SUMMARY of REVISION/REVIEW


APPROVED:

Harbans S. Deol, DO, PhD
Medical Director

Scott R. Frakes, Director
Nebraska Department of Correctional Services
PURPOSE

To ensure 24 hour emergency medical, dental and mental health care is available to patients.

GENERAL

It is the policy of the Nebraska Department of Correctional Services (NDCS) to provide twenty-four hour emergency medical, dental and mental health care according to a written plan (as defined by institutional Operational Memoranda). This policy applies to all institutions/programs.

Correctional and other personnel are trained to respond to health-related situations within a four-minute response time. The training program is established by the responsible institutional health care coordinator in cooperation with the Warden/Program Administrator and shall include the following:

I. Recognition of signs and symptoms, and knowledge of action required in potential emergency situations.

II. Administration of basic first aid and Cardiopulmonary resuscitation (re-certification is every two years and must be current for designated personnel).

III. Methods of obtaining assistance.

IV. Signs and symptoms of mental illness, retardation, violent behavior, and chemical dependency, intoxication and withdrawal.

V. Procedures for patient transfers to appropriate medical facilities or health care providers.

VI. Suicide intervention

DEFINITIONS

ACLS: Advanced Cardiac Life Support

BLS: Basic Life Support (i.e., Adult Cardiopulmonary Resuscitation).

CPR: Cardiopulmonary resuscitation.

AED: Automated External Defibrillator.

Emergency Health Care: Care for an acute illness or unexpected health need that cannot be deferred until the next scheduled sick call or clinic.

Local Emergency Medical Services (EMS): Community emergency response services such as 911 or private ambulance services.

Mock Code: The scenario will be decided by the Institutional Health Care Coordinator /or designee and the Facility Emergency Specialist.

Institutional Health Care Coordinator: An individual, who may or may not be a physician, designated to ensure the provision of appropriate health care for patients. When this authority is not a physician, medical judgments rest with a physician assistant/nurse practitioner, nurse or first responder

ABC: Airway, Breathing, Circulation
Triage: Screening of patients to determine priority for treatment

PROCEDURES

I. EMERGENCY CARE PLAN

Each institution provides for 24 hour emergency medical, dental and mental health care availability as outlined in a written plan (as defined by institutional Operational Memorandums). The plan includes arrangements for the following:

A. On-site emergency first aid and crisis intervention.
B. Emergency evacuation of the patient from the facility.
C. Use of an emergency medical vehicle.
D. Use of one or more hospital emergency rooms or other appropriate health facilities.
E. Emergency on-call physician, dentist and mental health professional services when the emergency health facility is not located in a nearby community.
F. Security procedures providing for the immediate transfer of patients when appropriate.

II. MEDICAL EMERGENCY RESPONSE.

A. During a medical emergency, the Shift Supervisor will be responsible for consulting with Medical Staff to determine the best course of action for response (i.e.; medical to report to the scene or transportation of patient to the medical area). The shift supervisor will follow the directions of the medical staff.

B. The responsible Institutional Health Care Coordinator / designee in each facility will develop written procedures (Operational Memorandums) for management of all unscheduled medical visits and emergencies. The procedures will address the following areas:

1. Initial response of correctional personnel to an emergency medical situation including the use of first aid, and CPR, when indicated, and the immediate notification of health care personnel.
2. The availability of on call providers when health care personnel (including dental) are not present in the facility, including the development of an on-call schedule with names, telephone and pager numbers of providers to be notified in case of emergency.
3. Location and use of emergency equipment, the crash cart and portable crash bag.
4. The use and location of ACLS protocols for facilities with ACLS capability.
5. Emergency evacuation of an patient, correctional employee, or visitor from within the facility when required.
6. Use of an emergency vehicle (including 911 or other local EMS utilized by the facility).

7. Use of one or more hospital emergency departments or other appropriate facilities, including the telephone number of a Poison Control Center.

8. Procedures to be followed in the event of a patient death. See Administrative Regulation (AR) 115.13, Hunger Strikes, Serious Illness or Injury, Advanced Directives and Death.

C. The responsible Institutional Health Care Coordinator/designee will be involved in and is responsible for the medical aspects of the facility’s emergency response plan and associated emergency drills, in accordance with AR 203.02, Emergency Preparedness.

III. TRAINING FOR MEDICAL EMERGENCIES.

A. Health Care Personnel

1. All health care personnel will receive training regarding emergency response during orientation to the facility. Training will include all aspects of the facility’s emergency procedures. Training records will be maintained electronically by the Employee Development Center. Each employee is responsible for the entry into the Employee Development Center.

2. All health care providers will be required to complete an On-the-Job Training Record of basic medical emergency information specific to the facility, prior to assuming unsupervised duties at that facility.

3. All health care providers will be certified in Basic Life Support (BLS) and the use of the AED. They will be certified every two years. Designated personnel will maintain documentation of re-certification.

B. Correctional Personnel

1. All department staff will receive training in universal precautions, CPR and First Aid as part of Pre-Service Training at the Staff Training Academy.

   a. All staff must maintain current certification in CPR and First Aid.

   b. During in-service training, all staff will be re-certified every two years in CPR, First Aid, and in use of the AED.

2. All department staff will receive training during pre-service regarding emergency preparedness procedures. Designated staff will receive training regarding local operating procedures for emergency preparedness procedures during the on the job training portion of pre-service training. This training will also include notification of health care personnel and the facility chain of command in the event of an emergency, accessing local emergency services, and other associated duties such as accurate documentation of emergency events and response.

3. All department staff will receive training during pre-service training regarding the location and contents of first aid kits.
4. The designated institutional Emergency Specialist will advise the Warden/Program Administrator and Institutional Health Care Coordinator regarding emergency response procedures as indicated.

C. Each institution shall have a medical representative act as part of the Institutional Emergency Preparedness Team. They shall assist in: developing emergency exercises, conducting and reviewing exercises, and evaluation of institutional emergency needs. They will also be involved in after-action review of actual emergency situations.

IV. EMERGENCY EQUIPMENT

Emergency equipment and supplies will be maintained in accordance with institutional procedures.

A. Medical response bags are available in designated areas of the facility, based on need. The contents, number, location and procedure for periodic inspection of the bags shall be the responsibility of the Institutional Health Care Coordinator / designee. An AED shall be available for use within each facility.

B. First Aid kits shall be available in designated areas of the facility, based upon need. The Institutional Health Care Coordinator and the Warden shall approve the location of First Aid kits.

1. The process for monthly inspections of First Aid kits shall be defined by each facility.

2. The procedures for re-supplying First Aid kits, following use, shall be defined by each facility.

3. At a minimum, there shall be one First Aid kit located within each independent building.

4. Floor plans shall identify the location of First Aid kits.

5. Each First Aid kit shall contain the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterile 4x4</td>
<td>4</td>
</tr>
<tr>
<td>Adhesive Bandages, 1” x 3” (Band Aids)</td>
<td>1 Box</td>
</tr>
<tr>
<td>Adhesive Tape,</td>
<td>1 Roll</td>
</tr>
<tr>
<td>CPR Mask</td>
<td>1</td>
</tr>
<tr>
<td>Medical Exam Gloves</td>
<td>2 pair</td>
</tr>
<tr>
<td>Sterile Telfa Pads</td>
<td>4</td>
</tr>
</tbody>
</table>

V. HEALTH CARE PERSONNEL RESPONSE TO EMERGENCY SITUATIONS.

A. Medical Emergencies Occurring in the Skilled Nursing Facility/Clinic Areas

1. When a medical emergency occurs in the Skilled Nursing Facility /clinic area, health care personnel will provide immediate BLS measures. (e.g., CPR, AED) at all facilities. If ACLS certified personnel are present, they will implement ACLS protocols, as clinically indicated by order of a physician. Resuscitation efforts will be documented in the medical file. The Institutional Health Care Coordinator/designee and local EMS will be notified as appropriate. Medical
personnel will notify the institutional Control Center. The Control Center staff will notify 911, if appropriate, and the shift supervisor.

2. If at all possible, the precise timing of vital signs, medications and treatments administered during the emergency will be recorded by a member of the health care team during the emergency and entered into the medical chart on the progress note. If this is not possible, documentation will be completed on the progress note after the emergency has been resolved.

3. If a medical emergency results in transport of the patient to a local hospital, the health care file is not to accompany the patient. A Community Wide Transfer Form will be completed with pertinent medical history and sent with the patient to the emergency room.

If the patient is admitted to a community hospital, the warden or designee will consult with the facility nurse manager/designee to determine if the patient’s emergency contact will be notified. Contact will generally be limited to when a patient is hospitalized for a serious, life threatening illness, injury, or accident or childbirth. The Warden/designee may authorize additional causes for notification as he/she deems appropriate and/or necessary. The nurse manager/designee may notify the emergency contact prior to admission in the event the patient’s condition is determined to be life threatening. The nurse manager/designee will provide the patient’s emergency contact limited details about the patient’s condition, typically, within one (1) hour of the patient’s departure from the facility.

The warden in consultation with the nurse manager/designee will determine whether the patient will be permitted to have visitors.

4. Medical emergencies occurring in the Skilled Nursing Facility /clinic area will be recorded in the appropriate nurse’s/officer’s log.

5. Any patient requiring resuscitation (e.g., CPR, or assisted ventilation) will be transported to a local hospital for stabilization.

B. Medical Emergencies Occurring Outside the Skilled Nursing Facility /Clinic Area

1. When a medical emergency occurs outside of the Skilled Nursing Facility /clinic unit, the responding staff will immediately notify the Control Center. The Control Center will then notify health care personnel.

2. The first responder will provide immediate first aid measures within four minutes. If staffing permits, health care personnel will respond immediately with appropriate equipment.

3. Health care personnel responding to the emergency scene will bring the medical response bag that includes a portable oxygen tank and the AED. If staffing does not permit health care personnel to respond to the emergency scene, staff will be responsible for ensuring the response bag is delivered to the scene.

4. If possible, the patient will be stabilized for transport to the medical unit. If this is not possible, the responding personnel will continue resuscitative efforts until EMS arrives on the scene.
5. If at all possible, the precise timing of vital signs, and treatments administered during the emergency will be recorded in the medical file. If this is not possible, documentation will be completed as soon as practical, after the emergency has been resolved.

6. If a medical emergency results in transport of the patient to a local hospital, the health care file is not to accompany the patient. A Community Wide Transfer Form will be completed with pertinent medical history and sent with the patient to the emergency room.

If the patient is admitted to a community hospital, the warden or designee will consult with the facility nurse manager/designee to determine if the patient’s emergency contact will be notified. Contact will generally be limited to when a patient is hospitalized for a serious, life threatening illness, injury, or accident or childbirth. The Warden/designee may authorize additional causes for notification as he/she deems appropriate and/or necessary. The nurse manager/designee may notify the emergency contact prior to admission in the event the patient’s condition is determined to be life threatening. The nurse manager/designee will provide the patient’s emergency contact limited details about the patient’s condition, typically, within one (1) hour of the patient’s departure from the facility.

The warden in consultation with the nurse manager/designee will determine whether the patient will be permitted to have visitors.

VI. EMERGENCY TRIAGE

In the event an emergency occurs at an institution, Medical staff must be prepared to respond to mass casualties. In the event of such an incident, medical staff will adhere to the following triage protocol.

A. The first medical staff at the scene will be designated the Triage officer. This person will go from patient to patient and conduct the initial assessment and determine who goes first for medical treatment.

B. During this brief “Triage Process” the medical staff is categorizing the patient(s) and instructing patients on self-aid when appropriate.

C. The Triage officer will quickly instruct staff (medical and non-medical) and they will render immediate first aid.

D. Medical staff will continuously evaluate the A, B, C’s of each patient.

E. Medical staff conducting the initial assessment will divide the casualties into the following Triage categories:

1. Deceased
2. EMERGENT – critical life threatening (save life, limb or eyesight)
3. **URGENT** – Serious non-life threatening (less risk with delay in treatment)

4. **NON-URGENT** – lowest priority (minimal risk and may provide self treatment)

F. As soon as an initial assessment is made a report to the Commander of the emergency will be made indicating the number of casualties according to the triage categories. Medical Staff will also request additional staff to assist in the first aid, if necessary, and transportation of patients.

VII. **MENTAL HEALTH EMERGENCIES**

Mental Health Emergencies can often be indicated as medical emergencies. Refer to ARs 116.02, *Use of Force*, 116.06, *Use of Restraints*, 115.30, *Suicide Prevention/Intervention* and 115.23, *Mental Health Services*.

VIII. **DOCUMENTATION OF EMERGENCY EVENTS**

Facility Operational Memorandum shall specify the procedures for documentation and review of all medical and other emergency events.

IX. **MEDICAL FOLLOW-UP OF EMERGENCY EVENTS**

The on-call medical duty officer will advise the responsible Institutional Health Care Coordinator regarding the transportation of an patient to any local hospital for any medical emergency. Emergency Referral form will be faxed to Central Office once disposition of patient is established. When the patient returns to the facility, he/she will be evaluated upon arrival by nursing staff and scheduled for follow-up appointment with a medical provider. The follow-up encounter will be documented on a progress note in the health care record.

X. **HUNGER STRIKES**

A. When any patient announces that he/she is on a hunger strike staff will meet with the patient to verify that a hunger strike is in progress and if possible, determine the patient’s reason(s) for the strike.

B. Staff will notify the Warden/designee. The Warden/designee will notify their respective Deputy Director and the Medical Director only after it has been determined that the patient has missed and/or refused nine consecutive meals/three days.

C. The Warden/designee will contact the Health Services staff and Mental Health staff to decide if the involved patient has a medical, physical and/or mental health condition that a hunger strike could aggravate (diabetes, kidney failure, heart condition, on medications that must be taken with meals, etc.). A patient with a pre-existing medical condition or demonstrating mental instability may be transferred to a skilled nursing facility (SNF) within NDCS or a local community hospital to receive treatment appropriate to medical and hospital protocol.

D. The Warden/designee, Health Services staff, Mental Health staff member and Unit Management staff member will determine the appropriate housing or classification assignment for the hunger-striking patient. The patient may be retained in general population, a restrictive housing unit or a SNF setting depending on the situation, circumstances and level of supervision required to adequately care for the patient. A
patient assigned to community custody that declares a hunger strike may be classified to a custody level that offers closer supervision and care.

E. If the patient has already been assigned to, or is in restrictive housing, any meals, food items and/or fluids consumed by the patient during the duration of the hunger strike shall be documented.

F. If the patient is in General Population, staff will:

1. Monitor any meals, food items, and/or fluids consumed by the patient, when possible, during the duration of the hunger strike and document such consumption.

2. Monitor any food items given to the patient by other patients or purchased from the canteen, when possible, and document such transactions.

3. Observe the patient on a routine basis (once per shift at a minimum) and note behavioral changes and/or evidence of physical/mental deterioration. Any observations of behavioral changes and/or evidence of physical/mental deterioration will be documented by Incident Report.

4. Advise the Warden/designee and Health Services staff daily of the status of the patient by Incident Report. Urgent notifications will be made by telephone.

G. Health Services staff will review the status of the patient on a hunger strike after 48 hours to determine if hospitalization or other medical intervention is necessary, and follow-up daily, thereafter. If transfer is deemed necessary due to compelling reason(s), the Warden/designee will be notified by the Health Services Authority and arrangements will be made to have the patient moved. The respective Deputy Director and Medical Director will be notified through the office of the Warden/designee.

H. The Health Services staff, Mental Health staff and Unit Management staff will evaluate the patient’s status once the patient resumes eating regular meals (not merely drinking liquids). The Warden/designee will be notified when the hunger strike ends and will determine when the patient will be returned to his/her pre-hunger strike status. The Warden/designee will notify their respective Deputy Director and the Medical Director that the hunger strike has ended.

I. If the patient was hospitalized, applicable Unit Management staff and Health Services staff will prepare a summary of the incident that will be placed in the patient’s institutional file.

J. Following resumption of pre-hunger strike status, staff will continue to monitor if the patient is eating routine meals in the dining hall/restrictive housing unit or obtaining food from the Canteen/other patients. (Duration of monitoring will be at the discretion of the applicable Unit Management staff following consultation with Mental Health staff.)

REFERENCE

I. ADMINISTRATIVE REGULATIONS

A. AR 115.13, *Serious Illness or Injury, Advanced Directives and Death*

B. AR 115.23, *Mental Health Services*
C. AR 115.30, Suicide Prevention/Intervention
D. AR 116.02, Use of Force
E. AR 116.06, Use of Restraints
F. AR 203.02, Emergency Preparedness

II. ATTACHMENTS
   A. Community Wide Transfer DCS-A-med-045

III. AMERICAN CORRECTIONAL ASSOCIATION (ACA) STANDARDS
   A. Standards for Adult Correctional Institutions (ACI) (4th edition) 4-4351, 4-4389, 4-4390
   B. Performance Based Standards for Adult Community Residential Services (ACRS) (4th edition): 4-ACRS-4C-02, 4-ACRS-4C-04 and 4-ACRS-4C-05.