

STANDARDS FOR HEALTH  
SERVICES IN JUVENILE  
DETENTION AND  
CONFINEMENT  
FACILITIES

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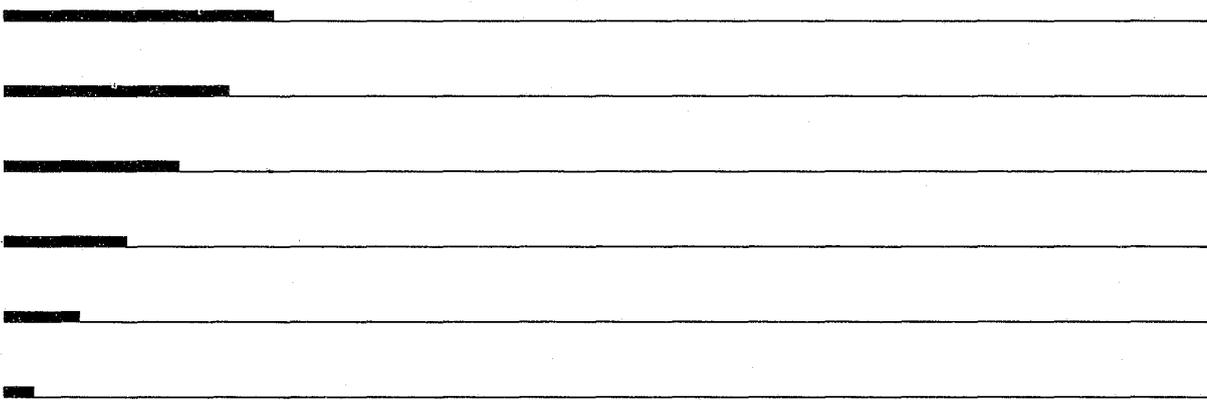
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NATIONAL COMMISSION ON  
CORRECTIONAL HEALTH CARE



1992



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# STANDARDS FOR HEALTH SERVICES IN JUVENILE DETENTION AND CONFINEMENT FACILITIES

These standards represent the official position of the National Commission on Correctional Health Care with respect to minimum requirements for health services in juvenile detention and confinement facilities. They do not necessarily represent the official position of supporting organizations or individuals represented on the National Commission on Correctional Health Care Board of Directors.

U.S. Department of Justice  
National Institute of Justice

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Early drafts of the standards were reviewed by the NCCHC Accreditation Committee which applies the standards to facilities seeking health care accreditation. Members of the committee and their affiliation are:

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In addition to the important work of these committees, the revision of the juvenile standards also benefitted from the special efforts of several organizations and individuals. The American Dietetic Association provided suggested revisions for the dietary standards (Y-25 and Y-53). The American Dental Association provided suggested revisions for the dental standard (Y-54). Jeffrey Mitchell, M.D., provided extensive help in the revision of the standard on the Use of Restraints (Y-40).

B. Jaye Anno, Ph.D., NCCHC Secretary, provided the committees with valuable insight on the development of standards for use in the accreditation of correctional health services and the evolution of the juvenile standards.

Many others on the NCCHC Board of Directors and staff have provided important contributions to the revision of these standards. The National Commission on Correctional Health Care is grateful for all these efforts, since the result promises to promote improved health services for youth in our nation's juvenile detention and confinement facilities.

Robert Burmeister, Ph.D.  
President

## PREFACE

*Standards for Health Services in Juvenile Detention and Confinement Facilities* represents a revision of standards first published by the American Medical Association (AMA) in 1979 and subsequently revised in 1984 by NCCHC. The National Commission on Correctional Health Care is a not-for-profit, 501(c)(3) organization working towards improving health services provided by the nation's jails, prisons, and juvenile detention and confinement facilities. Its board of directors is comprised of individuals named by the following organizations:

American Academy of Child and Adolescent Psychiatry  
American Academy of Family Physicians  
American Academy of Pediatrics  
American Academy of Physician Assistants  
American Academy of Psychiatry and the Law  
American Association of Public Health Physicians  
American Bar Association  
American College of Emergency Physicians  
American College of Healthcare Executives  
American College of Neuropsychiatrists  
American College of Physicians  
American Correctional Health Services Association  
American Dental Association  
American Diabetes Association  
American Dietetic Association  
American Health Information Management Association  
American Jail Association  
American Medical Association  
American Nurses' Association  
American Osteopathic Association  
American Pharmaceutical Association  
American Psychiatric Association  
American Psychological Association  
American Public Health Association  
American Society for Adolescent Psychiatry  
John Howard Association  
National Association of Counties  
National Association of County Health Officials  
National District Attorneys Association  
National Juvenile Detention Association  
National Medical Association  
National Sheriffs' Association  
The Society for Adolescent Medicine

## WHAT THE STANDARDS COVER

There are sixty-five (65) standards, grouped under five general areas, included in this manual. The general areas are: administration (17 standards); personnel (8 standards); care and treatment (33 standards); health records (4 standards); and medical/legal issues (3 standards). The standards are also classified as either "essential" or "important" for use in the awarding of accreditation. Accredited facilities are expected to be in compliance with all applicable essential standards and at least eighty-five percent of the applicable important standards. Generally, the essential standards are more directly related to the health, safety, and welfare of detained youth as well as to critical components of a health care system e.g., policies and procedures. The important standards represent recognized, acceptable practices for health care providers. Important standards and essential standards may not be applicable for a particular situation. Each standard is accompanied by a discussion section that elaborates on the intent of the standard, provides alternative approaches for achieving compliance, or defines key terms included in the standard.

In addition to the standards, NCCHC has periodically adopted "position statements" on important topics in the correctional health care field. Among the topics for which position statements have been adopted as of this publication are:

The Administrative Management of HIV in Corrections

DNA Analysis

Competency for Execution

Drug Testing of Correctional Staff

Tuberculosis as a Public Health Hazard in the Nation's Correctional Institutions

## CHANGES MADE SINCE THE LAST STANDARDS WERE PUBLISHED

The 1992 edition of the juvenile standards reflects three types of changes: (1) standards that have been re-classified from important to essential; (2) new standards that are included in the manual for the first time; and (3) changes and refinements to existing standards. Five standards have been re-classified from important to essential. They are:

Y-04 Liaison Staff (essential) (page 5)

Y-07 Special Handling: Patients with Acute Illnesses (essential) (page 7)

Y-09 Internal Quality Assurance (essential) (page 8)

Y-60 Confidentiality of the Health Record (essential) (page 54)

Y-63 Informed Consent (essential) (page 59)

Five new standards, three of which are essential for accreditation, are:

Y-08 Sexually Transmitted Disease and Bloodborne Disease Detection (essential) (page 8)

Y-17 Forensic Information (important) (page 13)

Y-27 Medical Clearance (essential) (page 25)

Y-57 Outside Programs (important) (page 49)

Y-64 Right to Refuse (essential) (page 60)

A number of the existing standards were changed to clarify the intent of the standard. For example, Y-16 Use of Tobacco formerly referred to smoking but was changed to prohibit the use of tobacco in any form. As another example, Y-21 Basic Training of Child Care Workers was amended to require that all child care workers who have direct responsibility for juveniles be certified in cardio-pulmonary resuscitation and trained to recognize symptoms of illness.

## HOW TO USE THIS BOOK

These standards represent NCCHC's recommended minimum requirements for juvenile health services. They are intended for use in evaluating short term facilities (such as detention centers) and long term facilities (such as residential treatment centers and training schools). Larger group homes and halfway houses may find the standards helpful for directing their operations. Facilities or governments contracting with community or private agencies for health services may find the standards useful for specifying contract expectations and evaluating contract performance. Once implemented, the standards can lead to: (1) increased efficiency of health services delivery; (2) greater organizational effectiveness; (3) better overall health protection for confined juveniles; (4) reduced risk of liability related to health services; and (5) NCCHC health care accreditation.

Every standard in this book applies to juvenile facilities and is numbered. The "Y" designation in the number identifies these standards as applicable to juvenile facilities (Jail and Prison standards are so designated with a "J" or "P" in their respective standards publications). Following the number and name of each standard is an identification (in

parenthesis) of the standard as either "essential" or "important." The difference is significant in that NCCHC requires that 100% of the essential standards must be met in order to have minimally acceptable health services. The NCCHC requires that at least 85% of the applicable important standards need to be met in order to have minimally acceptable health services.

The paragraph(s) immediately below the standard's name define the standard. It may contain special words in italics. Definitions for these words can be found in the glossary.

All standards are followed by a discussion. The discussion is intended to assist in the understanding of the standard by defining terms or elaborating on the intent. The discussion is not part of the standard itself.

For clarification on any of the standards, or for an evaluation of facility compliance, please contact the National Commission on Correctional Health Care, 2105 N. Southport, Chicago, IL 60614. Phone (312) 528-0818.

## SECTION A - ADMINISTRATION

Section A addresses management of the health care delivery system. The method of formalizing the health care system is outlined. However, the standards do not dictate specific organizational structure.

### Essential Standards

Y-01	Responsible Health Authority	3
Y-02	Medical Autonomy	3
Y-03	Administrative Meetings and Reports	4
Y-04	Liaison Staff	5
Y-05	Policies and Procedures	6
Y-06	Disaster Plan	6
Y-07	Special Handling: Patients with Acute Illnesses	7
Y-08	Sexually Transmitted Disease and Bloodborne Disease Detection	8
Y-09	Internal Quality Assurance	8

### Important Standards

Y-10	Support Services	10
Y-11	Sharing of Information	10
Y-12	First-aid Kits	11
Y-13	Access to Diagnostic Services	12
Y-14	Family Planning Services	12
Y-15	Notification of Next of Kin	13
Y-16	Use of Tobacco	13
Y-17	Forensic Information	13



**Y-01 Responsible Health Authority (essential)**

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

**Discussion**

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

The *health authority's* responsibilities include arranging for all levels of health care and ensuring quality and accessibility for all health services provided to juveniles. It may be necessary for the facility to enter into written agreements with outside providers and facilities in order to meet all levels of care. A *health administrator* is a person who by education (e.g., RN, MPH, MHA, or a related discipline) is capable of assuming responsibility for arranging for all levels of health care and ensuring quality and accessibility of all services provided to juveniles.

A *responsible physician* is required in all instances; he or she makes the final medical judgments regarding the care provided to juveniles at a specific facility. This includes reviewing the recommendations for treatment made by health care providers in the community. In most situations, the responsible physician will be the health authority. In many instances, the responsible physician also provides primary care.

*Local responsibility* means that the health authority must be someone who is on-site at least part-time. Even in a state system where policies are established from a central office, there must be a designated health authority at the local level to ensure that policies are carried out.

**Y-02 Medical Autonomy (essential)**

Matters of *medical* and dental judgment are the sole province of the responsible physician and dentist, respectively. However, security regulations applicable to facility personnel also apply to health personnel.

### Discussion

The provision of health care is a joint effort of administrators and health care providers and can be achieved only through mutual trust and cooperation. The health authority arranges for the availability and monitoring of health care services; the official responsible for the facility provides the administrative support for accessibility of health services to juveniles.

The term *medical* as used throughout these standards is intended to include alcohol and other drug treatment and psychiatric services, which are a part of the medical program. The primary responsibility for psychiatric services rests with the physician. Other health care staff (such as nurses, social workers, and psychologists) can provide psychiatric services under a physician's supervision.

#### Y-03 Administrative Meetings and Reports (essential)

Health services (including psychiatric) are discussed at least quarterly at documented *administrative meetings* between the health authority and the official legally responsible for the facility, or their designees. There is, at a minimum, an *annual statistical report* outlining the types of health care rendered and their frequency.

### Discussion

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

Regular staff meetings that involve the health authority and the official legally responsible for the facility and include discussions of health care services meet compliance if documentation exists (e.g., if minutes or a report of such meetings are kept).

If administrative and/or regular staff meetings are held but not documented, the health authority needs to submit a quarterly report to the facility administrator that includes the effectiveness of the health care system, description of any health environment factors that need improvement, changes effected since the last reporting period, and, if necessary, recommended corrective actions. Health environment factors that are of the greatest concern are those in which there are life-threatening situations (e.g., a high incidence of suicides and/or physical assaults and severe overcrowding that affects juveniles' physical and mental well being).

The annual statistical report should include but not be limited to the number of juveniles receiving health services by category of care, as well as other pertinent information (e.g., operative procedures, referrals to specialists, and ambulance services). The annual statistical report should be given to the facility administrator, the responsible physician, and, where applicable, (e.g., detention centers) the juvenile court judge.

Reports made more frequently than annually or quarterly also satisfy compliance guidelines.

#### Y-04 Liaison Staff (essential)

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

#### Discussion

Valuable services may be rendered by a health-trained child care worker or social worker who may, full- or part-time, review receiving screening forms for follow-up attention, facilitate sick call by having juveniles and records available for the health provider, and help to carry out physicians' orders regarding such matters as diet, housing, and work assignments on a full- or part-time basis.

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

*Health trained-staff* may include child care workers and other personnel without health care licenses who are trained in the use of protocols, collecting health related information, and in other limited aspects of health care as determined by the responsible physician.

#### Y-05 Policies and Procedures (essential)

There is a manual of written policies and defined procedures approved by the health authority that includes a statement regarding each standard listed in the table of contents of this document. Each policy, procedure, and program in the health care delivery system is reviewed at least annually and revised as necessary under the direction of the health authority. Each document bears the date of the most recent review or revision and signature of the reviewer(s) on the frontispiece of the manual.

##### Discussion

The importance of a manual that specifies the health care policies and procedures at a given juvenile facility cannot be over stressed. Such a document serves as an important reference for existing health care staff and as an excellent training tool for orienting new health care staff to the facility. A sample system for developing policies and procedures is included in this document in Appendix I.

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

Annual review of policies, procedures, and programs is considered good management practice. This process allows the various changes made during the year to be formally incorporated into the agency manual instead of accumulating in a series of scattered documents. More important, the process of annual review facilitates decision making regarding previously discussed but unresolved matters.

#### Y-06 Disaster Plan (essential)

Written policy and defined procedures require that the health aspects of the facility's disaster plan be approved by the responsible health authority and the facility administrator. The disaster plan is drilled at least annually.

##### Discussion

Policy and procedures for health care services in the event of a man-made or natural disaster, internal disaster (e.g., riots), or external disaster (e.g., mass arrests) disaster must be incorporated in the institution's plan and made known to all facility personnel. Health aspects of the disaster plan should include but not be limited to

the following: the triaging process, outlining where care will be provided; notification of ambulance and hospital evacuation of patients from the facility; specific roles of health care personnel; and laying out a backup plan. In case injuries must be treated on-site, separate disaster supplies should be planned, stored, and regularly checked. Routine fire drills or drills which do not involve a mobilization of health staff do not meet compliance.

The need to drill the disaster plan cannot be overemphasized. Drilling the disaster plan helps to identify weaknesses in it that might otherwise remain uncorrected. All staff members need to practice their roles, so they will respond appropriately in the event of an actual disaster. In addition, it is suggested in large facilities with more health staff that each shift of health care workers perform a disaster drill annually.

#### Y-07 Special Handling: Patients with Acute Illnesses (essential)

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

#### Discussion

Psychiatric and other acute medical problems identified either at receiving screening or after admission must be followed up by medical staff. The urgency of the problem determines the response. Suicidal and psychotic patients are emergencies and should be held for only the minimum time necessary. Juveniles awaiting emergency evaluation should be housed in a specifically designated area with constant supervision by health trained staff.

The following conditions should be met if treatment is to be provided in the facility:

- safe, sanitary, humane environment as required by sanitation, safety, and health codes of the jurisdiction;
- adequate staffing and security to help inhibit suicide and assault (e.g., staff within sight or sound of all juveniles); and
- trained personnel available to provide treatment and close observation.

**Y-08 Sexually Transmitted Disease and Bloodborne Disease Detection (essential)**

Written policy and defined procedures require that education and counseling for and diagnosis and treatment of sexually transmitted diseases (STDs) and bloodborne diseases be made available through age appropriate materials, group education, and one-to-one counseling.

Discussion

The incarcerated youth population are at high risk for infection with STDs, including HIV and hepatitis B. Critical areas which must be addressed on-site or by referral include:

Detection. The clinical management and prognosis of STDs and bloodborne diseases is greatly affected by early recognition of symptoms and early diagnosis. Sufficient resources should be made available to detect and diagnose STDs and bloodborne diseases.

Treatment. A medical, psychological, and social support plan for the care, referral, and treatment of those testing positive for STDs and bloodborne diseases is required.

Education and Prevention. Education in this age group is crucial. The use of age appropriate brochures, comics, and videos may be part of the program. Group education and one-to-one counseling should be provided.

Public health STD clinics, Planned Parenthood Clinics, and individual physicians are examples of community resources for sexually active juveniles. HIV pre- and post-test counselling and testing are best done by one person; therefore, a juvenile whose stay is too short to complete the entire process should be referred to the community HIV clinic or a physician treating HIV infected people.

**Y-09 Internal Quality Assurance (essential)**

Written policy defines the internal *quality assurance program* utilized by the facility. The program specifies the type of health services review that occurs, who conducts the review, and the frequency. The responsible physician (or a *quality assurance committee*) monitors the care rendered by health providers quarterly.

## Discussion

*Quality assurance programs* consist of formalized methods of ensuring the quality and consistency of the health services provided. There are many ways to accomplish this goal. The usual method employed is to review a sample of patient health records on a fixed schedule (e.g., weekly, semi-monthly, or monthly) to ensure that health care delivery is occurring according to established policies. Health records can be selected on a random basis (e.g., every tenth health record), a temporal basis (e.g., health records of patients seen in the last week), a diagnostic basis (e.g., all health records of current diabetic patients), or practitioner basis (e.g., all patients treated by certain practitioners).

The elements (i.e., "markers" or "indicators") to be monitored in health record review may include, but not be limited to:

- the adequacy of treatment plans initiated by health providers;
- the extent to which physicians' and dentists' orders have been carried out;
- the completeness and the legibility of the health record;
- the sufficiency of pharmaceutical matters (e.g., the types of medication ordered and notations regarding their administration); and
- the appropriate implementation and countersigning of standing orders, when utilized.

A *quality assurance committee* is a group of health providers working at the facility who meet on a fixed schedule to conduct health record reviews and/or to discuss the results of such reviews. In addition to the responsible physician, such committees usually include representatives of other health services and departments such as nursing, pharmacy, medical records, dentistry, and psychiatry. The number of individuals serving on such a committee and the services and departments represented will vary with the size of the staff and the types of health care provided on-site. In a small facility without separate health services departments, the responsible physician may carry out the quality assurance activities.

It should be noted that external peer review and/or periodic reviews by outside groups (e.g., grand juries, public health departments, and county medical societies) do not meet compliance. While reviews by legally entitled outside groups are to be

encouraged as additional checks on the quality of care provided, they do not take the place of a systematic internal quality assurance program.

**Y-10 Support Services (important)**

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

Discussion

The type of space and equipment for the examination and treatment area will depend upon the level of health care provided in the facility and the capabilities and desires of health care providers. In all facilities, space should be provided where the juvenile may be examined and treated in private.

Basic equipment generally includes the following: thermometers; blood pressure cuff; stethoscope; ophthalmoscope; otoscope; percussion hammer; scale; examining table; gooseneck light; sink with hot and cold water; transportation equipment (e.g., wheelchair and litter); bathroom; sharp containers; refrigerator for supplies; current medical reference textbooks and drug information, such as the *Physician's Desk Reference*, *AMA Drug Evaluations*, *Drug Facts and Comparisons*, and *Red Book*; a text on adolescent medicine; and a medical dictionary.

If female juveniles receive medical services in the facility, equipment appropriate for pelvic examinations and gynecological reference books should be available. If psychiatric services are provided in the juvenile facility, a private interviewing space, a desk, two chairs, a lockable file, and a copy of the DSM IV also should be available.

**Y-11 Sharing of Information (important)**

Written policy requires that the physician or his/her designee have access to information contained in the juvenile's confinement record when the physician believes such information may be relevant to the juvenile's health and course of treatment. In accordance with state statutes, facility staff members are apprised of certain medical conditions of juveniles, so they will be able to respond appropriately.

### Discussion

Arrested persons frequently are in a state of high anxiety and forget details of their lives that may be important from a health standpoint. A review of the record regarding previous drug and alcohol arrests, condition at the time of arrest, and possession of medication may be important to the physician in determining the juvenile's health status. In addition, particularly in states that have decriminalized public inebriation, information on previous alcohol usage, diagnosis, and treatment should be reviewed.

While facility personnel shall not have access to juveniles' medical records, including psychotherapy records, it is important that information on juveniles' medical conditions be shared. The staff should be told about juveniles with chronic conditions (e.g., diabetes and epilepsy), those with mental instabilities (e.g., psychoses; suicidal ideation) or physical limitations, and those on medication with potential side effects. Such information will alert child care workers to potential medical crises and help them respond appropriately should a crisis occur.

#### Y-12 First-aid Kits (important)

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

### Discussion

Examples of content for first-aid kits include roller gauze, sponges, triangle bandages, adhesive tape, and bandages. The first-aid kits should not routinely include emergency drugs.

Kits can be either purchased or improvised from assembled materials. All kits, whether purchased or assembled, meet compliance if:

- The kit is large enough and has the proper contents for the place where it is to be used.
- The contents are arranged, so the desired package can be found quickly without unpacking the entire contents of the kit.

- Material are wrapped, so unused portions do not become dirty through handling.
- Any materials with expiration dates are checked to ensure they have not expired.

**Y-13 Access to Diagnostic Services (important)**

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

Discussion

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

**Y-14 Family Planning Services (important)**

Written policy and defined procedures require that comprehensive family planning services, in accordance with state statutes, be available on the premises or by referral.

Discussion

Incarceration of sexually active juveniles often prevents access to appropriate family planning services. As an important aspect of health care provided in the facility, the following areas should be included:

Education regarding sexuality, pregnancy prevention, and options for those who become pregnant should be provided. Printed materials should be age-appropriate and in the main languages spoken in the community.

Counseling and social services regarding all aspects of sexuality should be available in the facility or by referral to appropriate community agencies. Contraceptive publications should be available for both males and females; contraceptive materials should be available upon discharge from the facility. Pregnancy detection and counseling regarding options for pregnant juveniles, including aborting or continuing the pregnancy, keeping the child or putting it up for adoption, should be included.

Liaison with Community Providers Public health family planning clinics, Planned Parenthood Foundation clinics, and individual physicians are examples of community resources for sexually active juveniles.

**Y-15 Notification of Next of Kin (important)**

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

Discussion

The facility should have a set procedure for notifying a juvenile's next of kin. Disclosure of confidential information (e.g., sexual abuse or positive HIV status) should be done in accordance with state statute. The written policy should specify when such notification must occur (e.g., "any illness or injury resulting in hospitalization and in all cases of death") and who has the responsibility for such notification.

**Y-16 Use of Tobacco (important)**

Written policy prohibits the use of tobacco in any form by juveniles at the facility.

Discussion

Recognizing the evidence that tobacco products, smoking, and second-hand smoke are dangerous to health, and the fact that most state laws prohibit the sale of tobacco products to minors, the use of tobacco products in juvenile facilities should be prohibited.

**Y-17 Forensic Information (important)**

Written policy and procedures prohibit the facility's health care personnel from participating in the collection of certain information for forensic purposes.

Discussion

The role of the health care staff is to serve the health needs of the juvenile patients. The position of its members as neutral, caring professionals is compromised when

they are asked to collect information about juveniles that may be used against the latter.

Performing psychological evaluation of youths for use in adversarial proceedings and conducting body cavity searches for contraband are examples of inappropriate uses of a facility's health care staff. Such acts undermine credibility of these professionals with their patients, and compromise them by asking them to participate in acts that are usually done without the youth's consent. Where state laws and regulations require that such acts be performed by health care professionals, the services of outside providers should be obtained.

Body cavity searches conducted for reasons of security should be done in privacy by outside health care providers (as noted above) or by correctional personnel of the same sex as the juvenile who have been trained by a physician or other health care provider to probe body cavities (without the use of instruments) so as to cause neither injury to tissue nor infection.

In the case of sexual assault, health care professionals may gather evidence for forensic purposes with the consent of the juvenile/victim. Similarly, court-ordered laboratory tests or radiology procedures may be performed by the facility's health personnel with the consent of the juvenile.

## SECTION B - PERSONNEL

Section B includes standards pertaining to qualifications, training, work appraisal and supervision of staff.

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**Y-18 Licensure (essential)**

State licensure, certification or registration requirements, and restrictions apply to qualified health care personnel who provide services to juveniles. *Verification* of current credentials is on file and made available for examination.

**Discussion**

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

Some states do not require licensure of persons working in government agencies or institutions. To promote the highest possible quality of health care, institutional health workers must be licensed if licensure would be required in a similar position in the community.

**Y-19 Job Descriptions (essential)**

Written job descriptions define the specific duties and responsibilities of personnel who provide services in the facility's health care system. These are approved by the health authority, reviewed at least annually and updated as needed.

**Discussion**

The job descriptions required by this standard are more detailed than standard civil service job classifications. They must be specific to the facility and to the position held. For example, a nurse working the evening shift who is assigned to the infirmary should have a job description for "Infirmary Nurse, Evening Shift" that specifies the responsibilities associated with that position.

**Y-20 Health Staff Orientation and In-service Training (essential)**

A written plan approved by the health authority provides for all health services personnel to participate in initial orientation and subsequent in-service training appropriate to their health care delivery activities. It outlines the frequency and number of hours of continuing training for each category of health care staff. A minimum of 12 hours of training is required annually for full-time health care providers. *Documentation* of all training is maintained.

## Discussion

Providing health services in a juvenile detention/confinement facility is a unique task that requires special orientation for new personnel. These needs should be formally addressed by the health authority based on the requirements of the institution. This training should include (1) an explanation of the mission of the institution, (2) an introduction to the juvenile justice environment, (3) a tour of the facility, (4) instructions concerning applicable security procedures, and (5) information specific to health services operations.

All levels of health care staff also require regular, continuing staff development and training in order to provide the highest quality of care. Proper initial orientation and continuing training may serve to decelerate burn-out of health providers and to help to reemphasize the goals and philosophy of the health care system.

### Y-21 Basic Training of Child Care Workers (essential)

Written policy and a training program established or approved by the responsible health authority in cooperation with the facility administrator should ensure that all child care workers who have direct responsibility for juveniles are trained in the following:

- types of action required for potential emergency situations;
- signs and symptoms of an emergency;
- administration of first aid, with training to have occurred, within the past three years;
- methods of obtaining emergency care;
- procedures for transferring patients to appropriate medical facilities or health care providers;
- signs and symptoms of mental illness, retardation, emotional disturbance, potential suicide, and chemical dependency; and
- signs and symptoms of suspected child abuse (including sexual abuse).

Further, all child care workers who have direct responsibility for juveniles are currently certified in cardiopulmonary resuscitation (CPR) and trained to recognize symptoms of the illnesses most common to juveniles.

### Discussion

It is imperative that facility personnel be made aware of potential emergency situations, what they should do in facing life-threatening situations, and their responsibility for the early detection of illness and injury. The intent of this standard is to ensure that juveniles are within sight or sound of health-trained child care workers at all times.

Current first-aid and CPR certification must be from an approved body, such as the American Red Cross; a hospital; a fire or police department; a clinic; a training academy or any other approved agency; or from an individual possessing a current instructor's certificate from an approved body.

#### **Y-22 Medication Administration Training (essential)**

Written policy and defined procedures guide the training of personnel (e.g., child care workers or nurses) who administer medication, and require training from or approval by the responsible physician and the facility administrator or their designees regarding accountability for administering medications in a timely manner according to physicians' orders, and recording the administration of medications in a manner and on a form approved by the health authority.

### Discussion

Training from the responsible physician encompasses the medical aspects of administering medications, including common side effects of specific drugs. Training from the facility administrator encompasses security matters inherent in distributing medications in a detention/confinement facility. The concept of distributing medications according to orders includes performance in a timely manner. (Please refer to standard Y-41 for the definition of distribution of medications).

#### **Y-23 Juvenile Workers (essential)**

Written policy prohibits juveniles from being used as health care workers in any capacity.

### Discussion

Understaffed detention/confinement institutions are inevitably tempted to use juveniles to perform health care delivery services for which civilian personnel are not

available. Their use frequently violates state laws, invites litigation, brings discredit to the correctional health care field, and gives them unwarranted power over their peers. If juveniles are used to clean the health services area, they must be supervised at all times.

This standard is not meant to prohibit peer education programs for the purposes of health education.

**Y-24 Food Service Workers: Health and Hygiene Requirements (important)**

Written policy and defined procedures require that (a) all residents and other persons working in food service are free from diarrhea, skin infections, and other illnesses transmissible by food or utensils, and (b) workers are monitored each day for health and cleanliness by the director of food services or his/her designee.

Discussion

Laws and regulations governing food service workers often differ by state. An administrator of the facility should know what is required in that jurisdiction with respect to pre-service examinations. If they are not required in that state or locality, it is not necessary to conduct pre-service physical examinations for food service workers. It is more important that workers be checked and that they follow hygienic practices. For example, workers should be told to wash their hands upon reporting to duty, after touching contaminated surfaces, before preparing food, and after using the toilet. Also, the use of hair nets or caps and plastic gloves should be considered for those working in food preparation or serving areas.

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

**Y-25 Decision-making: Special Problem Patients (important)**

Written policy requires consultation between the facility administrator and the responsible physician or their designees prior to the following actions being taken regarding patients who are diagnosed as having significant medical or psychiatric illnesses: housing assignments; program assignments; disciplinary measures; and admissions to and transfers from institutions.

### Discussion

Maximum cooperation between custody personnel and health care providers is essential, so both groups are made aware of movements and decisions regarding special problem patients. Medical or psychiatric problems may complicate work assignments. Medications may have to be adjusted for safety at the work assignment or prior to transfer.

Other aspects to consider in transferring medical or psychiatric patients may include:

- suitability for travel based on medical evaluation;
- preparation of a summary or copy of pertinent health record information medication or other therapy required en route; and
- instructions to transporting personnel regarding medication or other special treatment.



## SECTION C - CARE AND TREATMENT

Section C addresses care and treatment of patients, such as treatment philosophy, access to services, practices, and procedures.

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Y-26 Emergency Services (essential)

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

- emergency evacuation of the juvenile from the facility;
- use of an emergency medical vehicle;
- use of one or more designated hospital emergency department(s) or other appropriate health facilities;
- emergency on-call physician and dentist services when the emergency health facility is not located nearby; and
- security procedures that provide for the immediate transfer of juveniles when appropriate.

Discussion

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

It is desirable that health personnel be trained in advanced cardiac life support services or the use of a defibrillator. If neither is available at the facility, the nearest health care facility with that support should be identified and listed in the written plan.

Y-27 Medical Clearance (essential)

Written policies and defined procedures require that juveniles who are unconscious, semi-conscious, bleeding, or otherwise obviously in need of immediate medical attention are referred to a community hospital. Their admission or return to the juvenile facility is predicated upon written medical clearance.

Discussion

The intent of medical clearance is to prevent newly arrived juveniles who pose a health or safety threat to themselves or others from being admitted to the facility's general population and to obtain immediate medical care.

**Y-28 Initial Health Screening (essential)**

Written policy and defined procedures require *initial health screening* to be performed by health-trained or qualified health care personnel on all juveniles (including transfers) immediately upon arrival at the facility. The initial health screening findings are recorded on a printed form approved by the health authority (see sample form, Appendix II). At a minimum, the screening process includes the following:

**Inquiry into:**

- current illness and health problems, including mental, dental, and communicable diseases;
- medications taken and special health requirements;
- use of alcohol and other drugs, including types, methods, amounts, frequency, date or time of last use, and a history of problems that may have occurred after ceasing use (e.g., convulsions);
- immunization status;
- other health problems, as designated by the responsible physician; and
- where appropriate, a history of gynecological problems and pregnancies.

**Observation of:**

- behavior, which includes state of consciousness, mental status (including suicidal ideation), appearance, conduct, tremors, and sweating;
- physical deformities and ease of movement; and
- condition of skin, including trauma markings, bruises, lesions, jaundice, rashes, infestations, needle marks or other indications of drug use.

**Disposition, such as:**

- referral to an appropriate health care service on an emergency basis;
- placement in the general juvenile population and later referral to an appropriate health care service; or
- placement in the general juvenile population.

### Discussion

*Initial health screening* is a system of structured inquiry and observation to determine a juvenile's health status on admission. This screening can be performed by health personnel or health trained child care workers.

It must occur immediately upon the juvenile's admission to the facility and must be performed on all new arrivals. The only exceptions are juveniles who are transferred from other institutions and are accompanied by their initial health screening forms and a summary of their medical record information from the transferring institution. In this case, a new initial screening need not be conducted, but the medical information must still be reviewed and verified to ensure continuity of care.

Some studies indicate that suicide is the number one cause of death in detention facilities. Second is "cold turkey" withdrawal from alcohol and other drugs. Hence, it is extremely important for screeners to explore fully the juvenile's suicide and withdrawal potential. Reviewing with a juvenile any history of suicidal behavior and visually observing the juvenile's behavior (delusions, hallucinations, communication difficulties, speech and posture, impaired level of consciousness, disorganization, memory defects, depression, or evidence of self-mutilation), are recommended. Facilities following this approach, coupled with the training of all staff regarding mental health and chemical dependency aspects, should be able to prevent all or most suicides and "cold-turkey" withdrawals.

Particular attention should also be paid to careful descriptions of signs of trauma. All staff members should be reminded of their responsibility for reporting suspected abuse of juveniles to the appropriate authorities.

#### **Y-29 Intoxication and Withdrawal (essential)**

The responsible physician has approved written policy, procedures, and specific protocols for juveniles under the influence of alcohol or other drugs or undergoing withdrawal. Juveniles experiencing severe, life-threatening intoxication (overdose) or withdrawal are immediately transferred to a licensed acute care facility. Established guidelines for the treatment of individuals manifesting mild or moderate symptoms of intoxication or withdrawal from alcohol and other drugs are developed and followed. Individuals at risk for progression to more severe levels of intoxication or withdrawal are kept under constant observation by qualified health professionals or health-trained staff. *Detoxification* is done only under medical supervision in accordance with local, state, and federal laws.

### Discussion

A significant percentage of juveniles admitted to facilities have a history of alcohol and/or other drug use. Newly incarcerated individuals may enter intoxicated or develop symptoms of alcohol or drug withdrawal. Alcohol withdrawal is the abstinence syndrome with the highest mortality rate, although opiate and tranquilizer withdrawal are, on occasion, life-threatening. Barbiturate withdrawal, while rare in confinement settings, is also often life-threatening. Severe withdrawal syndromes should never be managed in the non-hospital setting.

With the exception of methadone detoxification, the treatment of most non-life-threatening withdrawal consists of the amelioration of symptoms and can be managed in the convalescent or out-patient setting. Abstinence syndromes in juveniles require special attention.

*Detoxification* refers to the process by which an individual is gradually withdrawn from a drug by the administration of decreasing doses of the drug upon which the person is physiologically dependent, one that is cross-tolerant (antagonistic) to it, or one that has been demonstrated to be effective on the basis of medical research. Detoxification in alcohol-dependent individuals does not involve administering decreasing doses of alcohol; it involves administering decreasing doses of drugs that are cross-tolerant to it.

### Y-30 Access to Treatment (essential)

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

### Discussion

The facility should follow the policy of orally explaining to all juveniles the procedures for gaining access to medical, dental, and mental health services. This notification should take place at the time of initial screening or upon arrival at a new facility. Special procedures should be developed to ensure that juveniles who have difficulty communicating (e.g., those who are developmentally disabled, illiterate, mentally ill, or deaf) have access to health services. Where the facility frequently has non-English-speaking juveniles, procedures should be written in their language(s) as well as in English, in the form of a handbook, a handout, or signs in the juveniles' housing areas.

### Y-31 Daily Handling of Medical Requests (essential)

Written policy and defined procedures require that juveniles' health requests be *documented* and processed at least daily as follows: they are solicited daily and acted upon by health-trained personnel, and followed by appropriate triage and treatment by qualified health personnel where indicated.

#### Discussion

Some facilities note on the request slip the action taken regarding triaging and file such slips in the juvenile's medical record; others use a medical log. These are examples of health requests being *documented*. All subsequent health encounters are documented in the patient's chart.

### Y-32 Sick Call (essential)

Written policy and defined procedures require that *sick call* be conducted by a physician and/or other qualified health personnel and available to each juvenile according to the following schedule:

- In small facilities of fewer than 25 juveniles, sick call is held once per week, at a minimum.
- In medium-sized facilities of from 25 to 100 juveniles, sick call is held at least three days per week.
- Facilities with over 100 juveniles hold sick call a minimum of five days per week.

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

#### Discussion

Some people refer to "sick call" as a "clinic visit." Clinic care or *sick call* is care for ambulatory juveniles with health care requests that are evaluated and treated at a particular point in time. It is the system through which each juvenile reports for and receives appropriate medical services for non-emergency illness or injury.

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

Y-33 Health Appraisal (essential)

Written policy and defined procedures require the following:

A full *health appraisal* is completed for each juvenile within seven days after the juvenile arrives at the facility, and includes:

- review of the initial health screening results;
- collection of additional data to complete the medical, dental and psychiatric histories;
- laboratory and/or diagnostic tests (as determined by the responsible physician with recommendations from the local public health authority) to detect communicable disease, including sexually transmitted diseases (STDs) and tuberculosis;
- recording of height, weight, pulse, blood pressure, and temperature;
- other tests and examinations as appropriate;
- medical examination (including gynecological assessment of females), with comments about mental and dental status;
- review of the results of the medical examination and tests, and identification of problems by a physician and/or his/her designee when the law allows such; and
- initiation of treatment when appropriate.

The collection and recording of health appraisal data are handled as follows: The forms are approved by the health authority. Health history and vital signs are collected by health-trained or qualified health personnel. Collection of all other health appraisal data is performed only by qualified health personnel. (Please refer to standard Y-04 for definitions of the terms "health-trained" and "qualified health personnel.")

In the case of a readmitted juvenile who has received a documented health appraisal within the previous six months, the prior results are reviewed and tests, examinations, etc. updated as needed. Full health appraisals are repeated annually for juveniles staying that length of time.

### Discussion

The *health appraisal* is the process of evaluating the health status of an individual. The extent of the health appraisal, including medical examinations, is defined by the responsible physician, but should include the steps listed above. When appropriate, additional investigation should be carried out regarding:

- the use of alcohol and/or drugs, including the type(s) of substance used, mode(s) of use, amounts used, frequency of use and date or time of last use;
- current or previous treatment for alcohol or drug use, including, when and where treatment was provided;
- whether the juvenile is taking any medication for an alcohol or drug use problem;
- current or past illnesses and health problems related to substance use, such as hepatitis, seizures, traumatic injuries, infections, and liver diseases; and
- whether the juvenile is taking medication for a psychiatric disorder and, if so, what drug(s) and for what disorder.

Further assessment of psychiatric problems identified at the initial health screening or after admission should be provided by either the medical staff or the psychiatric services staff within seven days. In many facilities, it can be expected that such assessment will be done by a general practitioner or family practitioner. Psychiatric services staff can include psychiatrists, family physicians with psychiatric orientation, psychologists, psychiatric nurses, or social workers.

Regarding waiver of laboratory tests for tuberculosis and STDs, a letter from the public health authority citing the incidence of the disease at issue in that locality and the justification for not conducting such tests on all juveniles is required for consideration of waiver.

#### Y-34 Direct Orders (essential)

Treatment by health-trained or qualified health personnel other than physicians and dentists is performed pursuant to direct orders written and signed by personnel authorized by law to give such orders.

### Discussion

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

#### Y-35 Skilled Nursing and Infirmiry Care (essential)

Written policy and defined procedures guide *skilled nursing* or *infirmiry care* and require: (1) a definition of the scope of skilled nursing care provided at the facility, (2) a physician on call 24 hours a day; (3) *supervision* of the infirmiry by a registered nurse who is there daily; (4) health care personnel on duty 24 hours per day; (5) all juvenile patients being within sight or sound of a staff person; (6) a manual of nursing care procedures; and (7) a separate and complete medical record for each juvenile.

### Discussion

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

*Skilled nursing* or *infirmiry care* is defined as in-patient bed care by or under the supervision of a registered nurse for an illness or diagnosis that requires limited observation and/or management and does not require admission to a licensed hospital. *Supervision* is defined as the overseeing of the accomplishment of a function of activity.

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

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

**Y-36 Suicide Prevention (essential)**

The facility has a written plan for identifying and responding to suicidal individuals.

Discussion

While juveniles may become suicidal at any point during their stay, high-risk periods include:

- the time immediately upon admission to a facility;
- after adjudication, when the juvenile is returned to a facility from court;
- following receipt of bad news regarding self or family (e.g., serious illness or loss of a loved one) or after suffering some type of humiliation or rejection;
- segregation; and
- prolonged stays in juvenile detention facilities.

The facility's plan for suicide prevention should include the following elements:

Identification. The initial health screening form should include observation and interview items related to each juvenile's potential suicide risk (see the sample screening forms in Appendix II).

Training. All staff who work with juveniles should be trained to recognize verbal and behavioral cues and to watch for signs of vulnerability that indicate potential suicide.

Assessment. This should be conducted by a qualified mental health professional with designation of the juvenile's level of suicide risk (see sample form in Appendix III).

Monitoring. The plan should specify the facility's procedures for monitoring a juvenile who has been identified as potentially suicidal. Regular supervision should be maintained. (See sample protocols on suicide precaution levels, Appendix III.)

Housing. If sufficient staff is not available to provide constant supervision when needed, the juvenile should not be isolated. Rather, s/he should be housed with

another resident and checked every 10-15 minutes. The room should be as suicide-proof as possible (i.e., without protrusions of any kind that would enable the juvenile to hang him/herself). It is inappropriate to place a suicidal youth in a maximum security isolation unit.

Referral. The plan should specify the procedures for referring potentially suicidal juveniles and attempted suicides to mental health providers or facilities for care.

Communication. Procedures for communication between health care staff and child care workers should exist to provide clear and current information regarding the status of the child.

Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide. The facility administrators and the health authority should receive reports about attempted and completed suicides.

Notification. Procedures for notifying facility administrators, outside authorities and family members of potential, attempted, and/or completed suicides should be in place.

Review. The plan should specify a review process if a suicide does occur.

### Y-37 Pregnant Juveniles (essential)

In recognition of the high-risk nature of adolescent pregnancy, juveniles remaining in the facility after pregnancy has been diagnosed receive regular pre-natal and post-natal care, including medical examinations, appropriate activity levels, safety precautions, nutrition, guidance, and counseling.

#### Discussion

Pregnant juveniles remaining in the facility should be followed by the physician who will deliver the baby, preferably one specializing in obstetrics and gynecology. When this is not possible, a physician who has had the appropriate training and experience should work with the youth. Physicians should be registered in the hospital where the delivery will take place.

**Y-38 Health Evaluation: Juveniles in Segregation (essential)**

The health authority and facility administrator should collaborate on and authorize the institution's *segregation* policies. Both should receive monthly reports on the frequency of use of segregation. Written policies and defined procedures require that juveniles removed from the general population and placed in segregation because of behavior problems be evaluated daily by qualified health personnel. These encounters should be documented, and the documentation filed in the juvenile's medical record.

**Discussion**

Owing to the possibility of injury and depression during periods of isolation, daily health evaluation should include personal contact with the segregated juvenile, notation of bruises or other trauma markings, and comments regarding the juvenile's attitude and outlook. The juvenile should be checked daily by a health care worker. A log should be kept of all interactions with the juvenile while in segregation. These evaluations are not to replace or to preclude the checks provided by program staff. Checks by program staff should be more than visual. They should involve personal contact with the segregated youth, and should occur at least every 15 minutes.

Evaluations by qualified health personnel are more than visual checks. The segregated juvenile should be interviewed and assessed for disturbances in mental status (e.g., depression, suicidal ideation, agitation, paranoia, self-injurious behavior, evidence of bruises, or other signs of trauma). Segregation policies should state that this intervention is to be reserved for incidents in which the youth's behavior has escalated beyond the staff's ability to control the youth by counseling or disciplinary measures and presents a risk of injury to the youth or others. If special (nonresidential) rooms are used for segregation, they should be as well-illuminated as regular unit rooms and have easy access to appropriate toilet facilities. In the rare instance that a segregated youth's out of control behavior lasts 24 hours, and there appears to be a need for continued intervention, qualified health personnel should evaluate the youth directly, approve continued isolation or generate a written plan for urgent mental health assessment by a qualified mental health professional, and/or the use of alternatives to segregation (e.g., return to living units under supervision, use of medications, or transfer to a mental health facility).

Further, in recognition of the deleterious effects of prolonged segregation on juveniles, it is recommended that health care staff be involved in the development and/or review of segregation policies.

A monthly report should be given to the health authority and facility administrator about the use of segregation. This report should include information about the number of juveniles in segregation during the month, the number of days spent in segregation, and the health status of segregated juveniles.

This standard reflects a number of findings and assumptions:

Segregation is a behavioral control measure (thus subjected to administrative responsibility) which may pose medical danger (thus subject to medical responsibility). This danger increases as segregation is prolonged.

The decision to place a youth in segregation should be left to the discretion of trained program staff, but this action should precipitate a series of monitoring actions by medical personnel to protect the segregated youth from harm. The longer a youth remains in segregation, the greater the role of the medical staff should be in the decision-making process. In the beginning, health staff involvement should be confined to monitoring the juvenile's psychological state; but as the segregation period lengthens, health personnel should have increasing authority to intervene and to approve the procedure.

*Prolonged segregation* is defined by scientific research, community standards, regulations, statutes, and case law. Animal and human studies reveal biological, behavioral, and mental status changes under conditions of social isolation and/or sensory deprivation within 24 hours. Surveys of psychiatric facilities indicate that 24 hours is usually the upper limit for segregation. Nationwide surveys of juvenile detention/confinement facilities indicate that most have upper time limits for segregation, with a range from one hour to 15 days, and a modal limit of 24 hours or less. In cases where litigation has determined the upper limit, judges have imposed ranges of two to five hours. It is reasonable to assume from these findings and the successful experiences of juvenile detention/confinement programs that have strict, self-imposed limits on isolation, that the vast majority of segregation events can be limited to minutes or hours, and the use of segregation for a day or more is unnecessary in all but a very few cases.

Although administrators and health personnel may wish to see segregation as an exclusive administrative measure, judges have consistently declared it a medical procedure on the basis of its medical dangers. Health care personnel, therefore, are strongly encouraged to learn about the risks of segregation and appropriate safeguards against its misuse. It is the responsibility of health care personnel to inform the facility administrator about any misuse of segregation.

### Y-39 Use of Restraints (essential)

If restraints are to be used in the facility, written policy and defined procedures guide the use of *fixed restraint*, and include an identification of the authorization needed, the duration, when, where, and how restraints are to be used. The health authority and facility administrator should collaborate in writing and authorizing restraint policies. Both should receive daily reports on the frequency of use of restraints.

#### Discussion

*Fixed restraint* is defined as the restraining of a youth to a bed with mechanical devices such as fleece-lined leather, canvas or soft rubber restraints, commonly referred to as "4- or 5-point restraints." This standard does not apply to handcuffs, shackles, or hard plastic straps when they are used to subdue and/or transport a juvenile. It is inappropriate to use these devices for fixed restraint. It is also inappropriate to restrain a person in an unnatural position (e.g., face down, spread eagle, hog tied), or to affix restraints to furnishings other than restraint beds. Fixed restraints, if used, should be used only in a behavior crisis in which there is danger of injury to self or others. Fixed restraints should be not used for discipline or punishment.

Medical *monitoring* of a youth in restraints by qualified or health-trained personnel should take place at least every fifteen minutes, and program staff should be in constant visual supervision of the restrained youth. Medical monitoring should consist of checks for circulation and/or nerve damage, airway obstruction, or psychological trauma. Restraining a youth for more than one hour should require the approval of qualified or health-trained personnel. Restraining a youth for more than two hours should require an evaluation by a qualified mental health professional, who should develop a plan for alternative interventions (e.g., return of the youth to the living unit under supervision, use of medications, or transfer to a mental health facility). When staff members note what they consider to be improper use of restraints, jeopardizing the health of a youth, they should communicate their concerns to the health authority or facility administrator.

This standard reflects a number of findings and assumptions:

Serious injuries and deaths, though rare, have occurred as a result of the process of applying restraints. Injuries usually occur during the restraint process, but can also be the result of nerve or artery constriction. Deaths are usually the result of airway restriction (e.g., aspiration of vomitus, gagging, or covering the mouth and/or nose of the restrained person).

When restraint practices are misused and result in litigation, judges have either forbidden their use or placed their use solely under the supervision of the medical staff. All staff who use restraints should be trained in their proper application. Medical staff should be aware of the medical risks involved and inform the facility administrator when restraints are being misused.

Many juvenile programs choose not to use fixed restraint as a behavior control measure. Other programs that do use restraints have found that carefully written policies and conscientious supervision can significantly reduce restraint time and the number of restraint incidents. For this reason, it is recommended that restraints be kept in a central location, rather than on units, and their access be controlled by supervisory personnel.

#### Y-40 Immunizations (essential)

Written policy and procedures require that immunizations be updated as necessary, within legal constraints. A pregnancy test should be done on all females of childbearing age before any immunization is given.

#### Discussion

All 50 states require immunization for school age children. When immunizations are not up-to-date, the facility should ensure that each juvenile is fully protected. The relevant information should be obtained from parents, family physicians, schools, and other available sources.

#### Y-41 Pharmaceutical Services (essential)

Sufficient pharmaceutical services are provided to meet the needs of the facility and are in accordance with all legal requirements.

The facility is in compliance with all applicable state and federal regulations regarding prescribing, dispensing, distributing, administering, and procuring pharmaceuticals.

All drugs must be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Antiseptics, other drugs for external use, and disinfectants are stored separately from internal and injectable medications. Drugs requiring special conditions for storage to ensure stability -- for example, drugs requiring refrigeration -- are properly stored.

An adequate and proper supply of antidotes and other emergency drugs, and related information, are readily available to staff to meet the needs of the facility.

The facility has written policies and procedures governing the pharmaceutical services, which include but are not limited to the following:

Development and subsequent updating of a facility *formulary* or drug list for pharmaceuticals stocked by the facility. The formulary also includes the availability of non-legend medications. (The existence of a formulary does not preclude the use of unlisted drugs.)

*Procurement, dispensing, distribution, accounting (i.e., monitoring), administration, and disposal* of pharmaceuticals.

Maintenance of records as necessary to ensure adequate control of and accountability for all drugs.

Maximum security storage of, and accountability for *DEA-controlled substances*, needles and syringes, and other abusable items.

Automatic drug stop orders or required periodic review of all orders for *DEA-controlled substances*, psychotropic drugs, or any other drug that should be restricted because it lends itself to use or for any other reason dictating that patient compliance be monitored.

A system to notify the responsible practitioner of the impending expiration of a drug order, so the practitioner can determine whether the drug administration is to be continued or altered.

Administration of drugs only upon the order of a physician, dentist, or other authorized individual with designated privileges.

The prescribing of psychotropic medications only when clinically indicated (as one facet of a program of therapy) and not for disciplinary reasons.

All medications are under the control of the appropriate staff. Juveniles do not prepare, dispense, or administer medication.

When there is no staff pharmacist, a consulting pharmacist is used to review pharmaceutical practices at least annually.

## Discussion

A *formulary* is a written list of prescription and non-prescription medications stocked in the facility. This does not restrict prescriptions of medication generated by community health care providers; however, these are still subject to review and approval by the responsible physician.

*Procurement* is the system for ordering medications for the facility.

*Dispensing* is the issuance of one or more doses of a prescribed medication in containers that are correctly labeled to indicate the name of the patient, the contents of the container, and all other vital information needed to facilitate correct drug administration. *State law controls the scope of authority of a physician or other clinicians dispensing medication.*

*Medication distribution* is the system for delivering, storing, and accounting for drugs from the source of supply to the nursing station point where they are administered to the patient.

*Medication accounting* is the act of recording, summarizing, analyzing, verifying, and reporting medication usage.

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

*Disposal* involves the destruction of medication upon the discharge of the user from the facility or the provision of the discharged juvenile with the medicine prescribed, in line with the continuity-of-care principle. When a facility uses the sealed, pre-packaged unit dose system, the unused portion often can be returned to the pharmacy.

*DEA-controlled substances* are the drugs that come under the jurisdiction of the Federal Controlled Substances Act. They are divided into five schedules (I through V). The Drug Enforcement Administration (DEA) is the leading federal law enforcement agency charged with the responsibility for combating drug use. Requirements of the Controlled Substances Act and a list of controlled drugs can be obtained from any office of the DEA.

Y-42 Hospital Care (important)

The facility has arrangements for providing in-patient hospital care for medical and psychiatric illnesses.

Discussion

The facility should develop a letter of agreement with each hospital it utilizes for in-patient medical and psychiatric services. This letter should indicate the willingness of the hospital to accept patients from the facility and the requirements of both parties (e.g., patient to be transferred with a summary of his/her medical record, procedures for transporting personnel to follow at the hospital, patient to be discharged with a summary of treatment received, and terms of payment).

Y-43 Treatment Philosophy (important)

Medical procedures are performed in privacy, with a chaperon present when indicated, and in a manner designed to encourage the patient's subsequent utilization of appropriate health services. When a rectal or pelvic examination is indicated, verbal consent is obtained from the patient.

Discussion

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

Y-44 Special Medical Program (important)

Written policy and defined procedures guide the *special medical program* that exists for juveniles requiring close medical supervision, including *chronic care* and *convalescent care*. A written, individualized *treatment plan*, developed by a physician, exists for these patients and includes directions to health care and other personnel regarding their roles in the care and supervision of these patients.

Discussion

The *special medical program* serves a broad range of health conditions and problems, including seizure disorders, diabetes, potential suicide, pregnancy, chemical dependency, and psychosis. These are examples of some of the special medical

conditions that dictate close medical supervision. In these cases, the facility must respond appropriately by providing a program directed to the individual's needs.

*Chronic care* is medical service rendered to a patient over a long period of time, for such conditions as diabetes, hypertension, asthma, and epilepsy. *Convalescent care* is medical service rendered to a patient to assist in the recovery from illness or injury.

A *treatment plan* is a series of written statements that specify the particular course of therapy and the roles of medical and non-medical personnel in carrying it out. It is individualized and based on assessment of the patient's needs, and it includes a statement of the short- and long-term goals as well as the methods to reach these goals. When clinically indicated, the treatment plan provides juveniles with access to a range of supportive and rehabilitative services (e.g., individual or group counseling, and self-help groups) as the physician deems appropriate.

Special medical problems should be identified on the outside of the patient's chart. A list of chronic medications as well as any known drug allergies also may be helpful.

#### Y-45 Standing Orders or Treatment Protocols (important)

Standing orders are not used by the juvenile detention/confinement facility. If *treatment protocols* exist, written policy requires that they be developed and signed by the physician and, when utilized, they be countersigned in the medical record by the physician.

#### Discussion

*Standing orders* are written orders that specify the same course of treatment for each patient suspected of having a given condition. *Treatment protocols* are written orders that specify the steps to be taken in appraising a patient's physical status. Treatment is initiated only upon the written or verbal orders of a licensed physician. Treatment protocols should not include any directions regarding dosages of prescription medications. An example of a standing order versus an acceptable treatment protocol is given in Appendix V.

The prohibition against standing orders is intended for routine cases when there is time to contact a physician, to describe the symptoms, and to obtain a direct order for treatment. This standard does not preclude protocols for emergency situations (e.g., anaphylactic shock) when immediate action is required.

Instructions for first-aid procedures written by the responsible physician are acceptable for the identification and care of such minor ailments as would ordinarily

be treated by an individual with self-care and over-the-counter medication, (e.g. mild colds and athlete's foot; minor cuts, abrasions, and burns; common headaches; and simple constipation and diarrhea). Administration of over-the-counter medication by health care personnel should be documented in the patient's record. However, it need not be countersigned by a physician unless required by the facility's own policy.

#### Y-46 Continuity of Care (important)

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

##### Discussion

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

Juveniles identified in the facility as having long-term or potentially serious conditions should be referred to follow-up clinics, if this is medically indicated. Examples of such conditions are hypertension, diabetes, epilepsy, psychiatric disorders, urinary tract infection, chronic otitis, serious trauma, and post-operative status. Files for such patients should be marked in some fashion (e.g., color-coded) to indicate the juvenile's special medical needs.

#### Y-47 Health Promotion and Disease Prevention (important)

Written policy and defined procedures require that *medical preventive maintenance* be provided to juveniles in the facility.

##### Discussion

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

Subjects for health education include personal hygiene and nutrition; sexually transmitted diseases (STDs), including HIV/AIDS; tuberculosis and other communicable diseases; the effects of smoking; self-examination for testicular and breast cancer; dental hygiene; drug use and the danger of self-medication; family planning, including, as appropriate, both services and referrals; physical fitness; and chronic diseases and disabilities.

**Y-48 Chemically Dependent Juveniles (important)**

Written policy and defined procedures regarding the clinical management of chemically dependent juveniles require diagnosis of *chemical dependency* by a physician or (if authorized by law) a properly qualified designee; an individualized treatment plan to be developed and implemented; and referral to specified community resources upon release, when appropriate.

Discussion

Existing community resources should be utilized if possible. The term *chemical dependency* refers to the state of physiological and/or psychological dependence on alcohol and/or other drugs.

**Y-49 Ectoparasite Control (important)**

Written policy approved by the responsible physician defines *ectoparasite* control procedures used in the facility. A means is available for the disinfection of bedding and clothing. Treatment must be carried out on an individual basis, after determining that no contraindicating condition (e.g., pregnancy) is present.

Discussion

*Ectoparasites* such as pediculosis and scabies are skin infestations. They are communicable and may lead to secondary infections. Screening for ectoparasites should occur at admission.

**Y-50 Infection Control Program (important)**

A written program specifying policies and procedures for the control of infection is adopted for the facility. The program is approved by the responsible health authority. The infection control program includes, but is not limited to, concurrent surveillance of patients and staff, prevention techniques, and treatment and reporting of infections.

Discussion

The facility should have an infection control committee that meets on a quarterly basis to review and to discuss infection control policies and procedures, surveillance, cleaning and disinfection techniques, and other matters related to infection control. The committee should include the responsible physician or a designated medical representative, the director of nursing or a designated nursing representative, and other professional personnel involved in infection control. Minutes or records of committee activities should be maintained. Health staff should strictly adhere to the universal precautions as developed by Centers for Disease Control.

**Y-51 Communicable Disease and Isolation (important)**

There are written policies and procedures regarding the care of juveniles with communicable disease, including provision for isolation if medically indicated. Juveniles who have or are suspected of having a reportable communicable disease are isolated.

Discussion

Isolation procedures for juveniles with a communicable disease should meet the following requirements:

Where possible, the juvenile is placed in a room without a roommate. The room should be equipped with a private toilet, hand washing facility, dispenser of soap, and single-service towels.

Procedural techniques include hand washing upon entering and leaving, proper handling and disposal of infectious materials, procedures for providing proper isolation techniques, instructions provided to the juvenile and to visitors, proper handling of food utensils and dishes, proper handling of patient care equipment, and cleaning and disinfection of isolation accommodations.

Y-52 Care of the Physically or Mentally Disabled Juvenile (important)

Written policy and defined procedures require post-admission screening and referral for care of physically or mentally disabled juveniles whose adaptation to the detention/confinement environment is significantly impaired. A treatment plan is developed for each of these juveniles. The health authority provides a written list of specific referral resources.

Discussion

All sources of assistance for physically or mentally disabled juveniles should be identified in advance of need.

Y-53 Prostheses (important)

Written policy and defined procedures require that medical and dental *prostheses* be provided when the health of the juvenile would otherwise be adversely affected, as determined by the responsible physician or dentist.

Discussion

*Prostheses* are artificial devices to replace body parts or compensate for defective body functions. They include such items as artificial limbs, eyeglasses, and full and partial dental plates.

Y-54 Dietary Services (important)

A nutritionally adequate diet incorporating the four food groups and based on the most recent recommended dietary allowances published by the National Research Council, should be provided to all juveniles. Special medical and dental diets are served to juveniles when ordered by the treating physician and/or dentist. Regular and special meals are approved by a registered dietitian every six months.

Discussion

Nutritionally adequate diets are derived from foods in the basic four food groups with minimum amounts provided from each of the four food groups. (See Appendix IV)

It is recommended foods be prepared without excessive amounts of salt and that total fat in the diet should be limited. Interpretation of nutritional guidelines into menus

providing specific caloric requirements requires consultation and approval by a registered dietitian due to the special nutritional needs of adolescents during different phases of growth and development.

Certain chronic conditions, for example, diabetes and obesity, as well as temporary ones such as pregnancy and post-oral surgery, require individual attention. Orders for special diets should include the type of diet, the duration of the diet, the duration for which the diet is to be provided, and any special instructions. The facility should have a procedure for ensuring that the right patient receives the diet which has been prescribed.

#### Y-55 Dental Care (important)

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

- *dental screening* within seven days of admission;
- *oral hygiene* instruction and dental health education within 14 days of admission;
- *dental examination* within one month of admission;
- dental treatment, not limited to extractions, when the health of the juvenile would otherwise be adversely affected, as determined by the dentist; and
- access to the preventive benefits of fluorides in a form considered appropriate for the needs of the individual as determined by the dentist.

In the case of a re-admitted juvenile who has received a dental examination within the past six months, a new exam is not required except as determined by the supervising dentist. Fluoride toothpaste must be available for all juveniles.

#### Discussion

As part of the initial health appraisal, *dental screening* is performed by a dentist or health personnel properly trained and designated by a dentist. It includes visual observation of the teeth and gums, noting any obvious or gross abnormalities requiring immediate referral to a dentist. *Oral hygiene* instruction and dental health education should be provided by dentists, dental hygienists, or dentally trained health

personnel, and should consist of measures to assist the patient in caring for his/her own oral health, such as instruction in the proper brushing and flossing of teeth.

Dental examinations and treatments are performed only by licensed dentists. The *dental examination* should include the taking or review of the patient's dental history, charting of teeth, and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination. X-rays for diagnostic purposes should be available if deemed necessary. The results of the examination are recorded on a uniform dental record system, such as the Attending Dentist's Statement, (see sample form, Appendix II). A professional dental prophylaxis should be performed as part of the treatment provided to the patients when prescribed by the dentist.

Consideration should be given to the use of topical fluorides when the dentist determines these to be needed.

Assistance should be provided for those juveniles who, because of mental, physical or other disabilities, are unable to perform daily oral hygiene techniques.

#### Y-56 Exercise (important)

Written policy and defined procedures outline a program of exercise and require that each juvenile be allowed a daily minimum of one hour of exercise involving *large-muscle activity*, on a *planned, supervised basis*.

#### Discussion

Examples of *large-muscle activity* are walking, jogging in place, basketball, ping-pong, and isometrics.

To meet compliance with exercise on a *planned, supervised basis*, the facility should provide a separate facility or room. The dayroom adjacent to the living units may be used for this purpose if planned, programmed activities are directly supervised by staff and/or trained volunteers. Otherwise, the designated hour would be no different from the rest of the day. Television and board games do not meet compliance.

Daily exercise should take place outside where possible. Regarding the use of outside yards, gymnasias and multi-purpose rooms, making available exercising opportunities (e.g., basketball, handball, jogging, running, and calisthenics) satisfies compliance even if juveniles do not take advantage of them. While such activities may be more productive under the supervision of a recreational staff person, this is

not required. For the purposes of supervision, juveniles should be within sight or sound of a staff person.

It is recommended that medical personnel advise staff about strenuous exercise during inclement environmental conditions (e.g., extreme heat or cold).

#### **Y-57 Outside Programs (important)**

Written policy and defined procedures guide outside programs such as Outward Bound or forestry camp. Recognizing the potential for health care crises in a wilderness setting, staff who accompany juveniles should be trained in first-aid and CPR.

#### Discussion

Activities and supplies for outside programs must be structured to take into account environmental conditions to avoid health problems such as dehydration or hypothermia. Policies and procedures should address the activity plan, supplies, and clothing for the outside programs.

#### **Y-58 Personal Hygiene (important)**

Written policy and defined procedures outline a program of personal hygiene and require that every facility that would normally expect to detain a juvenile at least 48 hours furnish bathing facilities in the form of either a tub or a shower with hot and cold running water, permit regular bathing at least every other day, permit daily bathing in hot weather in facilities without air temperature control, and make the following items available to juveniles: soap, toothbrush, fluoridated, toothpaste, comb, toilet paper, sanitary napkins and tampons when required, and laundry services at least weekly. Haircuts and implements for shaving are made available to juveniles subject to security regulations.



## SECTION D - HEALTH RECORDS

The standards in Section D cover the contents, form and format, confidentiality, transfer and retention of the health care records, based upon practices and jurisdiction.

### Essential Standards

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### Important Standards

Y-61 Transfer of Health Records and Information .....	54
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### Y-59 Health Record Format and Contents (essential)

At a minimum, the health record file contains:

- the completed initial health screening form;
- health appraisal data forms;
- master problem list;
- all findings, diagnoses, treatments, and dispositions;
- prescribed medications and their administration;
- reports of laboratory, x-ray, and diagnostic studies;
- signature and title of each documenter;
- consent and refusal forms, when applicable;
- release of information forms, when applicable;
- place, date, and time of health encounters;
- discharge summary of hospitalizations;
- health service reports (e.g., dental, psychiatric, and other consultations); and
- specialized treatment plan, if any.

The method of recording entries in the record and the form and format of the record are approved by the health authority. A record should be maintained on every juvenile in confinement.

#### Discussion

The problem-oriented medical record structure is suggested. *The chart should contain a master problem list, which includes all medical, dental, or psychiatric problems, allergies, and chronic medications.* However, whatever the record structure, every effort should be made to establish uniformity of record forms and content throughout the confinement system. The record is to be completed and all findings are to be recorded, including notations concerning psychiatric, dental and other consultative services. If a juvenile is admitted more than once, existing medical records should be re-activated.

When patients are seen only at the physician's office, the record is generally kept there. However, a form for recording the visit should accompany the juvenile, so the physician can provide information regarding diagnosis, treatment, and recommended follow-up care.

**Y-60 Confidentiality of the Health Record (essential)**

Written policy and defined procedures that establish the principle of confidentiality of the health record require that the active health record is maintained under secure conditions, separate from the confinement record, and that access to the health record is controlled by the health authority.

Discussion

The principle of confidentiality protects the patient from disclosure of certain confidences entrusted to a physician and other health professionals during a course of treatment. Special restrictions on disclosure under federal regulations may exist for information gathered and recorded about alcohol and drug use. On the other hand, health professionals are required in all states to report cases of suspected child abuse. The health authority should maintain a current information file on the rules and regulations covering the confidentiality of medical records and the types of information that can and cannot be shared.

The confidential relationship of doctor and patient extends to juvenile patients and their physicians. Thus, it is necessary to maintain active, secured health record files, completely separate from the juvenile's confinement record.

**Y-61 Transfer of Health Records and Information (important)**

Written policy and defined procedures regarding the transfer of health records and information to the outside community require that when a request for health record information is received, it is transmitted to specific and designated physicians or medical facilities in the community upon the written authorization of the juvenile.

Written policy and defined procedures regarding the transfer of health records and information require that:

Summaries or copies of the health record are routinely sent to the facility to which a juvenile is transferred either before or at the same time as the juvenile, and

Written authorization by the juvenile is necessary for the transfer of health records and information, unless otherwise provided by law or administrative regulation having the force and effect of law.

### Discussion

In the event of a transfer of a juvenile within the justice system, a juvenile's health record summary addressing medical, dental, and mental health problems should accompany or precede the juvenile in order to ensure continuity of care and to prevent the duplication of tests and examinations at the receiving institution. For juveniles with critical or chronic health problems, the files should be flagged in some fashion (e.g., with color coding) to trigger an immediate referral to medical personnel.

The transferring institution should provide a discharge summary (see sample Health Status Form in Appendix II) that includes at least these elements: medical history, date of last physical, immunization record, summary of medical problems, current health status, current level of activity, current therapy (including medications), and anticipated future health care needs.

#### Y-62 Record Retention (important)

Written policy and defined procedures requiring that inactive health record files are retained to legal requirements of the jurisdiction, and are re-activated if a juvenile returns to the system or facility.

### Discussion

Inactive health records need to conform to legal requirements for record retention. The inactive files should be marked in such a way that juveniles can be identified as long-term care patients if they re-enter the system or facility.



## SECTION E - MEDICAL-LEGAL ISSUES

The standards in Section E address medical-legal issues that frequently arise in correctional health care.

### Essential Standards

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### Important Standard

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### Y-63 Informed Consent (essential)

All examinations, treatments, and procedures governed by *informed consent* practices applicable in the jurisdiction are likewise observed for juvenile care. The informed consent of parent, guardian, or legal custodian applies when required by law.

#### Discussion

*Informed consent* is the agreement by the patient to a treatment, examination, or procedure after the patient receives the material facts regarding the nature, consequences, risks, and alternatives concerning the proposed treatment, examination, or procedure. As a general rule it is required prior to performing any invasive procedure or any treatment that has potential risks for the patient. This would include oral surgery.

The law regarding consent to the medical treatment by juveniles, and their right to refuse treatment, varies greatly from state to state. Some states allow juveniles to consent to treatment without parental consent, as long as they are mature enough to comprehend the consequences of their decision. Others require parental consent until majority, but the age of majority varies among the states. The law of the jurisdiction within which the facility is located should be reviewed by legal counsel, and, based upon counsel's written opinion, a policy regarding informed consent should be developed. In all cases, however, consent of the person to be treated is important.

Obtaining informed consent is not necessary in all cases. These exceptions to obtaining informed consent should be reviewed in the light of each state's laws, as the latter vary considerably. Examples of such situations are emergencies that require immediate medical intervention for the safety of the patient, emergency care involving patients who do not have the capacity to understand the information given, and public health matters, such as communicable disease treatment. Physicians must exercise their best medical judgment in all such cases. It is advisable that the physician document the medical record for all aspects of the patient's condition and the reasons for medical intervention. Such documentation facilitates review and provides a defense from charges of battery. In certain exceptional cases, a court order for treatment may be sought, just as it might be in the general community.

Consent is implied in a life threatening situation or when a juvenile's judgment is impaired, rendering him/her incapable of making an informed decision. In the latter situation, parental consent may still be required.

**Y-64 Right to Refuse (essential)**

Juveniles have the right to refuse examinations, treatments, and procedures in accord with laws within the jurisdiction. Written policy and defined procedures should allow juveniles to refuse, in writing, medical treatment and care. Policy and procedure should guide staff in dealing with juveniles who refuse care.

Discussion

The right to refuse treatment is an extension of informed consent. Medical treatment of a juvenile without his/her consent (or without the consent of parent, guardian, or legal custodian) can result in legal complications. In other words, the decision to refuse treatment should be an informed one. The juvenile should be brought to the clinic and the benefits and risks of the proposed treatment explained. If a juvenile refuses treatment, the health authority should notify the appropriate legal custodian.

Health professionals should counsel juveniles against refusals of treatment and should continue to counsel youths who have refused a particular treatment when they believe it to be in the patient's best interest. Refusals of treatment should be made to health staff. The right to refuse does not apply when the individual exhibits an altered mental state, impaired judgment, or in life threatening situations where consent is implied.

**Y-65 Medical Research (important)**

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

Discussion

This standard recognizes past abuses in the area of research on involuntarily confined individuals and stresses the protective measures and the interests of patient autonomy that must be considered in a decision to include such persons in clinical research. There should be adequate assurance of safety to the subject. The research should meet standards of design and control, and the juvenile must have given his/her informed consent. Federal restrictions, as well as the legal requirements of each jurisdiction, should be checked before such research is initiated. In some areas, the prior approval of a human subjects review committee is required.

When ethical, medical, and legal standards are observed, clinical trials may be an effective part of an individual treatment plan, as in the example of drug trials to treat HIV-infected individuals.



APPENDIX I

SAMPLE POLICIES AND PROCEDURES

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Sample Policy Directive and Accompanying Procedure ..... 67



## DEVELOPMENT OF A MANUAL OF POLICIES AND PROCEDURES<sup>1</sup>

All organizations have policies and procedures. Such policies and procedures may not be in writing; they may not even be called by those names. They may be referred to simply as "routines" or "the way we always do things." Whatever form they take, policies and procedures are important guides to decision-making and efficient management. Standardized and consistently interpreted policies and procedures provide the staff with a clear sense of the organization's directions and provide management with a means of control. When decisions are not in accord with written policies, the decisions can be examined and brought into line with policy. If current practices turn out to be inappropriate, or different practices make more administrative sense, policies can be changed in accordance with the management's objectives. To be most effective, policies and procedures should be formally established and in written form.

### Definition of Terms

A *policy* is a general statement of the goals of the organization in a specific topic area, and is a guideline for specifying and regulating operations designed to accomplish organizational objectives. It answers the question of why a certain action is favored.

A *procedure* is a specification of how a policy is to be carried out. It usually describes who will do what, when and how.

### Content Issues

In the final analysis, the most important issue involved in the development of policies and procedures is the content thereof. There are certain criteria that prescribe the nature of the content of policies and procedures. For example, written procedures should clearly specify the actions required of employees. The specific questions to be answered by a procedure statement are: Who does what? When? How?

There are other questions that can be asked to test how well a policy or procedure is written. For example:

- Does the procedure address policy objectives?
- Is the procedure realistic?
- Is the procedure adequate?
- Are all relevant contractual arrangements and requirements covered?
- Are other policies and procedures compatible with this one?
- Are procedural steps in the best order?
- Is the sequence of procedural steps unnecessarily rigid?

---

<sup>1</sup>This section was adapted from a publication entitled The Development of Policy and Procedure Manuals for Correctional Health Care Programs (Michigan Department of Corrections, 1979).

- Can any procedural step(s) be eliminated?
- Does the procedure avoid bottlenecks?
- Are the procedural steps designed to operate at the lowest level of authority?
- What is the effect of proposed changes on other policies and procedures?
- Will the procedure work on all shifts?

Two other questions should be asked once the manual is complete:

- What arrangements are needed to keep manuals current?
- Who should receive copy of the manual, and how should these people be trained in its use?

### Form

Clarity of the content of the policy or procedure is far more important than either its form or its format. Nevertheless, serious thought should be given to form and format, since they can contribute to clarity. The content of policies and procedures is usually typed onto official forms. Consideration should be given to providing space on the forms for the following items:

- The title of policy or procedure
- The date it goes into effect
- The date of revision
- The page number out of how many pages (e.g., page 1 of 4)
- The application: for example, when there are institutional differences in policies or procedures, this space shows the institution(s) to which this particular policy or procedure applies.
- The number of the policy or procedure
- The number of the policy or procedure it supersedes
- The signature(s) of approval and title(s) of the signer(s)
- The department, division or issuing agency and office of origin
- A reference to professional standards and state laws or administrative rules

Some of these items may appear in the body of the policy or procedure as part of the text, while others may be incorporated into the form itself. These are stylistic differences that have little consequence as long as the items are included somewhere in the written statement.

### Summary

Policies and procedures need to be developed for each of the Commission's standards.

<b>POLICY DIRECTIVE</b>	EFFECTIVE DATE:	NUMBER:
	<b>HEALTH SERVICES UNIT</b>	SUPERSEDES: NO.
		DATED:
<b>BASIC TRAINING OF CHILD CARE WORKERS</b>		Page <u>1</u> of <u>1</u>

**OBJECTIVE:** To provide all child care workers with basic health training, to achieve the skills and knowledge necessary to provide first aid in emergency situations.

**APPLICATION:** Health Services Unit and Child Care Workers of the \_\_\_\_\_ Juvenile facility.

**POLICY:** Training will be provided for the child care workers in the \_\_\_\_\_ Juvenile facility to enable them to respond to health related emergency situations.

This training shall include, but not be limited to, an awareness of potential emergency situations, response to life threatening conditions, and the responsibility of early detection of illness or injury.

The first aid training course will include a certified course in CPR with periodic in-service training to maintain certification.

**AUTHORITY:** NCCHC Juvenile Standards  
Responsible Health Authority  
Juvenile Administration

**REFERENCE:** NCCHC Standards 120

**APPROVED:** \_\_\_\_\_ Date \_\_\_\_\_  
Name, Title, Affiliation

\_\_\_\_\_ Date \_\_\_\_\_  
Name, Title, Affiliation

Name of Juvenile Facility  
Health Services Unit  
Address  
City, State Zip

POLICY DIRECTIVE	EFFECTIVE DATE:	NUMBER:
	HEALTH SERVICES UNIT	SUPERSEDES: NO.
		DATED:
BASIC TRAINING OF CHILD CARE WORKERS		Page <u>1</u> of <u>3</u>

**PROCEDURE:**

1. A training program will be established, approved by the Health Authority and the Juvenile Administration, to provide child care workers knowledge of the following:
  - A. Types of and action required for potential emergency situations;
  - B. Signs and symptoms of an emergency;
  - C. Administration of first aid, with training to have occurred within the past three years;
  - D. Methods of obtaining emergency care;
  - E. Procedures for transferring juveniles to appropriate medical facilities or health care providers; and
  - F. Signs and symptoms of mental illness, retardation, emotional disturbance and chemical dependency.
  
2. The training program will be the responsibility of the senior supervisor responsible for training and personnel. It will be coordinated with the Health Administrator.
  
3. Training for newly hired personnel (rookie training) will be held as needed. This training includes:
  - A. Emergency medical procedures, two (2) hours;
  - B. Supervision of all juveniles, two (2) hours;
  - C. Juvenile Detention and Confinement climate, two (2) hours; and
  - D. Handling juveniles with chronic disease: epilepsy, diabetes, alcoholics, etc. two (2) hours.
  
4. Each child care worker will attend the correctional academy within 18 months of employment. Included in the academy classes are:
  - A. Developing communication skills and coping skills, four (4) hours;
  - B. Critical incident role playing, four (4) hours;
  - C. Medical Administration, two (2) hours;
  - D. Special classification of juveniles, two (2) hours;
  - E. Crisis intervention, eight (8) hours;
  - F. Abnormal behavior, four (4) hours;
  - G. First aid procedures, four (4) hours;
  - H. Emergency evacuation behavior, four (4) hours; and
  - I. Basics of human behavior, four (4) hours.

POLICY DIRECTIVE	EFFECTIVE DATE:	NUMBER:
	HEALTH SERVICES UNIT	SUPERSEDES: NO.
		DATED:
BASIC TRAINING OF CHILD CARE WORKERS		Page <u>2</u> of <u>3</u>

5. Mandatory training classes will be held four (4) hours monthly including:

A. American Red Cross certification or equivalent:

1. First Aid - recertification every three (3) years
2. CPR - recertification yearly

B. Classes instructed by the Division of Mental Health totaling 20 hours

1. Identification and screening of psychiatric problems
2. Substance abuse disorders
3. Suicide
4. Other management problems
5. Crisis intervention
6. Facility procedures
7. Interviewing and communication skills
8. Additional training, held on a need basis, in conjunction with the mandatory training classes include review and up-dating of:
  - A. Previous training
  - B. Policies and procedures
  - C. Disaster planning
  - D. Certification in CPR and first aid for new employees

6. Child Care Workers, certified in CPR, will:

- A. Be available to respond to any emergency situation immediately
- B. Respond to all "man down" situations on their assigned floors:
  1. Request assistance as needed
  2. Stand by to assist Health Services personnel

7. Child Care Workers, trained in observation of signs and symptoms of life threatening situations (including psychiatric patients) will report the situations to the Health Services personnel by:

- A. Referring juvenile to Mental Health using Form #HS-7
- B. Referring juvenile to the medical unit by:
  1. Contacting the medical unit by phone or 2-way radio
  2. Writing a memo to be delivered to the Health Services Unit

POLICY DIRECTIVE	EFFECTIVE DATE:	NUMBER:
	HEALTH SERVICES UNIT	SUPERSEDES: NO.
		DATED:
BASIC TRAINING OF CHILD CARE WORKERS		Page <u>3</u> of <u>3</u>

8. Transferring of juveniles to outside medical facilities, when the Transportation Unit is off duty, may become the responsibility of a child care worker.

- A. The Health Service Unit will notify the shift supervisor
- B. See transportation procedure in the \_\_\_\_\_  
Juvenile Policies and Procedures Manual

APPROVED: \_\_\_\_\_ Date \_\_\_\_\_  
Name, Title, Affiliation

\_\_\_\_\_  
Name, Title, Affiliation Date \_\_\_\_\_

APPENDIX II  
SAMPLE FORMS

Medication Administration Information - Medication Log ..... 73

Sample Initial Health Screening - Long Form ..... 75

Sample Initial Health Screening - Short Form ..... 79

Health History Form ..... 81

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Attending Dentist's Statement ..... 85

Health Status/Transfer Sheet ..... 87

Sick Call Slip ..... 89







SAMPLE INITIAL HEALTH SCREENING FORM - LONG FORM

(This form is to be used when the full health appraisal is not likely to be performed within the first 48 hours of a juvenile's admission. It provides comprehensive information that may be useful to health care staff until a full health appraisal can be performed.)

Date \_\_\_\_\_  
Time \_\_\_\_\_

NAME OF INSTITUTION \_\_\_\_\_

Juvenile's Name \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth \_\_\_\_\_ Juvenile's Number \_\_\_\_\_

Examiner's Name \_\_\_\_\_

Examiner's Observations  
(where applicable, circle specific condition)

	<u>Yes</u>	<u>No</u>
1. Unconscious?	_____	_____
2. Visible signs of trauma or illness requiring immediate emergency or doctor's care?	_____	_____
Describe: _____		
3. Obvious fever, swollen lymph nodes, jaundice other evidence of infection that might spread through the facility?	_____	_____
Describe: _____		
4. Poor skin condition, vermin, rashes, or needle marks?	_____	_____
Describe: _____		
5. Under the influence of alcohol, barbiturates, or other drug(s)?	_____	_____
6. Visible signs of alcohol or drug withdrawal (extreme perspiration, pinpoint pupils, shakes, nausea, cramping, vomiting)?	_____	_____
Describe: _____		
7. Behavior suggesting risk of suicide or assault?	_____	_____
8. Carrying medication or reporting being on medication?	_____	_____
List: _____		
9. Visible Signs of Physical Deformities?	_____	_____
List: _____		

Examiner/Juvenile Questionnaire

10. Admits to the following (indicate by number and letter below):

- 1 (over one year ago)
- 2 (within past year)
- 3 (present now)

- H (hospitalized)
- M (medications, current)

- |                              |                                 |
|------------------------------|---------------------------------|
| _____ allergies              | _____ heart condition           |
| _____ arthritis              | _____ hepatitis                 |
| _____ asthma                 | _____ high blood pressure       |
| _____ delirium tremens (DTs) | _____ physician-prescribed diet |
| _____ dental condition       | _____ psychiatric disorder      |
| _____ diabetes               | _____ tuberculosis              |
| _____ epilepsy               | _____ ulcers                    |
| _____ fainting               | _____ urinary tract             |
| _____ venereal disease (VD)  | _____ other (specify) _____     |

11. Use alcohol?

- a. How often? \_\_\_\_\_
- b. How much? \_\_\_\_\_
- c. When were you drunk last? \_\_\_\_\_
- d. When did you drink last? \_\_\_\_\_

12. Use any "street" drugs?

- a. What type(s)? \_\_\_\_\_
- b. How often? \_\_\_\_\_
- c. How much? \_\_\_\_\_
- d. When did you get high last? \_\_\_\_\_
- e. When did you take drugs last? \_\_\_\_\_

13. (For female)

- a. Are you pregnant? \_\_\_\_\_ Number of months \_\_\_\_\_
- b. Have you delivered recently? \_\_\_\_\_ Date \_\_\_\_\_
- c. Are you on birth control pills? \_\_\_\_\_
- d. Any gynecological problems? (Specify) \_\_\_\_\_

Examiner/Juvenile Questionnaire (continued)

14. Immunization history (specify dates and diseases)

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Remarks (e.g., unusual behavior, special diet, type of VD, etc.)

---

---

---

Disposition or referral (circle appropriate response)

general population

emergency care

sick call

medical isolation

other (specify) \_\_\_\_\_

(A copy of this form should be included in the juvenile's medical record.)



SAMPLE INITIAL HEALTH SCREENING FORM - SHORT FORM

(this form is to be used when the full health appraisal is likely to be performed within the first 48 hours of a juvenile's admission)

Date \_\_\_\_\_

Time \_\_\_\_\_

NAME OF INSTITUTION

Juvenile's Name \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth \_\_\_\_\_ Juvenile's Number \_\_\_\_\_

Examiner's Name \_\_\_\_\_

Examiner's Observations  
(where applicable, circle specific condition)

	<u>Yes</u>	<u>No</u>
1. Does juvenile have obvious pain or injury? Describe: _____	_____	_____
2. Is there obvious sign of infection? Describe: _____	_____	_____
3. Does juvenile appear to be under the influence of alcohol or drugs? Describe: _____	_____	_____
4. Are there visible signs of alcohol and/or drug withdrawal? Describe: _____	_____	_____
5. Does juvenile appear to be despondent?	_____	_____
6. Does juvenile appear to be irrational or crazy? Describe: _____	_____	_____
7. Is juvenile carrying medication? List: _____	_____	_____
8. Are you taking any medications?	_____	_____
9. (If female) Are you pregnant?	_____	_____
10. Is this the first time you have been detained?	_____	_____

Examiner/Juvenile Questionnaire

- |  | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 11. Have you ever tried to kill yourself or done serious harm to yourself?   | _____      | _____     |
| 12. Do you have any serious medical or mental problems that you haven't told me about? (If yes, specify under remarks) | _____      | _____     |

Remarks

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---

---

Disposition or referral (circle appropriate response)

general population

emergency care

sick call

medical isolation

other (specify) \_\_\_\_\_

Note: Each "yes" answer requires a response. Guidelines for disposition that tell the examiner what to do or whom to call for each of the items on the form should be developed.

(A copy of this form should be included in the juvenile's medical record.)

Name & Number \_\_\_\_\_

Date: \_\_\_\_\_

Medical Confidential

## Health History

HAVE YOU EVER?	YES	NO	DO YOU?	YES	NO		
Lived with anyone who had TB			Wear glasses or contact lenses				
Coughed up blood			Have vision in both eyes				
Bled excessively after injury			Wear a brace or back support				
Attempted suicide							
HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW	HAVE YOU EVER HAD OR HAVE YOU NOW?	YES	NO	DON'T KNOW
Asthma				Night Sweats			
Tuberculosis				Tumors, Cysts, or Growths			
Cancer or Tumor				Cramps in your Legs			
Diabetes				Rupture or Hernia			
Emphysema				Recent gain or loss of Weight			
Ear, Nose, or Throat Trouble				Frequent Indigestion			
Hearing Loss				Stomach Trouble or Ulcer			
Chronic or Frequent Colds				Hepatitis or Jaundice			
Hay Fever				Gall Bladder Trouble			
Severe Tooth or Gum Trouble				Hemorrhoids or Rectal Trouble			
Shortness of Breath				Head Injuries			
High Blood Pressure				Epilepsy or Seizures			
Pain or Pressure in Heart				Frequent or Severe Headaches			
Pounding Heart				Loss of Memory or Amnesia			
Arthritis or Bursitis				Periods of Unconsciousness			
Fractures (Broken Bones)				Paralysis, Numbness, Weakness			
Bone, Joint, or Other Deformity				Dizziness, Fainting Spells			
Painful or Trick Shoulder				Nervous Problem of Any Type			
Foot Trouble				Alcoholism			
Recurrent Back Trouble				Syphilis, Gonorrhea			
Swollen or Painful Joints				Drug Allergies			
Kidney Trouble				Lumps, Pain, Discharge on Breast			
Frequent or Painful Urination				Change in Menstrual Pattern			
Blood in Urine				Pregnancy/Abortion/Miscarriage			
Recurrent Infections				Treated for Female Disorder			
Rheumatic Fever				Thyroid Trouble			
YOUR PRESENT DOCTOR'S NAME (Address, Phone)				Have you ever been a patient or received treatment in a hospital? (surgery/injuries); state where, when, why & address			
Have you ever been treated for a mental condition? (If yes, state reason and give details)				Have you ever taken narcotics? (If yes, state what kind, when you last took it, and if you are in a treatment program)			
Highest level of education (years)				Additional Remarks: (use reverse side)			
Have you ever been incarcerated in this jail before? (if so, when?)							



# Receiving Screening Form

DATE \_\_\_\_\_

TIME \_\_\_\_\_

NAME \_\_\_\_\_ SEX \_\_\_\_\_ D.O.B. \_\_\_\_\_

JUVENILE NO. \_\_\_\_\_ OFFICER OR PHYSICIAN \_\_\_\_\_

## INTAKE OFFICER'S VISUAL OPINION

- |   |     |    |
|---|-----|----|
| 1. Is the juvenile conscious?   | YES | NO |
| 2. Does the new juvenile have obvious pain or bleeding or other symptoms suggesting need for Emergency Service?                                 | YES | NO |
| 3. Are there visible signs of trauma or illness requiring immediate Emergency or Doctor's care?   | YES | NO |
| 4. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection which might spread through the juvenile facility?       | YES | NO |
| 5. Is the skin in good condition and free of vermin?  | YES | NO |
| 6. Does the juvenile appear to be under the influence of alcohol?   | YES | NO |
| 7. Does the juvenile appear to be under the influence of barbiturates, heroin or any other drugs?   | YES | NO |
| 8. Are there any visible signs of Alcohol/Drug withdrawal symptoms?   | YES | NO |
| 9. Does the juvenile's behavior suggest the risk of suicide?  | YES | NO |
| 10. Does the juvenile's behavior suggest the risk of assault to staff or other juveniles?   | YES | NO |
| 11. Is the juvenile carrying medication or does the juvenile report being on medication which should be continuously administered or available? | YES | NO |

(Officer-Juvenile Questionnaire on back)

## OFFICER-JUVENILE QUESTIONNAIRE

- |   |     |    |
|---|-----|----|
| 12. Are you presently taking medication for diabetes, heart disease, seizures, arthritis, asthma, ulcers, high blood pressure, or psychiatric disorder? | YES | NO |
| 13. Do you have a special diet prescribed by a physician?   | YES | NO |
| Type _____  |     |    |
| 14. Do you have history of venereal disease or abnormal discharge?  | YES | NO |
| 15. Have you <u>recently</u> been hospitalized or recently seen a medical or psychiatric doctor for any illness?  | YES | NO |
| 16. Are you allergic to any medication?   | YES | NO |
| 17. Have you fainted recently or had a recent head injury?  | YES | NO |
| 18. Do you have epilepsy?   | YES | NO |
| 19. Do you have a history of tuberculosis?  | YES | NO |
| 20. Do you have diabetes?   | YES | NO |
| 21. Do you have hepatitis?  | YES | NO |
| 22. If female, are you pregnant?  | YES | NO |
| 23. Are you currently on birth control pills?   | YES | NO |
| 24. Have you recently delivered?  | YES | NO |
| 25. Do you have a painful dental condition?   | YES | NO |
| 26. Do you have any other medical problem we should know about?   | YES | NO |

REMARKS:

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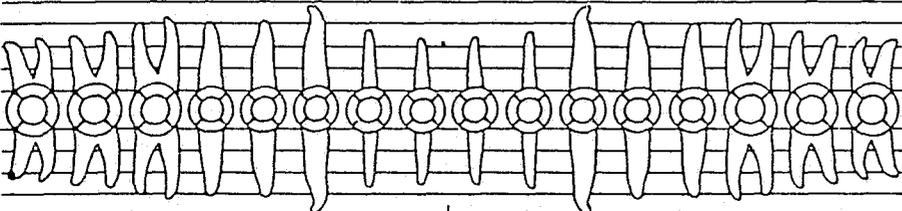
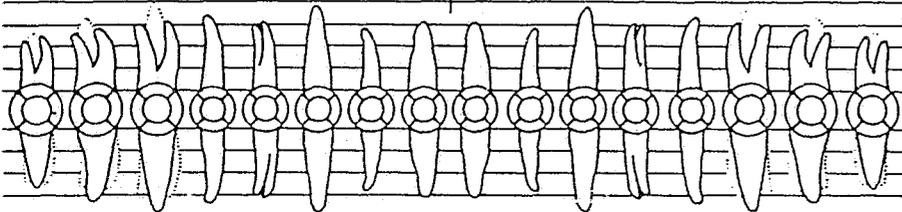
(A copy of this form is included in the patient's medical record)

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ SPOUSE'S FIRST NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ PATIENT NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHYSICIAN'S NAME AND PHONE NUMBER \_\_\_\_\_ DATE OF EXAMINATION \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ COPY OF DIAGNOSIS TO BE SENT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----



32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

General Health \_\_\_\_\_ Reactions to Anesthetics? \_\_\_\_\_  
 Physician's Care? \_\_\_\_\_ Rheumatic Fever? \_\_\_\_\_  
 Medications? \_\_\_\_\_ Heart Murmur? \_\_\_\_\_  
 Diabetes? \_\_\_\_\_ High Blood Pressure? \_\_\_\_\_  
 T.B.? \_\_\_\_\_ Heart Disease? \_\_\_\_\_  
 Hepatitis? \_\_\_\_\_ Bleeding? \_\_\_\_\_  
 Venereal Disease? \_\_\_\_\_ Lung Disease? \_\_\_\_\_  
 Radiation Therapy? \_\_\_\_\_ Kidney Disease? \_\_\_\_\_  
 Anemia? \_\_\_\_\_ Breathing Problem? \_\_\_\_\_  
 Epilepsy? \_\_\_\_\_ Other? \_\_\_\_\_  
 Last Elective Dental Treatment? \_\_\_\_\_

CODE: S.C. - Space Closed C.R. - Crown X - Missing Teeth

1	2	3	4	5	6	7	8	UPPER	9	10	11	12	13	14	15	16
⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙		⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙
RIGHT							LINGUAL							LEFT		
⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙		⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙
32	31	30	29	28	27	26	25	LOWER	24	23	22	21	20	19	18	17

**MEDICAL HISTORY - SUMMARY**

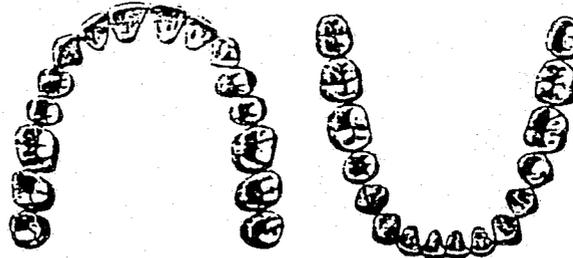
General Health \_\_\_\_\_  
 Existing Illness \_\_\_\_\_  
 Medicine/Drugs \_\_\_\_\_  
 Allergies \_\_\_\_\_ Blood pressure S \_\_\_/ D \_\_\_/ \_\_\_

**DENTAL HISTORY - SUMMARY**

Attitude \_\_\_\_\_  
 Home Care \_\_\_\_\_

**CLINICAL DATA**

General Condition of Teeth \_\_\_\_\_  
 Plaque \_\_\_\_\_ Stains \_\_\_\_\_ Abrasions \_\_\_\_\_  
 Condition of Present Restorations \_\_\_\_\_  
 Overhangs \_\_\_\_\_ Contact Points \_\_\_\_\_  
 Inflammation of Gingival Tissue: Slight \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_  
 Color \_\_\_\_\_ Recession \_\_\_\_\_ Pockets \_\_\_\_\_  
 Condition of the Floor of Mouth \_\_\_\_\_  
 Palate: Hard \_\_\_\_\_ Soft \_\_\_\_\_ Cheeks \_\_\_\_\_ Lips \_\_\_\_\_  
 Frenum \_\_\_\_\_ Tongue \_\_\_\_\_ Ridges \_\_\_\_\_  
 Presence of Exudate \_\_\_\_\_ Areas of Food Retention \_\_\_\_\_ Saliva \_\_\_\_\_  
 Calculus: Slight \_\_\_\_\_ Moderate \_\_\_\_\_ Excessive \_\_\_\_\_ Oral Cancer Exam \_\_\_\_\_  
 TMJ \_\_\_\_\_ Neck \_\_\_\_\_ Occlusion \_\_\_\_\_  
 Results of X-Ray: Bone \_\_\_\_\_ Root Tips \_\_\_\_\_ Impactions \_\_\_\_\_  
 Supernumerary \_\_\_\_\_ Abscesses \_\_\_\_\_



X-Rays	_____
Study Models	_____
Photographs	_____
Clinical Exam	_____
Vitality Test	_____
Mobility	_____

NAME				
TOOTH	SERVICES NECESSARY	FEES		
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# Health Status

Transferring Facility: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Time: \_\_\_\_\_ AM PM

Name: \_\_\_\_\_

Number:       Race: B W H Other

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F

Allergies: \_\_\_\_\_ Food Handler Approved: Y / N Review Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Acute Conditions/Problems: \_\_\_\_\_

Chronic Conditions/Problems: \_\_\_\_\_

Current Medications - Name, Dosage, Frequency, Duration: \_\_\_\_\_

Acute Short-term Medications: \_\_\_\_\_

Chronic Long-term Medications: \_\_\_\_\_

Chronic Psychotropic Medications: \_\_\_\_\_

Current Treatments: \_\_\_\_\_ Dietary Restrictions: \_\_\_\_\_

Follow-up Care Needed: \_\_\_\_\_

Chronic Clinics: \_\_\_\_\_ Specialty Referrals: \_\_\_\_\_

Significant Medical History: \_\_\_\_\_

Physical Disabilities/Limitations: \_\_\_\_\_

Assistive Devices/Prosthetics: \_\_\_\_\_ Glasses: \_\_\_\_\_ Contacts: \_\_\_\_\_

Mental Health History/Concerns: \_\_\_\_\_ Substance Abuse:  Alcohol:  Drugs:

Hx Suicide Attempt: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hx Psychotropic Medication

Former MPC/Dixon STC Placement

Signature and Title \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Transfer Reception Screening

Facility: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Time: \_\_\_\_\_ AM PM

P: Disposition: (Instructions: Check or circle as appropriate)

S: Current Complaint: \_\_\_\_\_

Current Medications/Treatment: \_\_\_\_\_

O: Physical Appearance/Behavior: \_\_\_\_\_

Deformities: Acute/Chronic \_\_\_\_\_

T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ B/P \_\_\_\_\_ / \_\_\_\_\_

A: \_\_\_\_\_

- Routine, Sick Call
- Instructions Given
- Emergency Referral
- AIDS Instruction Given
- Physician Referral:
  - Urgent / Routine
  - Medication Evaluation
  - Therapeutic Diet
  - Special Housing
  - Work/Program Limitation
  - Specialty Referrals
  - Chronic Clinics
  - Other
- Infirmiry Placement

Other: \_\_\_\_\_

Signature and Title \_\_\_\_\_



---

# Sick Call Slip

Date \_\_\_\_\_ Time \_\_\_\_\_

Name \_\_\_\_\_

Cell \_\_\_\_\_

Complaint \_\_\_\_\_

For how long \_\_\_\_\_

TO BE FILLED OUT BY SHIFT COMMANDER:

Disposition and Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ Initials \_\_\_\_\_



APPENDIX III

SUICIDE PREVENTION GUIDELINES

Suicide Assessment and Prevention Guidelines .....	93
Sample Mental Status Assessment Sheet .....	95
Sample Suicide Precaution Protocols .....	97



## SUICIDE ASSESSMENT AND PREVENTION GUIDELINES

The initial health screening form (see samples, Appendix II) should contain some items regarding potential suicide risk. When it is suspected that a youth is suicidal, s/he should be referred to a mental health professional to determine the degree of suicide risk and the supervision level required. Degree of risk can be assessed using a form such as the sample included here. Also included are two sample protocols for supervising juveniles placed on various precaution levels.



SAMPLE MENTAL STATUS ASSESSMENT SHEET

Date \_\_\_\_\_

Institution \_\_\_\_\_

Juvenile's Name \_\_\_\_\_

Examiner \_\_\_\_\_

	<u>Yes</u>	<u>No</u>
1. Depressed mood	_____	_____
2. Suicidal ideation or behavior	_____	_____
3. Agitation	_____	_____
4. Paranoia	_____	_____
5. Loose associations	_____	_____
6. Hallucinations	_____	_____
7. Delusions	_____	_____
8. Bizarre thoughts or behavior	_____	_____
9. Emotional or social withdrawal	_____	_____
10. Violent behavior or threats	_____	_____
11. Other	_____	_____

Specify \_\_\_\_\_

Descriptions and additional remarks:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## SAMPLE SUICIDE PRECAUTION PROTOCOLS

If any staff suspects that a youth is depressed and/or suicidal, the medical department should be notified. The physician and/or on-call psychiatrist should then be consulted. Any of the following levels of precaution may be recommended:

### LEVEL 1

In most circumstances, this level will pertain to juveniles who have actually recently attempted suicide. The on-call psychiatrist will have been notified. Efforts will be in progress to have the youth committed to a mental health facility.

The youth should be in a "safe room" or in the health clinic. Health staff should provide one to one constant attention while the youth is awake, with visual checks every five to ten minutes while the youth is asleep in a safe environment (described in Level 2). Toileting and bathing may or may not be visually supervised, depending on juvenile's mood at the time; if visually unsupervised, staff should be standing close by with the door slightly ajar.

### LEVEL 2

This level will pertain to youth who are considered at high risk for suicide. The on-call psychiatrist will have been consulted. Efforts will probably be made to have the youth committed to a mental health facility.

The juvenile should be either in a "safe room" or in the health clinic. Safety precautions should be observed. These should include searches of room and clothes for removal of all potentially harmful objects such as glass, pins, pencils, pens, and matches. Plastic bags should be removed. The room should be near the staff office, with no access to breakable glass and no electrical outlets (or outlets that can and should be turned off.) There be no bed in the room if possible, and no pipes from which sheets could be hung. There may be a mattress and pillow on the floor. The juvenile may have clothes (no belts), linen, and blankets. If the youth verbalizes or demonstrates immediate intent to harm himself/herself, bedding should be removed and the health staff notified. The youth should be checked at least every five minutes while awake and every ten minutes while asleep. He/she should have one to one attention when out of room, if potentially harmful objects (pencils, T.V., etc.) are brought into room, or if he/she seems unusually distraught. Toileting and bathing: same as for Level 1.

### LEVEL 3

This level will pertain to juveniles whom the physician or on-call psychiatrist feel are at moderate risk for suicide. They may be youths who have previously been on Level 1 or 2 and whose mental status is improving.

Safety precautions should be taken. These should include searches of room and clothes for removal of obviously potentially harmful objects, such as broken glass, pins, and matches. Plastic bags should not be permitted. Bed and linen may be allowed in room. The youth may have writing materials (and T.V in the health clinic) at staff discretion, but these should be removed when not in use. Toileting and bathing may be done in the as in the normal

routine. The youth should be checked visually at least every ten minutes while awake, every one-half hour while asleep.

#### LEVEL 4

This level will most often pertain to children who are at risk for becoming severely depressed/suicidal. This assumption may be based on past history.

The youth may be dealt with as in the normal unit routine; however staff should observe the youth for symptoms of depression and signs of suicidal ideation, and should notify health staff if new signs or symptoms occur. The youth should be checked visually at least every half hour while awake and asleep.

The mental status of any given juvenile may vary greatly from day-to-day and sometimes from hour to hour; therefore, it is imperative that staff have good observational skills and knowledge of signs and symptoms to look for. If any staff member has reason to feel that a youth who is already on a precaution level should be moved to a higher level of precaution, the medical department should be notified, and the physician and/or psychiatrist again consulted.

**APPENDIX IV**  
**NUTRITION GUIDELINES**

<b>General Food Service Guidelines .....</b>	<b>101</b>
<b>Menu Patterns for Adolescents .....</b>	<b>101</b>



## GENERAL FOOD SERVICE GUIDELINES

The nutritional requirements of teenagers vary according to age, sex, activity, and level of maturation. The amounts and types of food suggested below will satisfy the needs of most teenagers. However, those who are still growing or are very active will require increased portion sizes, primarily of grain and milk products, as well as fruits and vegetables. Meats add unnecessary protein and fat so should not be counted on alone to provide the additional nourishment. Foods that are rich in fat and sugar contribute energy (calories) with little other nutritional value and in excess are detrimental to health of all individuals. They should be limited especially for individuals of adequate or above average weight. For more specific suggestions for planning menus for adolescents see next page.

### MENU PATTERNS FOR ADOLESCENTS

Teenagers have a wide range of energy needs, from 1,500 to 4,000 calories. Those who are still growing, very active, or male need the most. Females, those who have finished growing or who are not active need less. Pattern A is designed for those in the lower range and Pattern B for those in the higher range. (Approximately 2,100 and 3,400 calorie levels were used because they are midpoints in the lower and upper halves of the range.) The most suitable Pattern for an individual will be the one which allows that teenager to maintain an appropriate weight for height. Using the suggested types of foods will insure that the diet has a balance of nutrients as well as energy.

#### PATTERN A

(Calories are approximate and will vary with  
serving size and preparation)

<u>Breakfast</u>	(calories)	<u>Lunch</u>	(calories)	<u>Dinner</u>	(calories)
Fruit (citrus) 1	(40)	Fruit 1	(40)	Milk 1	(120)
Milk 1	(120)	Milk 1	(120)	Protein 2 oz.	(200)
Cereal 1	(100)	Protein 2 oz.	(200)	Carbohydrate 1	(70)
Bread	(70)	Bread 2	(140)	Bread 2	(140)
Butter and Jam	(45+20)	Vegetable	(25)	Vegetable	(25)
		Butter (fat)	(45)	Dressing 1 Tb.	(135)
				Butter	(45)
				Dessert	(100)
				Snack Protein	(100)
				Snack Carbo 1	(115)

**PATTERN B**

Breakfast

	(calories)
Fruit (citrus) 1	(40)
Milk 2	(240)
Cereal 2	(200)
Bread 2	(140)
Butter and Jam	(90+40)

Lunch

	(calories)
Fruit 1	(40)
Milk 1	(120)
Protein 4 oz.	(400)
Bread 3	(210)
Vegetable 1	(25)

Dinner

	(calories)
Milk 1	(120)
Protein 2 oz.	(200)
Carbohydrate 2	(140)
Bread 2	(140)
Vegetable 2	(50)
Butter (fat)	(45)
Dressing 2 Tb.	(270)
Butter	(45)
Dessert 2	(200)
Snack Protein	(100)
Snack Carbo 2	(230)

**SAMPLE MEAL - PATTERN A [for PATTERN B increase to amounts in parentheses]**

Breakfast

1/2 c. juice, or 1 fruit  
 1 c. milk  
 1 c. cold cereal (2 c.)  
 1 slice toast (2)  
 Butter and jam (2)

Lunch

Sandwich (ww brd.) (2)  
 with cheese/cold cuts  
 1/2 c. corn, etc. (1c.)  
 Apple  
 Milk 1 c.

Dinner

1 c. milk (2 c.)  
 2 oz. beef (4 oz.)  
 1 potato (2)  
 Salad  
 Dressing 1 tb.  
 Ww roll (2)  
 Butter  
 2 cookies (4)  
 Snacks - cheese  
 Wedges, 1 oz.  
 Peanut butter  
 Crackers

Nutritionally adequate diets are derived from foods in the four basic food groups with minimum amounts provided from each group as follows:

Every teenager should have at least:

4 Servings from the Milk Group\*

1 serving = 1 c. milk or yogurt or  
2 c. cottage cheese or  
1 1/2 oz. cheese or  
1 c. pudding or  
1 3/4 c. ice cream

\*These products should ideally be low fat.

2 servings from the Meat Group

1 serving = 2 oz. cooked lean meat, fish, or poultry or  
2 eggs or  
2 slices of cheese or  
1/2 c. cottage cheese or  
1 c. dried beans or peas or  
4 Tb. peanut butter

4 servings from the Fruit/Vegetable Group

1 serving = 1/2 c. cooked vegetable or  
1/2 c. vegetable juice or  
1 c. raw vegetable or  
1 c. raw fruit or  
1 medium size fruit, i.e., apple, banana, etc.  
Dark green vegetables and fruit 3-4 times weekly for Vitamin A.  
Citrus fruit daily for Vitamin C.

4 servings from the Grain Group

1 serving = 1 slice bread  
1 c. ready-to-eat cereal  
1/2 c. cooked cereal  
1/2 c. pasta  
1/2 c. grits  
Preferably, these should be whole grains.



APPENDIX V

STANDING ORDERS VS. TREATMENT PROTOCOLS

Standing Orders vs. Treatment Protocols ..... 107



## STANDING ORDER VERSUS TREATMENT PROTOCOLS

*Standing orders* are written orders that specify the same course of treatment for each patient suspected of having a given condition. *Treatment protocols* are written orders that specify the steps to be taken in appraising a patient's physical status.

### Standing Order for Moderate Alcohol Withdrawal

Administer Chlordiazepoxide (Librium) 50 mg IM stat and q 8 hours. Thiamine 50 mg IM stat and po q A.M.

### Treatment Protocol for Moderate Alcohol Withdrawal

1. Symptoms/Presentation
  - History of alcohol abuse
  - History of recent (12 -72 hours) abstinence
  - Tremulousness
  - Diaphoresis
  - Restlessness
  - No hallucinations, no disorientation, no convulsions
2. Take vital signs.
3. Evaluate for history or signs of trauma.
4. Contact physician to discuss disposition/medication.
5. House in area of constant observation.
6. If disorientation, confusion, convulsions, etc. occur, arrange for immediate hospital emergency department transfer.

**Note:** More detailed therapeutic guidelines are acceptable in sites where nurse practitioners/physician assistants are employed and state regulations allow for enhanced responsibility.



APPENDIX VI

HEALTH CARE ACCREDITATION INFORMATION

About Health Care Accreditation ..... 111

Fact Sheet - NCCHC's Accreditation Process ..... 113

Application for Accreditation of Correctional Health Services Programs ..... 117

Annual Maintenance Report ..... 121



## ABOUT HEALTH CARE ACCREDITATION

The National Commission on Correctional Health Care uses the standards in evaluating facilities which voluntarily seek accreditation. Accreditation serves as recognition that an organization and its staff are performing at a level which experts have determined to be acceptable.

### HOW DOES THE NCCHC ACCREDITATION PROCESS WORK?

Upon application from a juvenile confinement or detention facility (an Application Form is this Appendix), NCCHC requests the facility to complete a Self Survey Questionnaire (SSQ) to determine its current level of compliance with the standards. Based upon review of the questionnaire, the facility may be offered technical assistance to correct areas that do not meet the standards. Once it appears that the facility is in sufficient compliance with the standards, arrangements are made for an on-site visit by a survey team.

NCCHC surveyors are experienced health professionals who have worked in the corrections field. The size of survey team and the length of their on-site visit depends upon the size of the facility. The team may include clinicians (i.e., physicians, nurses, physician assistants, dentists, psychiatrists, etc.) and others (i.e., administrators, pharmacists, mental health professionals) who have experience in the setting they are surveying (i.e., juvenile confinement or detention, jail, prison). Through accreditation, surveyors determine the existence of a policy and procedures manual and evidence of practice demonstrating that the approved guidelines are being followed by facility staff. The survey process includes: structured interviews with key personnel (e.g., the responsible health authority, the person legally responsible for the facility, health services staff, correctional officers) and resident youth; protocols for the review of documents and health records; and an exit conference summarizing the findings of the survey team. Some helpful information on applying and preparing for the accreditation site visit is included in this Appendix.

All survey reports are reviewed by the NCCHC's Accreditation Committee. The committee meets three times a year (February, June, and October). Accreditation is awarded to facilities that demonstrate compliance with all applicable essential standards and eighty-five (85) percent of the applicable important standards. Aside from the decision to accredit a facility, the committee may decide to: 1) accredit a facility upon further verification of some items (e.g., that all health professionals have valid licenses that could not be determined during the on-site survey); 2) defer the accreditation pending the receipt of more material or information (e.g., a disaster drill report that was not available during the on-site survey); or 3) deny accreditation (e.g., the facility is not in compliance with all applicable essential standards and at least 85% of all the applicable important standards).

On-site survey visits are required at least every three years. In the interim years, accredited facilities are required to submit annual verification of continued compliance with the standards through an Annual Maintenance Report (AMR). AMRs are also reviewed by the Accreditation Committee that, as with on-site survey reports, may: (1) continue accreditation; (2) request verification through additional information; (3) defer accreditation pending an on-site special survey (e.g., as may be required when there has been a change in the facility's administration); or (4) withdraw accreditation if the facility no longer meets accreditation standards. Accreditation decisions may be appealed through a defined process.

## CONFIDENTIALITY

Confidentiality in the accreditation survey process is essential in the determination of compliance with standards. Except as required by law, all information obtained by the NCCHC during an accreditation survey, and the resulting accreditation report that may include recommendations for standards compliance, are privileged and confidential information. Only upon the explicit request of an accredited correctional health program, by the person legally responsible for that program, or as required by law, will an accreditation report be released to a party other than the accredited facility. None of this information will be released to the public or media by NCCHC except as required by law or as explicitly directed by the accredited facility. The following general information is available from NCCHC upon request:

Description of the accreditation process.

Historical involvement of the American Medical Association and general history on NCCHC.

Summary, aggregate information on accredited correctional health programs (e.g., by state, type, size, etc.).

Names, positions, addresses of NCCHC's Board of Directors and members of the Accreditation Committee.

Names and addresses of NCCHC's supporting organizations that have named person's to the Board of Directors.

Additionally, the following information is available from the National Commission about the health service of a specific correctional facility.

Whether or not the facility is accredited by NCCHC.

The dates of the last on-site survey and of the accreditation award.



**NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE**  
2105 N. Southport, Chicago, Illinois 60614, (312) 528-0818

**FACT SHEET**  
**NCCHC's ACCREDITATION PROCESS**

A completed application, signed by the person legally responsible for the facility, should be submitted at the earliest possible date.

**PRE-SURVEY ACTIVITY**

1. One copy of the completed self survey questionnaire (SSQ) should be returned to the National Commission for review. If problems are encountered or questions arise, call the Vice President for Professional Services at (312) 528-0818.
2. You may submit a copy of your manual of health services policies and procedures for review prior to the site survey.
3. When it appears, from the data contained in the SSQ and/or discussion, that your facility is ready for a site survey, you will be contacted and a date will be agreed upon for the survey.
4. Site surveys must be completed at least four weeks before the meeting of the Accreditation Committee (meetings are held in February, June and October). In order to include all facilities in the appropriate review schedule, it is necessary to have your assistance in setting the earliest possible date for the survey of your facility.

**SURVEY**

It is our intention to not interfere with your daily activities and we hope to make the process operate efficiently so that you can maximize the benefits of the survey. Your preparation and assistance in the areas listed below will help to ensure a smooth visit.

**Correctional Staff**

1. Notify the sheriff, warden or administrator of the visit and the need for a personal interview.

2. Inform security personnel that the surveyor(s) will choose a random sample of inmates from a current inmate roster, and a sample of correctional officers to conduct private interviews with these persons. Please arrange for a private interview room.
3. Advise security personnel that the surveyor(s) will need to tour the facility at some point during the survey.

#### Medical Staff

1. Arrange for the chief health administrator to schedule time for an extensive interview.
2. Arrange for all applicable individuals listed below to be available for private interviews. Please arrange for an appropriate room.

responsible physician	psychiatrist
dentist	psychologist
food service director	pharmacist
medical staff	health care personnel

3. Have your policy and procedures manual readily available.
4. Review the standards. Have documentation relative to the standards readily available. Facilities often provide a binder or folders of documentation which supports each NCCHC standard. For example, a folder with credentials of health services staff would be labelled J-15 (or P for prisons).
5. Have the following documentation assembled and available for review:
  - ▶ Job descriptions for all health care staff (medical, dental and mental health).
  - ▶ Minutes of meetings between the health authority and facility administrator for the past year.
  - ▶ Documentation of monthly meetings of health staff for the past year.
  - ▶ Statistical reports for a one-year period.
  - ▶ Health services policy manual.
  - ▶ Institution's standard operating procedure manual.
  - ▶ Separate policy manuals for special services (if any): laboratory, radiology, physical therapy, etc.
  - ▶ Documentation of physician chart reviews.
  - ▶ Minutes of quality assurance committee meetings.
  - ▶ Documentation of external peer review (if any) in the form of letters or reports.
  - ▶ The facility's disaster plan.
  - ▶ Monthly sanitation reports or checklists.

- ▶ Copies of credentials for all health staff employed full or part-time (medical, dental and mental health).
- ▶ Plan/curriculum for orientation of new health staff.
- ▶ In-service training plan/schedule/curriculum for health staff.
- ▶ Documentation of in-service training received in the past year for each full-time health professional.
- ▶ Curricula/schedule for health-related training of correctional staff.
- ▶ Documentation indicating the number of correctional staff who have had:
  - (a) first-aid training, (b) CPR training, (c) other health-related training.
- ▶ List of health professionals who are CPR-trained.
- ▶ First-aid kit inspection logs or records.
- ▶ Inventory sheets/logs/records for: (a) syringes and needles; (b) sharp instruments; (c) controlled drugs.
- ▶ Copies of written agreements with all hospitals that provide services to inmates.
- ▶ The formulary used by the facility.
- ▶ A copy of the inmate handbook (if any) or other written material given to inmates regarding access to health services.
- ▶ A mock (blank) medical record containing copies of all forms used, filed in the order in which they appear in patients' charts.
- ▶ Blank copies of any other health service forms used (except fiscal) that are not filed in the patients' charts.
- ▶ Sick call logs/appointment lists for a two-week period for medical, dental and mental health services.
- ▶ Copies of any standing orders or treatment protocols used.
- ▶ Meeting minutes (if there is an infection control committee) or other documentation regarding infection control practices.
- ▶ Examples of pamphlets, other materials and/or lists of video tapes used in the inmate health education program.
- ▶ A list of the names and phone numbers of people, hospitals, ambulances, etc. to be called in an emergency.
- ▶ A list of dental treatment priorities.
- ▶ Sample menus (regular and therapeutic).
- ▶ Sample logs, cell cards or other evidence that health staff check individuals in segregation.
- ▶ A description of the scope of services provided in the infirmary (if any).
- ▶ A manual of nursing procedures for the infirmary (if any).

- ▶ The facility's plan and/or policies addressing suicide prevention.
  - ▶ A list of any deaths at the facility during the past five years.
6. The surveyors will randomly select individual medical records for review.
  7. An exit conference will be conducted at the end of the survey. This conference is intended to provide you with feedback regarding the survey, but is not conclusive and binding on the Accreditation Committee. Please allow one hour with the facility principals to review the surveyor(s) findings.

#### ACCREDITATION COMMITTEE

1. The data collected during the site survey are correlated, analyzed and presented to the Accreditation Committee for review and decision.
2. The Committee may:
  - (a) Award -- accreditation for an annual period;
  - (b) Award with Verification -- the facility's accreditation is contingent upon receipt and verification of relevant data (usually some missing information from the survey).
  - (c) Defer -- the decision on accreditation until the next review period (usually on the basis of deficiencies and/or missing data); or,
  - (d) Deny -- no accreditation is awarded to the facility.
3. Under deferral, the facility is asked to reimburse the Commission for out-of-pocket expenses incurred in a revisit to the facility. Only two (2) deferrals are permitted per accreditation.

#### NOTIFICATION

The Commission will notify the sheriff, warden or administrator by letter of the action of the Accreditation Committee. A certificate of accreditation will be sent with this letter, if payment of all outstanding fees has been received. If you have not received notice of the decision within thirty days of the meeting date, please contact the Commission directly.

11/91



**NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE**

2105 N. Southport, Chicago, Illinois 60614, (312) 528-0818

**APPLICATION FOR ACCREDITATION OF  
CORRECTIONAL HEALTH SERVICES PROGRAMS**

Legal Name of Facility (to appear on certificate of accreditation):

---

Check one:     Jail     Prison     Juvenile Confinement

We hereby apply to the National Commission on Correctional Health Care (NCCHC) for the accreditation of the medical and health services program of the institution, named above, for which I am legally responsible. The survey and review of health care practices at this facility will be guided by standards originally developed by the American Medical Association and adopted and revised by the NCCHC. We agree to abide by NCCHC accreditation policies and to permit, at the time of the site survey, private and confidential interviews with correctional officers, inmates/residents, health care personnel and food service personnel; and, a tour of the facility including general population and segregated and/or other special housing areas, health care locations, exercise and work areas and dining rooms and kitchens. We hereby acknowledge that if the facility is accredited, the health care program must be maintained during the period of accreditation and agree to notify the NCCHC in writing of any substantive change in the management of the health care program within 30 days of such occurrence. We understand that enrollment in the NCCHC accreditation program will continue automatically. We will submit Annual Maintenance Reports and be billed annually for approximately half the initial accreditation cost. We further understand that a site visit will take place at least once every three years and that the facility may terminate enrollment in the NCCHC accreditation program at any time upon 60 days written notice.

---

Signature of Person Legally Responsible

Date

---

Name and Title (Printed or typed)

**Note:** A check or voucher for \$100.00, payable to the National Commission on Correctional Health Care, should accompany this application. This amount will be applied to the full accreditation charge, with the balance due at the time of the site survey. In the event of cancellation of this application for accreditation, we agree to be responsible for any travel expense incurred by NCCHC in the scheduling of the on-site visit.

Check enclosed     Check to follow under separate cover

Billing/invoice required to process check.



12. Inmate/Resident length of stay (in percentages):

Jails/Juvenile Detention

\_\_\_\_\_% 0 - 24 hours  
 \_\_\_\_\_% 1 - 7 days  
 \_\_\_\_\_% 8 - 14 days  
 \_\_\_\_\_% 15 - 30 days  
 \_\_\_\_\_% 31 - 90 days  
 \_\_\_\_\_% 91+ days  
 100% Total

Prisons/Juvenile Correctional

\_\_\_\_\_% 1 - 30 days  
 \_\_\_\_\_% 31 - 90 days  
 \_\_\_\_\_% 91 - 180 days  
 \_\_\_\_\_% 181 - 365 days  
 \_\_\_\_\_% 1 - 3 years  
 \_\_\_\_\_% 3+ years  
 100% Total

**HEALTH CARE SERVICES DATA**

13. Number of health providers on-site:

Full-time

\_\_\_\_ Administrators  
 \_\_\_\_ Physicians  
 \_\_\_\_ PAs  
 \_\_\_\_ NPs  
 \_\_\_\_ RNs  
 \_\_\_\_ LPNs  
 \_\_\_\_ EMTs/MAs  
 \_\_\_\_ Psychologists  
 \_\_\_\_ Psychiatrists  
 \_\_\_\_ Dentists  
 \_\_\_\_ Dental Assistants  
 \_\_\_\_ Dental Hygienists  
 \_\_\_\_ Medical Records Personnel  
 \_\_\_\_ X-Ray Technicians  
 \_\_\_\_ Lab Technicians  
 \_\_\_\_ Pharmacists/pharmacy techs  
 \_\_\_\_ Mental health workers  
 \_\_\_\_ Other (please specify)

Part-time

\_\_\_\_ Administrators  
 \_\_\_\_ Physicians  
 \_\_\_\_ PAs  
 \_\_\_\_ NPs  
 \_\_\_\_ RNs  
 \_\_\_\_ LPNs  
 \_\_\_\_ EMTs/MAs  
 \_\_\_\_ Psychologists  
 \_\_\_\_ Psychiatrists  
 \_\_\_\_ Dentists  
 \_\_\_\_ Dental Assistants  
 \_\_\_\_ Dental Hygienists  
 \_\_\_\_ Medical Records Personnel  
 \_\_\_\_ X-Ray Technicians  
 \_\_\_\_ Lab Technicians  
 \_\_\_\_ Pharmacists/pharmacy techs  
 \_\_\_\_ Mental health workers  
 \_\_\_\_ Other (please specify)

14. Contracted off-site health consultants (type and number of hours per month)

---



---

15. Does the facility operate an infirmary? If yes, total number of beds: \_\_\_\_\_

Medical:        Male \_\_\_\_\_        Female \_\_\_\_\_  
 Psychiatric:    Male \_\_\_\_\_        Female \_\_\_\_\_

16. Is there a forensic unit (separate housing available for mental health prisoners)?

If yes total number of beds: \_\_\_\_\_

17. Number of hours per day that at least one health provider is on-site:

At the main facility: \_\_\_\_\_

Satellite #1: \_\_\_\_\_

Satellite #2: \_\_\_\_\_

Satellite #3: \_\_\_\_\_

Satellite #4: \_\_\_\_\_

18. Are health services contracted? (Yes/No) \_\_\_\_\_

If yes, name of contractor and date of current contract:

\_\_\_\_\_

19. Community hospital(s), clinic(s), and/or other health care facilities used for inpatient, mental health or emergency services provided outside the facility:

\_\_\_\_\_

20. Are there any plans to make substantial changes in the health care delivery system at the facility? If so, please describe:

\_\_\_\_\_

21. Is the facility currently involved in any litigation alleging inadequate medical care? If so, please describe:

\_\_\_\_\_

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature

Date

Name and Title (Printed or typed)



8. Number of satellites (in addition to the main unit): \_\_\_\_\_

\_\_\_\_\_  
Name Average Daily Population

\_\_\_\_\_  
Name Average Daily Population

\_\_\_\_\_  
Name Average Daily Population

9. Total population (in recent count) for all units combined: \_\_\_\_\_

\_\_\_\_\_ Adult Males                      \_\_\_\_\_ Juvenile Males

\_\_\_\_\_ Adult Females                      \_\_\_\_\_ Juvenile Females

10. Any construction/renovation in progress or anticipated? Please explain.

\_\_\_\_\_  
\_\_\_\_\_

11. How are health services provided? (If provided by contractor, please give name and address of contractor; when contract began and when it expires; and the scope of services included (e.g. "all health services including hospital and on-site mental health").

\_\_\_\_\_  
\_\_\_\_\_

#### QUALITY ASSURANCE

12. How many charts does the responsible physician review monthly? \_\_\_\_\_ If applicable (facility has ADP of 200+), please attach minutes of last two Quality Assurance Committee meetings.

13. Has there been any lessening of health care services since the last report (for example, decrease in staffing or in services provided)?

\_\_\_ Yes \_\_\_ No If yes, please describe (use additional sheets if necessary):

\_\_\_\_\_

14. Overall, I/we believe the quality of care at this facility is: \_\_\_ as good, \_\_\_ better, \_\_\_ not as good, since the last report. If "better" or "not as good", please describe.

\_\_\_\_\_  
\_\_\_\_\_

15. Having reviewed the last report and NCCHC standards, I/we believe that the following standards which were not met then are being met now:

\_\_\_\_\_  
\_\_\_\_\_

16. Having reviewed the last report and NCCHC standards, I/we believe that the following standards which were then met are not being met now:

---

---

**HEALTH SERVICES PROFILE**

17. Does the facility operate an infirmary? If yes, how many beds? \_\_\_\_\_ What services are provided?

---

18. Since the last report, has there been a significant change in the health services staffing pattern?

Yes  No If yes, please describe (example: "We now have 24 hour coverage at annex; have added a second full-time dentist").

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19. Percentage of COs (or youth counselors) current in CPR: \_\_\_\_\_

20. Percentage of COs (or youth counselors) current in First Aid: \_\_\_\_\_

21. Since the last report, has there been any occasion when security has overruled a medical decision?

Yes  No If yes, please describe:

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22. Since the last report, have all health professionals maintained in-service training that should enable them to meet the 12 hour requirement?

Yes  No If no, please describe:

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23. Since the last report has there been any significant change in the management of pharmaceuticals?

Yes  No If yes, please describe:

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24. a) Since the last report, has there been any change in the sick call process?

Yes  No If yes, please describe:

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b) are sick call requests triaged every day?  Yes  No

c) how long after making a medical request will the youth/inmate see a health professional? \_\_\_\_\_

d) how long after referral before seeing a physician? \_\_\_\_\_

e) how long before seeing a dentist? \_\_\_\_\_

25. Are all health assessments completed within the time frame set by the standard?

Yes  No If no, indicate the approximate percentage of health assessments that are delayed after the allotted period:

From 1 to 5 days late: \_\_\_\_\_%

From 6 to 14 days late: \_\_\_\_\_%

From 15 to 30 days late: \_\_\_\_\_%

More than 30 days late: \_\_\_\_\_%

26. Since the last report, has there been a change in the arrangements or procedures for emergency service?

Yes  No If yes, please describe:

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27. Since the last report, has there been a change in the provision of dental care?

Yes  No If yes, please describe:

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28. Since the last report, has there been a change in the provision of mental health care?

Yes  No If yes, please describe:

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29. Since the last report, has there been a change in the charting or maintenance of medical records?

Yes  No If yes, briefly describe:

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30. a) Where are inmates/prisoners who are AIDS asymptomatic and seropositive housed?

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b) Where are inmates/prisoners who are AIDS symptomatic housed?

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31. Since the last report, has there been:

- a) Legal action against the facility, its officials or staff alleging inadequate medical or other health care for prisoner(s) or detainee(s)?

Yes  No If yes, approximately when filed?: \_\_\_\_\_

Please describe:

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- b) Action by a community, government or quasi-government, public or quasi-public agency or group to review, investigate or look into health services provided at the facility?

Yes  No If yes, state name of group and describe its purpose. If a draft, intermediate or final report has been issued, please provide a copy.

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- c) If the court has appointed a special master or monitor, and a report has been issued with respect to health services, please furnish a copy.

32. Are administrative meetings held at least quarterly?  Yes  No Attach a copy of the most recent administrative meeting minutes.
33. Does the health staff meet monthly?  Yes  No Attach a copy of the most recent health staff meeting minutes.
34. Is the health portion of the disaster drill rehearsed at least annually?  Yes  No Provide a report or critique of the last practiced disaster drill.
35. Is the policy/procedure manual reviewed at least annually, revised as necessary and approved by the health authority?  Yes  No Provide a copy of the face sheet that indicates current annual review of the facility's policy manual and signatures by appropriate individuals (see standards). Also provide a brief summary statement on any policies and/or procedures that have been revised since the last report.
36. Have there been any inmate deaths since the last report?  Yes  No If so, please provide a listing and include cause of deaths.
37. Are statistical reports on the utilization of health services kept?  Yes  No Attach a copy of the most recent statistical report.

**Confidential:** The information provided herein is confidential and for the exclusive use of the National Commission on Correctional Health Care's Accreditation Program. Data if used for statistical purposes will be cumulative and not specific to any jail, prison or juvenile confinement facility.

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO MY BEST INFORMATION AND BELIEF.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Title (printed or typed) of Person  
Submitting This Report

\_\_\_\_\_  
Telephone Number



## GLOSSARY

**ADMINISTRATION OF MEDICATION** is the act in which a single dose of an identified drug is given to a patient.

**ADMINISTRATIVE MEETINGS** are held at least quarterly between the health authority and the official legally responsible for the facility, or their designees. At these meetings, problems are identified and solutions sought.

**ALCOHOL DETOXIFICATION:** See **DETOXIFICATION**.

The **ANNUAL STATISTICAL REPORT** should indicate the number of juveniles receiving health services by category as well as other pertinent information (e.g., operative procedures, referrals to specialists, ambulance services).

**CHEMICAL DEPENDENCY** refers to the state of physiological and/or psychological dependence on alcohol, opium derivatives, synthetic drugs with morphine-like properties (opiates), stimulants, and depressants.

**CHRONIC CARE** is medical service rendered to a patient to assist in recovery from illness or injury.

**CLINIC CARE** is medical service rendered to an ambulatory patient with health care complaints that are evaluated and treated at sick call or by special appointment.

**COMMUNICABLE DISEASE** - see attached form

**CONVALESCENT CARE** is medical service rendered to a patient to assist in recovery from illness or injury.

A **DEA-CONTROLLED SUBSTANCE** is a drug regulated by the Drug Enforcement Administration under the authority of the Federal Controlled Substances Act.

The **DENTAL EXAMINATION** should include the taking or review of the patient's dental history; charting of teeth; examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination; and x-rays if needed for diagnosis.

**DENTAL SCREENING**, a part of the initial health appraisal, includes visual observation of the teeth and gums.

**DETOXIFICATION** refers to the process by which an individual is gradually withdrawn from a drug by the administration of decreasing doses of the drug upon which the person is physiologically dependent, one that is cross-tolerant to it, or a drug that has been demonstrated to be effective on the basis of medical research.

**DISASTER PLAN, HEALTH ASPECTS OF:** Health aspects of the disaster plan, among other items, include the triaging process, outlining where care can be provided, and laying out a back-up plan.

**DISPENSING OF MEDICATION** is the issuance of one or more doses of a prescribed medication in containers that are correctly labeled with the name of the patient, the contents of the container and all other vital information needed to facilitate correct drug administration.

**DISPOSAL OF MEDICATION** is the system of delivery and storage of and accounting for drugs from the source of supply to the nursing station or the point at which they are administered to the patient.

**DISTRIBUTION OF MEDICATION** refers to the destruction of the patient's medication upon his/her discharge from the facility or discontinuation of the medication, the return of the sealed, unused packaged medication to the pharmacy, or the provision of the discharged patient with the medication, in line with the principle of continuity of care.

**DOCUMENTED** health requests include such examples as: (1) the recording on the request slip of the action taken regarding triaging and the filing of such slips in the patient's medical record, and (2) the use of a log to record the request and its disposition.

**DRUG DETOXIFICATION:** See **DETOXIFICATION**.

**ECTOPARASITES** are animals (such as insects) that infest human skin.

**EMERGENCY CARE (MEDICAL, DENTAL, AND MENTAL)** is care for an acute illness or unexpected health care needs that cannot be deferred until the next scheduled sick call or clinic.

A **FORMULARY** is a written list of prescribed and non-prescribed medication stocked within the facility.

The **FOUR BASIC FOOD GROUPS** are milk products; meat, fish, and other protein foods (e.g., eggs, dried beans and peas, cheese); breads and cereals; and vegetables and fruits.

A **HEALTH ADMINISTRATOR** is a person who by education (RN, MPH, MHA, or a related discipline) is capable of assuming responsibility for arranging for all levels of health care and ensuring quality and accessibility of all services provided to juveniles.

The **HEALTH APPRAISAL** is the process whereby the health status of an individual is evaluated. The extent of the health appraisal, including medical examination, is defined by the responsible physician, but includes at least the items noted in standard Y-33.

The **HEALTH AUTHORITY** is the individual to whom has been delegated the responsibility for the facility's health care services, including arrangements for all levels of health care and the ensuring of quality and accessibility of all health services provided to juveniles.

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

**HEALTH-TRAINED STAFF** are personnel without health care licenses who are trained in limited aspects of health care, as determined by the responsible physician.

**HOSPITAL CARE** is the inpatient care for an illness or diagnosis that requires observation and/or management in a licensed hospital.

An **INFIRMARY** is an area established within the confinement facility in which organized bed care facilities and services are maintained and operated to accommodate two or more patients, and which is operated for the express or implied purpose of providing skilled nursing care for persons who are not in need of hospitalization.

**INFIRMARY CARE** is defined as inpatient bed care by or under the supervision of a registered nurse for an illness or diagnosis that requires limited observation and/or management but does not require admission to a licensed hospital.

**INFORMED CONSENT** is the agreement by the patient to a treatment, examination, or procedure after the patient receives the material facts regarding the nature of, consequences of, risks of, and alternatives to the proposed treatment, examination, or procedure. The right to refuse treatment is inherent in this concept.

**INITIAL HEALTH SCREENING:** See **RECEIVING SCREENING**.

**INTERNAL QUALITY ASSURANCE:** See **MONITORING OF SERVICES**.

Examples of **LARGE-MUSCLE ACTIVITY** are those activities involving large muscle groups such as walking, jogging in place, basketball, ping-pong, and isometrics.

The term **MEDICAL** includes "psychiatric."

**MEDICAL PREVENTIVE MAINTENANCE:** See **RESTRAINTS**.

**MEDICAL RESTRAINTS:** See **RESTRAINTS**.

**MEDICATION ACCOUNTING** is the system of recording, summarizing, analyzing, verifying, and reporting medication usage.

**MONITORING OF SERVICES** is the process for ensuring that high-quality health care services are being rendered in the facility by all providers. The monitoring is accomplished by on-site observation and review (e.g., study of juveniles' complaints about care; review of health records, pharmaceutical processes, standing orders, and performance of care). This process is also referred to as **INTERNAL QUALITY ASSURANCE**.

**OPIATES** are derivatives of opium, e.g., morphine and codeine, and synthetic drugs with morphine-like properties.

While **ORAL HYGIENE** by standard definition includes clinical procedures taken to protect the health of the mouth and chewing apparatus, minimum compliance is met by instruction in the proper brushing of teeth.

**PLANNED, SUPERVISED BASIS** (for exercise). Facilities meet compliance of exercise on a "planned, supervised basis" under the following conditions. It is recognized that many facilities do not have a separate facility or room for exercising. The dayroom adjacent to the living area may be used for this purpose, and meets compliance if planned, programmed activities are directly

supervised by staff and/or trained volunteers. Television and table games do not meet compliance. Regarding the use of outside yards, gymnasias, and multi-purpose rooms, making available opportunities for exercise (e.g., basketball, handball, jogging, running, and calisthenics) satisfies compliance even if juveniles do not take advantage of these opportunities.

Medical PREVENTIVE MAINTENANCE refers to health promotion and disease prevention. This includes the provision of individual or group health education and medical services, such as inoculations and immunizations provided to take advance measures against disease, and instruction in self-care for chronic conditions.

PROCUREMENT of medication is the system for ordering it for the pharmacy.

PROSTHESES are artificial devices to replace missing body parts or compensate for defective bodily functions. Examples are items such as artificial limbs, eyeglasses, and full and partial plates.

PSYCHIATRIC PERSONNEL or psychiatric services staff are psychiatrists, general family physicians with psychiatric orientation, psychologists, psychiatric nurses and social workers.

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

A QUALITY ASSURANCE COMMITTEE is a group of health providers working at the facility (the responsible physician and representatives of other departments) who meet on a fixed schedule to monitor and evaluate the health care services provided.

QUALITY ASSURANCE PROGRAMS ensure the quality and consistency of the health services provided in the facility, usually through periodic review of patients' charts.

RECEIVING SCREENING is a system of structured inquiry and observation designed to prevent newly arrived juveniles who pose a health or safety threat to themselves or others from being admitted to the facility's general population, and to identify those newly admitted juveniles in need of medical care. This process is also referred to as INITIAL HEALTH SCREENING.

RESPONSIBLE PHYSICIAN is an individual physician who is responsible for the final decisions regarding matters of medical judgement at the facility.

RESTRAINTS are physical and chemical devices used to limit patient activity as a part of health care treatment. The kinds of restraints that are medically appropriate for the general population within the jurisdiction may likewise be used for medically restraining incarcerated individuals (e.g., leather or canvas hand and leg restraints, chemical restraints, strait-jackets).

SELF-CARE is defined as care for a condition that can be treated by the patient; it may include over-the-counter-type medications.

**SICK CALL** is the system through which each juvenile reports for and receives appropriate medical services for non-emergency illness and injury. Some people refer to sick call as a **CLINIC VISIT**.

**SKILLED NURSING CARE:** See **INFIRMARY CARE**.

The **SPECIAL MEDICAL PROGRAM** refers to care developed for patients with certain medical conditions that dictate a need for close medical supervision (e.g., seizure disorder, diabetes, potential suicide, pregnancy, chemical dependency, and psychosis).

**STANDING MEDICAL ORDERS** are pre-established written medical orders for the definitive treatment of identified conditions and for on-site treatment of emergency conditions for persons having conditions to which the orders pertain.

**SUPERVISION** is defined as the overseeing of an accomplishment of a function or activity.

A **TREATMENT PLAN** is a series of written statements that specify the particular course of therapy and the roles of medical and non-medical personnel in carrying out the current course of therapy. It is individualized and based on assessment of the individual patient's needs, and includes a statement of the short- and long-term goals and the methods by which the goals will be pursued.

**TREATMENT PROTOCOL** are pre-established written orders that specify the steps to be taken in appraising a patient's physical status. Treatment protocol do not any directions regarding danger of prescription medications.



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