 1/4inch, 1/2inch
Disposable suture trays
Clamps – Kelly, mosquito (curved and/or straight)
Pickups (e.g. Adsons +/- teeth)
Scissors (e.g. Mayo, iris; curved & straight)

Respiratory Supplies

Ambu bag
Nasal cannulas
Venturi mask
Suction source-wall suction, portable pump
Suction tubing, canister

Miscellaneous

Automated External Defibrillator (AED)
Monitor Leads
Defibrillator pads
Non-sterile pads
Compression board
IV pole

Oxygen tank
External electronic pacer
Sphygmomanometer
Automated blood pressure monitor
Gowns, face/eye shields
Disposable sharps container
IV start kits
IV tubing & extension kits
IV catheters (14, 16, 18, 20 gauge) (5 each);
 Butterflies (19, 21, 23, 25 gauge) (5 each)
IV pump (e.g. IVAC)
Syringes – 1, 3, 5, 10, 20 ml
Needles – 18, 20, 22, 25 ga
Luer adaptors
Central line kit
Alcohol & skin preps
Betadine swabs
Benzoin swabs
Gauze – 4x4s, 2x2s
Tourniquets
Urinary catheter set, urometer
Pressure bags
Soft restraints
Ring cutter
Silvadene cream
Sterile tongue blades
Large tube gauze net dressing

Handbook describing operation of equipment and administration of the medications (dosages, drip mixes, indications)
Set of ACLS protocols, medication dosages

APPENDIX II

DPSCS First-Aid Kit Stock List

The First Aid Kit shall contain the following supplies:

Dressings (4x4, 2x2, and roll gauze)
Ammonia inhalant (4)
Band-Aids (1 box)
Tape (1 roll)
Alcohol pads (10 each)
Laerdal pocket mask (1)
Gloves (4 pairs)

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 4
EMERGENCY SERVICES

Section 2
AUTOMATIC EXTERNAL DEFIBRILLATOR (AED)

I. Policy:

All licensed medical and mental health providers contracted for the department and designated as first responders shall be trained in the use and maintenance of the Automatic External Defibrillator (AED) for utilization as an adjunct in providing emergency Basic Life Services (BLS) to inmates, employees and visitors.

II. Procedure:

- A. The Heartstart FR2 AED Trainer and Training Tool Kit will be used by a licensed BLS or ACLS instructor to train all health care providers in the use of the AED.
1. Training for all healthcare staff will be conducted in conjunction with CPR re-certification.
 2. Additionally, self-learning packets will be accomplished at least every 6 months.
 3. All newly hired healthcare providers will be trained in the proper use of the AED within one month of employment.
 4. Training shall include a review of operation, troubleshooting AED problems, changing the battery and performing a battery check in addition to the use of the apparatus in an emergency
- B. The AED will be located in the trauma room in the dispensary area. It will be stored and be readily available with other emergency equipment.
1. The User's Manual will be clearly labeled and kept in the AED carrying case.
 2. A copy of the Required Equipment List will be placed on each AED carrying case.

- C. The progress note should reflect the use of the AED on the patient during the emergency situation and why its usage was clinically indicated.
- D. The AED will be maintained in good working condition.
 - 1. A Daily Safety Inspection Log (attachment 3) will be completed by the dispensary night shift nurse at each facility.
 - 2. The daily safety inspection log will consist of:
 - a. An inspection of the carrying case
 - b. A charged battery check of the hourglass status indicator
 - c. A visual count of all equipment in the carrying case.
 - 3. Any/all discrepancies will be corrected by performing the appropriate trouble shooting. The nurse will:
 - a. Record discrepancies on the daily safety inspection log.
 - b. Report discrepancies to the nurse manager accordingly.
- E. All supplies depleted from the use of the equipment will be replaced immediately following use. The same will apply to replenishing expired supplies.
- F. Considerations/Precautions to be taken include:
 - 1. Avoidance of the use of radio transmissions within 6 feet of the patient
 - 2. Avoidance of placing defibrillation pads over implanted pacemakers or defibrillators and
 - 3. Removing any medication patches from the patient's chest and wiping the area clean.
- G. A monthly State wide report on AED utilization shall be submitted by the contractor to the Office of Inmate health services.

III. References:

- A. DPSCS Directive 130-100-140A (AED)

IV. Rescissions: DPSCS Directive 130-100-140A (AED)

V. Date Issued: October 15, 2007

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OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 5
CONSULTATIONS

I. Policy:

All Maryland DPSCS detainees and inmates shall have timely access to medical, surgical, mental health and dental consultations when medically indicated. Consultations will be conducted pursuant to the Utilization Management contractor protocols and procedure manual.

II. Procedure:

- A. Contractors shall abide by the Agency approved comprehensive Utilization Management (UM) Protocol and Procedure manual. Once authorization has been received from the UM contractor for DPSCS, a formal consultation shall be written. Accordingly, pre-certification process includes but is not limited to:
1. Outpatient procedures and consultation
 2. Specialty diagnosis, imaging services
 3. Surgeries
 4. Twenty-three (23)hour admission requests
 5. Urgent /ER submissions
 6. Inpatient hospitalizations (non emergent)
- B. All DPSCS medical consultations shall have a written order in the medical record by a physician, midlevel provider, psychologist, psychiatrist or dentist.
- C. The medical indication for all consultations shall be documented on the DPSCS On-Site Consultation form, which is an NCR paper triplicate form.
- D. The medical contractor staff shall discuss the reasons for the consultation with the Regional Medical Director who will participate with the requesting provider in the Utilization Management collegial review

process as referenced in the Utilization Review manual. The requesting provider will forward the original and yellow copies to the consultant.

- E. The medical contractor shall place the second (pink) page in the medical record in the section assigned to consults.
- F. The medical contractor shall submit a Consultation Summary report to the ACOM on a weekly basis. The DPSCS Medical Director will be copied on all consultation appeals.
- G. The consultant shall return the completed original and yellow copies back to the originating facility.
- H. The medical contractor shall maintain a binder of the third (yellow) page at each facility.
- I. The original (white) copy shall be placed in the medical record.
- J. All appropriate staff shall receive in-service training on the proper use of the consultation form.
 - 1. Documentation of the in-service including a list of persons attending the training shall be forwarded to the DPSCS Agency Contract Operations Manager.
 - 2. All old unused single page consultation forms will be destroyed upon completion of the in-service.
- K. The consultation form shall be forwarded to nursing and/or medical records staff. Consultations shall be scheduled in accordance with institutional procedures.
- L. Medical record staff shall document the consultation type and location, order date, scheduled appointment date, completed consultation date, utilization review request and approval or denial date on a Consultation Log.
- M. The time period for scheduling and completion of the routine consultation will follow the UM contractor guidelines.
 - 1. Consultations exceeding an eight-week time frame shall be reviewed by the regional health care manager and the contractor medical director or physician designee.
 - 2. The reasons for delay shall be documented in the medical record and communicated to the patient.

3. If there has been a "missed appointment" related to scheduling or transport, the contractor is to submit to the Utilization Management contractor, on a monthly basis, a "missed appointment" listing and a completed appointment listing as part of the specialty consultation log submission.
 4. The log shall identify the rescheduled date.
 5. The contractor shall Incorporate UM missed appointments in the monthly CQI agenda along with the UM approval and alternative option recommendations.
- N. Emergent/Urgent consultations shall be completed within a 24/48 hour period respectively utilizing the procedure outlined in the UM manual.
- O. All canceled or denied consultations shall be documented by a physician in the inmate's medial record progress notes, including an explanation as to why the consultation is no longer medically indicated.
1. These cases will be discussed during collegial review.
 2. The DPSCS Medical director shall be advised in writing of any desire for an appeal of the UM decision by the contractor's Regional Medical Director and the UM Medical Director.
- P. Medical records or nursing staff shall ensure that all completed consultations are forwarded to a physician for review.
1. No completed consultation will be filed unless it is initialed and dated by the contractor physician.
 2. The viewing physician shall initial the completed consultation form and order any medically indicated diagnostic studies, evaluations, or treatments and then documents the review in the progress note and schedule a follow up appointment with the inmate to discuss the results within 30 days of the completed consultation.
- Q. Depending upon the urgency of the consultative matter, a physician shall review the consultation results with the inmate:
1. Within 2-4 weeks after receiving the consultant's recommendations but within 5 days for more urgent conditions.
 2. Document the discussion and the inmate's treatment plan in the progress notes of the inmate's medical record.

- R. The ordering physician shall be responsible for ensuring that inmates in need of urgent consultations or major surgery are not transferred to another DPSCS facility by implementing the following procedures:
1. Urgent consultations are marked "urgent" on the offsite consultation form.
 2. Initiate a written Physician Order for "Medical Hold."
 3. The institutional case management supervisor or facility administrator shall be notified that the inmate cannot be transferred without medical clearance, using the appropriate DPSCS form.
 4. The form shall be marked in the Transfer/Housing Assignment section for Restricted: Medical Hold Evaluation in process, inmate should not be transferred.
 5. When appropriate, the clinician will indicate length of the restriction.
- S. The clinician shall lift any restriction ordered when the evaluation is completed by using the same DPSCS Form as used to make the restriction.
- T. The DPSCS Medical Consultation Log will be submitted monthly to the Agency Contract Operations Manager and Utilization Management contractor.
- III. References: NCCHC P-E-12, Continuity of Care ACA, Section E: 4-4347
- IV. Rescissions: DPSCS 130-100- 126 PRIMARY/SPECIALTY MEDICAL SERVICES Consultations
- V. Date Issued: July 15, 2007
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OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 6
INMATES WITH SPECIAL NEEDS

I. Policy:

Inmates admitted into DPSCS facilities who demonstrate physical or mental health needs that require special adjunctive support in order to secure their safety and well being shall be identified during the initial Intake receiving process and/or during other clinical encounters. Appropriate measures that include treatment and discharge planning shall be done to accommodate the inmate's disability such that continuity of care and support is maintained upon entrance and at discharge from the facility.

Special need patients are inmates who are medically stable but cannot be housed in general population because of their physical or medical condition. These patients include, but are not limited to: persons with machines for sleep apnea, persons with dialysis catheters, wheel chair bound persons, or those with other impairments or disabilities, vision, hearing, language or cultural barriers. Mental health inmates whose conditions limit mainstreaming may be housed in special mental health units or infirmaries.

II. Procedure :

- A. All inmates upon entry into any DPSCS facility shall receive a medical and mental health Receiving Screening as part of the intake process within 2 hours, conducted by a clinician and followed up utilizing the DPSCS Intake History and Physical Examination Form within 7 days.
- B. All physical examinations will be reviewed by a physician and the reviewing physician will ensure that all identified medical, dental and mental health problems are documented on the DPSCS Problem List
- C. All detainees and inmates with active acute or chronic medical conditions identified at Receiving Screening shall be referred immediately for clinical evaluation by an RN or midlevel provider.
- D. The initial Intake examination shall identify physical and mental disabilities that require specific treatment accommodations in order for the inmate to successfully navigate the routine demands of the correctional environment. The examination may require the following:

1. Snellen Vision Test – On all DPSCS or Patuxent inmates unless one has been performed and documented within the past 12 months at local detention centers or other DPSCS facilities.
 2. Hearing Testing – Audiometric testing for DPSCS or Patuxent inmates in accordance with the following:
 - a. Bell-tone audiometry for all inmates under 21 years of age,
 - b. Tuning Fork Test for all inmates 21 years of age and older unless performed and documented within the past 12 months at local detention centers or other DPSCS facilities, and
 - c. Identification of need for interpretive services.
- E. All sentenced inmates identified with disabilities by a clinician at the time of physical examination shall have documentation of the disabilities included in the medical record on the DPSCS Disabilities Assessment Form.
- F. Disabilities shall be described in functional terms only without disclosure of related medical problems such as hypertension, diabetes, cancer or HIV infection. (Example: description may include such descriptions as limited mobility of legs or visually impaired without stating the diagnosis associated with the impairment)
1. The evaluating clinician shall determine the level of medically permissible activity and medically necessary housing assignments for all sentenced and pretrial inmates including special consideration – to the extent reasonable possible - for sight and sound separation of juveniles from adults.
 - a. At the time of admission to a special needs unit, the clinician will document in the medical record the reasons for admitting the inmate to the special need unit, how long he is likely to remain in the special need unit and what would be required to move the inmate from special housing.
 - b. Any medication given to the patient will be documented on the MAR per standard medication protocol.
 - c. Where possible, a multidisciplinary team approach to the management of the needs of the patient may be done on a monthly or as needed basis

2. Individuals requiring durable medical equipment or special assistive devices shall be allowed to maintain equipment from home. If none is available from the home, the department will provide medically approved assistive devices.
 3. Special needs inmates shall be considered for work assignments consistent with the level of abilities associated with their perspective challenges.
 4. The clinician's recommendations shall be documented using the Medical Clearance: Program and Work Assignment Form which shall be forwarded to the case management manager or supervisor.
 5. Inmates with special needs housed in onsite special medical housing or cells will be monitored by the contracted medical staff.
 - a. If an inmate's medical condition changes or becomes unstable, the clinician will provide admission orders to the infirmary. If the condition is stable but requires observation, transfer to a special needs unit if available within the facility may be done, if acute care hospital housing is not deemed necessary.
 - b. The nurse or the clinician will assess the suitability of housing for an inmate in a special care unit and, he/she will make the determination on the disposition for a patient housed in a special need unit.
 6. Inmates with special needs may require additional care and contracted medical staff will assess clothing, mattress, blankets, commissary, access to phone, meals and other privileges to assure that these will be similar to those of inmates housed in the general population unless otherwise ordered or restricted by the nurse, clinician, or custody staff.
- G. A copy of the form shall be forwarded to the case management manager or supervisor of the intake facility for case management purposes related to housing, jobs etc.
- H. A physician will develop an individual treatment plan that is documented in the medical record on the Intake History and Physical Examination Form for all inmates with special needs.

- I. Inmates admitted to the infirmary or any special medical or mental health unit, who return from the hospital or the emergency room, will have their treatment plan updated to reflect any additional findings resulting from that medical encounter.

- J. A Psychiatric treatment plan, when applicable, shall be documented by a psychiatrist/mental health professional in the medical record progress notes. The treatment plan shall include, but not be limited to the following:
 1. Assessment of active medical problems,
 2. Special dietary consideration to include increased caloric needs for Juveniles , renal dialysis, diabetics, etc.,
 3. Enumeration of all medically indicated diagnostic studies and treatments,
 4. Nursing plan review,
 5. Recommendations for specialty referrals, durable medical equipment, wheel chairs, C-pap machines, specialized medication, chemotherapy, prosthetic support etc.,
 6. Chronic Care Clinic assignment,
 7. Special housing assignments, Infirmary, ADA, special medical tiers,
 8. Juveniles housed under conditions maintaining sight and sound separation from adults when reasonably possible.
 9. Specialty consultation, and
 10. Social and psychological services.

- K. Discharge Planning – Continuity of Care will include appropriate discharge planning for all inmates who are being released from the infirmary, special needs units or housing and transferred to another jurisdiction, discharged from chronic care or discharged to the community etc. A copy of the discharge plan shall be sent with the inmate, and will include, at a minimum:
 1. Problem list,
 2. A written assessment of the inmate's active medical problems,
 3. A list of current medications/allergies,

4. Treatments,
5. Pending consultations,
6. Follow-up appointment, and
7. Activity and housing needs.

- III. References: None
- IV. Rescissions: None
- V. Date Issued: September 15, 2007
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OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 7

INMATE TRANSFER SCREENING

I. Policy:

The contracted medical vendor will assure that continuity of care is maintained when an inmate is transferred and will provide health screening for inmates moving from one DPSCS facility to another or from a DPSCS facility to another jurisdiction.

II. Procedure:

- A. A clinician at both the sending and the receiving DPSCS facilities will review the medical record and enter data onto "Health Services Transfer Screening."
- B. When given at least 24 hours notice that an inmate is being transferred to another DPSCS facility, a health care practitioner shall review the inmate's paper medical record and complete the top portion of the form. If the inmate has health care interventions that require urgent attention at the receiving institution, "S-Medical" will be entered onto the form in the column containing the inmate's name.
- C. Within 4 hours of transfer into the receiving facility, a medical professional shall review the medical record of the inmate and document that review on the lower portion of transfer form. However, if an inmate has the "S-Medical" code by his name on the form, his chart shall be reviewed within one hour of arrival.
- D. When a DPSCS electronic medical record is fully utilized in all DPSCS facilities, the Transfer Screening template may be printed at the receiving facility as an adjunct to the clinician's review. The receiving facility clinician may also print a "Patient Overview" from the EMR as an adjunct to the health practitioner's review.
- E. The clinician completing the review at the receiving institution will ensure that any identified necessary follow up occurs:

1. Appoint the inmate to be seen in the appropriate setting, including chronic care clinics within 30 days of arrival;
 2. Refer an inmate to the mental health provider;
 3. Refer an inmate to the Infection Control staff for any necessary follow up;
 4. Refer an inmate with a current dental need to the dental department; and
 5. Ensure that current medications are continued or discontinued by a clinician.
- F. In those facilities that are ACA accredited, a registered nurse shall interview the inmate upon arrival and complete a DPSCS form that documents the required face to face screening.
- G. The transfer form will be completed for both permanent and temporary housing transfers including but not limited to court appearances or surgical procedures scheduled in a location distant from the maintaining facility.
- H. When an inmate is transferred from a DPSCS facility to another jurisdiction for a period of time greater than one day, a health care practitioner will provide to the facility's Case Management Department a written assessment of the inmate's active medical problems, including a list of current medications and treatments. A copy of this assessment will be provided to the facility's representative of the Office of Inmate Health.

- III. References: None
- IV. Rescissions: DPSCS 130-100-122
- V. Date Issued: September 15, 2007
- VI. Date Reviewed: October 1, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 8
OPHTHALMOLOGICAL SERVICES

I. Policy:

To provide standardized guidelines for early and periodic screening, diagnosis, and treatment of vision needs of DPSCS inmates, all inmates received in DPSCS facilities shall receive an initial visual screen examination including, but not limited to, the Snellen chart at the time of the intake physical examination and at each periodic medical examination. Optometric and/or ophthalmologic evaluations, including vision corrective prescriptions, shall be provided within a time frame consonant with acceptable medical practice.

II. Procedure:

- A. Inmates found to have visual acuity worse than 20/40 in either eye shall be referred for optometric evaluation by an optometrist or ophthalmologist.
- B. The optometric evaluation shall occur within 30 calendar days of the initial examination, and documented in the patient's medical record.
- C. If the optometric examination confirms visual acuity worse than 20/40 in either eye and the optometrist/ophthalmologist deems corrective lenses necessary, then eyeglasses shall be prescribed.
- D. Within 30 days of the writing of a medically necessary prescription for eyeglasses, the health care provider shall properly fit, with a correctly filled prescription, the inmate for whom the prescription was written.
 1. If the nature of the prescription or other reason satisfactory to DPSCS will result in delay beyond 30 days, the inmate and the regional health care administrator shall be notified in writing with the reason(s). The Department reserves the right to order a change of supplier and/or any other changes they deem necessary in order to provide services in the time-frames specified above.

2. Contact lenses shall not be prescribed solely for cosmetic purposes. If a recently incarcerated inmate is admitted to a DPSCS facility with contact lenses, the inmate can keep the contact lenses until he/she is provided regular glasses. At that time, the inmate must surrender his/her contact lenses. The medical contractor must supply the necessary medical supplies for the maintenance of the contact lenses during the time period when the inmate has retained the contact lenses.
 3. Wire eyeglass frames and glass lenses shall be prohibited. Unless medically indicated, tinted lenses shall not be provided.
 4. Eyeglasses shall be distributed to inmates by nursing staff on site. The inmate shall sign a receipt form (DPSCSD Form 130-100, Sect. 130bR (Rev. 5/00) when eyeglasses are issued.
 5. Frequency of replacement/repairs of broken eyeglasses shall be reasonable and conform to community standards. Each inmate shall be provided eyeglasses on an every two year basis providing that the inmate's vision status requires a new prescription. Broken eyeglasses shall be replaced/repared within a 60 day time period following the inmate's request.
- E. All inmates over the age of 40 will have an optometric examination and tonometry to be performed annually to screen for glaucoma.
 - F. Self-referral for eye examination shall not be more frequent than one examination every two years. Any inmate who submits a request for eye examination more frequently than every two years shall be evaluated by a physician to determine the medical necessity for such an examination.
 - G. Self-referrals for vision examination by the inmate must be submitted on a Sick Call Request.
 - H. The inmate shall be evaluated by an optometrist within 30 calendar days when the conditions in Section IV. L. above has been met.
 - I. The medical record shall contain complete documentation of all optometric care including evaluations and prescriptions, and the provision and receipt of eyeglasses.

III. References:

- A. DPSCSD 130-11, Sections 112 and 114
- B. Secretary's Directive 07-94

- IV. Rescissions: Form DPSCS 130-233aR
Form DPSCS 130-251aR (Revised 1/92)
DPSCS 13-100-130 issued 5/2007
- V. Date Issued: October 15, 2007
- VI. Date Reviewed: September 13, 2009

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 9
BOOT CAMP SCREENING

I. Policy:

Prior to acceptance into the DPSCS boot camp program, all inmates will be evaluated and screened medically.

II. Procedure:

- A. All inmates will be medically screened by a physician's assistant, nurse practitioner or physician to determine eligibility for boot camp.
- B. Screening of inmates will include a chart review, history and physical examination, urinalysis, electrocardiogram (EKG), and completion of the Boot Camp Medical Screening Form (Appendix A).
 - 1. Female inmates considered for boot camp shall receive a pelvic examination and pregnancy test.
 - 2. The electrocardiogram (EKG) will be read by a licensed physician (with an over read by a cardiologist) and the results documented in the medical record.
 - 3. Immunization history will be documented for all inmates prior to assignment to boot camp.
 - a. Verification of immunization status (by disease or chemical prophylaxis) against Tetanus/Diphtheria, Measles, Mumps, Rubella, Varicella, Poliomyelitis and Hepatitis B will be confirmed.
 - b. Instances where immunity cannot be confirmed, treatment as appropriate will be initiated.
 - 4. A progress note will be made in the inmate's electronic medical record (EMR) stating whether the inmate is or is not medically cleared for boot camp training. Instances where the inmate is not cleared will require a statement as to why the inmate is not acceptable

- C. Inmates with the following medical conditions shall not be medically cleared for boot camp:
1. Uncontrolled hypertension,
 2. Heart disease,
 3. Diabetes mellitus,
 4. Hernias,
 5. Orthopedic problems
 6. Unstable mental health problems
 7. Chronic medical problems requiring recurrent medical interventions,
 8. Inmates receiving NRTT, NNRTI and Protease Inhibitors therapy unless viral load suppressed
 9. Pregnant females
 10. Inmates undergoing dialysis
- D. Exceptions to the chronic disease elimination include the following:
1. Inmates with asthma are eligible for boot camp if a careful history and physical examination reveals a stable respiratory status and no evidence of severe exercise-induced asthma.
 2. Individuals with documented HIV infection are eligible for boot camp if the T4 cell count is above 500 and no other medical contraindications are present.
 3. Inmates with a history of severe hypersensitivity to bee stings may be medically cleared for boot camp. Injectable epinephrine will be made emergently accessible to allergic inmates during outdoor activities.
- E. An updated "Medical/Mental Health Report for Inmate Assignments" form will be completed and attached to the Medical Screening Form for Boot Camp (Appendix A). Only inmates, classified as being able to participate in any and all activity shall be accepted for boot camp training.

- F. Any inmate with a previous history of medical clearance for boot camp or physical examination requires a repeat physical examination if the last exceeds 30 days.
- G. A registered nurse will review all boot camp files for completeness prior to final inmate acceptance.

III. References: None

IV. Rescissions: DPSCS 130-100, Section 154 – January 15, 1999
DPSCS 130-100-154 Boot Camp Screening (Undated)

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Appendix A
STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
DIVISION OF CORRECTION
BOOT CAMP MEDICAL SCREENING FORM

SECTION I: HISTORY

Name: _____ DOC#: _____

Facility: _____ DOB: _____ AGE: _____

CHECK IF POSITIVE:

1. Are there any chronic or newly diagnosed medical or mental health problems? (If yes, refer for psychiatric clearance.)
 - a. Has inmate been on psychotropic medications? y _____ n _____
 - b. Has inmate had any suicide attempts? y _____ n _____
 - c. Has inmate had any mental health referrals in last 6 months? y _____ n _____

- 2a. Are there any drug, food, or insect sting allergies present?
food _____
insect sting _____
drug allergy _____

- 2b. Immunization History
Chicken pox _____
measles _____
tetanus _____

- 2c. Family History
Cardiac _____ Hypertension _____ Asthma _____
Diabetes _____ Sudden Death _____ Seizures _____ Other _____

3. Is the inmate currently taking medications? y _____ n _____
controlled (C) _____
non-controlled (NC) _____

4. Smoker _____
Non-Smoker _____

5. Are there any medical problems that contraindicate the inmate's ability to meet program requirements according to applicable regulations?
PMH _____ date _____
Fractures _____ date _____
Operations _____ date _____
GSW _____ date _____
Prosthesis _____

Asthma _____
Seizures _____

Explain:

SECTION II: PHYSICAL EXAMINATION

Date of last physical _____
VS: Temp: ___ Pulse: _____ Resp: _____ Hgt. _____ Wgt. _____ BP _____

HEENT:

Lungs: clear _____ wheezes _____ cough _____

Heart: NSR y _____ n _____ murmur y _____ n _____ carotid bruit y _____ n _____

Abdomen: GU _____ Hernia _____ Pelvic _____

Musculoskeletal: No restrictions y _____ n _____

Mobility problem y _____ n _____

Swelling y _____ n _____

SECTION III: LABORATORY

Urinalysis _____ Pregnancy Test: results _____

EKG date: _____ Reading date: _____

SECTION IV: EMPLOYMENT ACTIVITIES EVALUATION

Section A, B and D of the "Medical Mental Health Report for inmate assignments" should be completed and attached to this form.

SECTION V: MEDICAL CLEARANCE

Recommend _____

Do not recommend _____

Comments:

SECTION VI: INMATE AUTHORIZATION

To the best of my knowledge the above information is correct and I have conveyed all known medical problems during this evaluation. I authorize the release of the information for items 1-5 above for inclusion in my base file and distribution as necessary for purposes of screening and classification for Boot Camp.

Inmate Signature/Date

Screened by: _____ Date: _____

OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 10

PRIVATE MEDICAL/PSYCHIATRIC/PSYCHOLOGICAL PROFESSIONAL
EXAMINATION OF INMATE

I. Policy:

The Department of Public Safety and Corrections System (DPSCS) will permit the admission of private physicians, psychiatrists, and/or psychologists into its facilities under certain conditions, but because the Department contracts full medical services for its inmates, the expense will be borne by the inmate.

II. Procedure:

A. Examinations of inmates by private medical, psychiatric, and psychological professionals which pertain to areas involving issues or events not related to the Department of Public Safety and Corrections System (DPSCS) mandated responsibilities will be permitted on an individual basis.

1. This will be permitted only after the Department receives documentation that sufficiently justifies the request.

2. The examination will be permitted only for the purposes of evaluation and diagnosis.

B. Any examination by the above named professionals for any other purpose must be initiated by Court Order or cleared by the Office of the Attorney General through established Departmental policies and procedures.

C. Any expenses attendant to any of the examinations whether inmate initiated or Court Ordered will be borne by the inmate.

III. References: None

IV. Rescissions: DCR 130-30 (Issued September 1, 1979)

V. Date Issued: October 15, 2007

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OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 11
ORAL HEALTH PROGRAM

I. Policy:

Oral health care will be provided to the inmate population in the State's correctional system and will be based on the severity of oral disease, the medical status of the inmate, and the projected length of time of incarceration. Dental sick call services will be provided.

II. Procedure:

A. Each inmate treated in a Division of Correction dental facility will be informed of the status of his/her oral health and of the appropriate procedures to access care. Diagnostic and treatment recommendations will be forwarded with the inmate to any other assigned institution.

B. Inmates will be placed into one of the following Oral Health Classification at the institution where dental care is sought. Minimally, all inmates who seek routine dental care will be maintained at a Class II classification.

1. Class I patients:

- a. Will have scheduling priority over other classes of treatment; and
- b. Shall be provided care immediately require emergency dental treatment for conditions such as acute oral infections (abscesses, periodontitis), fractured bones, traumatic injury of soft tissues, fractured tooth with vital pulpal exposure, severe pain, suspected neoplasm, or swelling.

2. Class II patients:

- a. Will have the second highest scheduling priority.
- b. Require treatment for conditions such as extensive or advanced caries, severe periodontal disease, asymptomatic pulpal or apical infections, or have a dental status that affects the individual's ability to obtain adequate nutrition.

3. Class III patients:
 - a. Will have the third highest scheduling priority.
 - b. Require treatment that is not of an urgent nature. Dental conditions in this class include moderate periodontal disease, caries not affecting the pulp, and multiple missing teeth.
 4. Class IV patients:
 - a. Require no dental other than preventive care.
 - b. If their classification changes, care will be provided using the established priorities as noted above.
- C. The maintaining facility to which the inmate is assigned will be responsible for providing oral care under the following Oral Care Criteria:
1. Twenty-four hour emergency care shall be provided to all Class I inmates in all facilities.
 - a. If indicated, hospital-based emergency care will be provided.
 - b. Telephone triage by a dentist will be available to the medical and nursing staff at times when the dentist is not in the facility.
 2. Oral self-care education will be provided to as many inmates as resources allow by dental personnel of the maintaining facility.
 3. An oral screening will be conducted by health care personnel at the time of reception into the Division.
 - a. The purpose of this screening will be to determine if there are acute dental needs and referral for care if acute problems are identified.
 - b. If resources allow, an examination will be completed on all inmates within three months after assignment to a facility.
 - c. Each patient will be classified according to the priority of his/her dental needs and care will be provided, if needed, under the established priority guidelines.

4. Routine treatment for Class II, III, and IV inmates may include all necessary examinations, radiographs, diagnostic tests, periodontal scaling and root planning procedures, amalgam and composite restorations, limited endodontic treatment (see criteria below), extractions, pre-prosthetic surgery, and full and removable partial dentures.
 - a. Priority on scheduling for routine treatment will be given to those inmates whose remaining sentences are more than 12 months.
 - b. Routine dental care will be provided to medically compromised patients, regardless of the length of incarceration, to preclude dental disease as a complication in the overall health status of the patient.
 - c. This care, however, shall be appropriate for the health status of the individual and will control foci of infection or other pathological processes that may negatively affect the patient's overall health.
 - d. The extent of routine care will be dictated by patient responsiveness and interest in their oral health, and the availability of dental personnel.
 - e. Services will be provided to ensure the patient a healthy oral status that is caries free, periodontally stable, and with enough teeth for adequate mastication.

D. There are necessary limitations of care as described below:

1. Endodontic care will not be routinely provided and will be limited to structurally and periodontally sound anterior or bicuspid teeth that are critical to the overall oral health of the patient. Since endodontic treatment requires a significant commitment of dental time, treatment planning, and administrative management, endodontic procedures will be monitored to ensure efficiency and conserve resources.
2. Treatment of Periodontal Class II or III cases will be limited to the removal of supra and sub gingival calculus and augmentation with self care.
3. No cast restorations (crowns, inlays and bridges) will be provided.

4. Full dentures will be provided for those patients who need but do not have dentures at the time of incarceration.
 - a. Denture relines (lab or chair-side) will be provided where indicated.
 - b. Full dentures will not be provided more often than once every six years and reline procedures will not be provided more often than once every two years (regardless of intercurrent release and reincarceration).
 - c. Partial dentures will be all acrylic, with or without wrought clasps, and will only be provided where the minimal level of periodontal health has been achieved and all caries has been eliminated.
 - d. Replacement of missing teeth for cosmetic reasons will not be performed.
 - e. Partial dentures will only be provided to establish a minimal functional occlusion. Minimal functional occlusion shall consist of the presence of posterior masticatory function, functional guidance, and incisal function.
 - i. Posterior masticatory function consists of at least four posterior teeth in each arch in a positive stable occlusion.
 - ii. Functional guidance consists of bilateral cuspid lift or bilateral cuspid/bicuspid group function or any combination there of. Incisal function consists of an adequate number of opposing incisors in each arch to incise food.
 - iii. Third molars are excluded from this definition.
 - iv. Partial dentures will not be replaced more often than once every six years (regardless of intercurrent release and reincarceration).
 - f. In the event of a lost or broken appliance, a replacement will be completed.
 - i. However, laboratory and material costs for replacements shall be paid by the inmate.

- ii. Dental time priority will be given to inmates requiring initial prosthodontic appliance fabrication.
- E. There are exceptions to the Limitations of Care under the conditions described below:
 - 1. The scope of treatment in the Oral Health Care Program is intended to be limited to those services provided in the general practice of dentistry and as outlined in this program description.
 - 2. All exceptions to this limitation of care shall be approved by the regional director and dental contract administrators before initiating care.
 - 3. The Regional Health Care Managers (ACOMS) have the authority to provide a final disposition if conflicts arise. DPSCS dental consultants have the authority to direct the contractor to provide referrals or additional care to inmates on a case-by-case basis.
- F. Accessory treatment includes orthodontic tooth movement, fixed prosthetics, dental implants, edentulous ridge augmentations, orthographic surgery, TMJ appliances or surgery, or any other elective procedure requiring outside hospitalization or treatment by a dental specialist. Accessory treatment services will not be authorized services.
- G. Quality assurance/inmate oral health care services will be evaluated using the DPSCS Oral Health Care Quality Assurance Program.
- H. In the event dental sick-call backlogs to the equivalent of more than one month, the contractor upon the request of the Regional Health Care Manager (ACOM) in consultation with the DPSCS dental consultants will make arrangements to come into compliance within 30 days of the request.
- I. Documentation
 - 1. All oral health care shall be documented in accordance with the oral health care treatment form.
 - 2. All inmates shall consent to and authorize dental treatment and/or oral surgery in accordance with DPSCS policies and procedures

- III. References: DCDs 130-2, 130-4
- IV. Rescissions: DCD: 130-500 Oral Health Care Program Description (Issued 1995)
- V. Date issued: October 15, 2007
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OFFICE OF TREATMENT SERVICES
OFFICE OF INMATE HEALTH SERVICES

MEDICAL EVALUATIONS MANUAL

Chapter 12
CLEARANCE FOR INMATES TO WORK

I. Policy:

Inmates will be placed in jobs within the prison system only after medical clearance according to DPSCS established procedures and in compliance with applicable laws and regulations. If mental health clearance is also needed, the inmate will be referred to mental health for additional information to be added to the clearance form. Note: Food Handler Clearance is covered individually under the Infection Control Manual.

II. Procedure:

A. All inmates identified as eligible and targeted for specific jobs within the prison system shall be medically cleared by a licensed health care provider in the institution where the inmate will work prior to beginning that job and whenever there is a medical issue raised regarding the infectious disease status of the inmate.

1. Inmates with the following suspected or confirmed food borne illnesses or other potential food borne illnesses will not be cleared for food service (as stated in the Food Handlers' Clearance Policy in the Infection Control Manual):

- a. Hepatitis A
- b. Salmonellosis
- c. Shigella infection
- d. Campylobacteriosis
- e. Ambiasis
- f. Vibrio species infection
- g. Giardiasis
- h. Viral gastroenteritis

- i. Other enteric infections and /or non-specific diarrhea
 - j. Staphylococcal skin infections/or any open sores or draining wounds
 - k. Streptococcal skin infections, MRSA
 - l. Streptococcal (Group A, Beta-hemolytic) pharyngitis
 - m. Trichinosis
 - n. Typhoid fever
2. Persons expecting to be assigned to non-food handling jobs are subject to scrutiny of the same infectious diseases in their clearance process and the medical director for the Service Delivery Area/designee will have the final decision as to whether an individual with a disease in the list above can be placed into a specific job after taking into consideration the contact with others a job will require and the physical constraints that might be necessary to assure the medical well-being of the inmate or those with whom s/he may come into contact.
 3. Clearance results from a medical assessment which shall include a chart review, physical inspection and a brief history to identify any potential infectious diseases. Some inmate work assignments require that a mental health assessment be completed before the final clearance is made.
 4. Results of findings shall be documented in the medical record and on Clearance to Work form.
 5. Workers involved in any job that involves contact with others shall be provided education on personal hygiene and a demonstration of proper hand washing by the health care provider. Documentation of the education shall be placed in the individual's EMR or medical record if the EMR is unavailable.
 - a. If the clinician approves the inmate for a job, a copy of the Clearance to Work form shall be forwarded to the case management department.
 - b. If the clinician approves the inmate for a job pending mental health approval, the Clearance to Work Form shall be passed to the mental health specialist assigned to the area

for the additional screening and completion of the form. The mental health specialists shall forward the completed form to the medical staff for inclusion in the file and forward to the case management department.

- c. If the clinician disapproves an inmate for a job, a medical referral shall be made to a physician for further evaluation and appropriate action.
- B. An inmate with suspected or confirmed diagnoses that impact on their work assignments or those individuals they are in routine contact with (e.g. shigella, Salmonella, Hepatitis A etc...) will be referred immediately to the site Infection Control Coordinator and the medical provider or the mental health specialist as appropriate.
1. The inmate will be medically treated for the indicated infection and medically cleared once again for the job after the clinician feels the inmate is safe to return to work. Or
 2. The inmate will receive the necessary treatment for his mental health disorder and communication between the mental health and somatic clinicians will determine the final outcome regarding clearance for work.
- C. An inmate with a psychiatric history or behaviors that might impact a specific job for which he or she has shown interest (such as suicide prevention companion) will be referred to mental health for additional clearance before the inmate may initiate service for that job regardless of the current status of the mental health disorder.

III. References:

- A. DCD 130-200: Infection Control Manual, Section-Prevention (Food Services Control and Sanitation); Section-Reporting
- B. COMAR 10.06.01-Communicable Diseases (reviewed date--2007)
- C. COMAR 10.16.01.09-Foodborne and Waterborne Diseases
- D. DCD 160-9, Food Service Handler Sanitation and General Orientation
- E. Maryland Commission on Correctional Standards C-3, C-4, C-5, C-8
- F. Federal Bureau of Prisons OPI: HSD/FDS 4700.05 Food Service Manual (June 2006)

- IV. Rescission: None
- V. Date issued: October 15, 2007
- VI. Date reviewed: September 13, 2009