
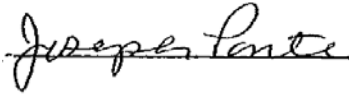


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CHAPTER 13: HEALTH CARE SERVICES		
	STATE of MAINE DEPARTMENT OF CORRECTIONS Approved by Commissioner: 	PROFESSIONAL STANDARDS: See Section VII
	EFFECTIVE DATE: February 10, 2004	LATEST REVISION: June 10, 2013

I. AUTHORITY

The Commissioner of Corrections adopts this policy pursuant to the authority contained in 34-A M.R.S.A. Section 1403.

II. APPLICABILITY

All Departmental Juvenile Facilities
 Juvenile Community Corrections (Procedure Q only)

III. POLICY

It is the policy of the Department of Corrections to support resident health by offering quality health care services and maintaining a continuity of health care. To accomplish this objective, these services shall be provided at the facility and through the utilization of community health resources.

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VI. PROCEDURES

Procedure A: Diagnostic Services

1. All residents shall have access to diagnostic services either on-site or in the community (e.g. radiology, laboratory testing, EKG, glucose testing, peak flow testing, pregnancy testing) as ordered by the facility physician, physician assistant, nurse practitioner, dentist, or optometrist.
2. Each facility shall maintain a current list of the types of diagnostic services that are available and whether they are available on-site or in the community. At a minimum, there shall be available on-site dipstick urinalysis, blood glucose testing, peak flow testing, and stool blood testing. For a facility housing female residents, pregnancy testing shall also be available.
3. All diagnostic equipment located at the facility shall be maintained to meet factory specifications and applicable state regulations. Instructions for the use of any diagnostic equipment and the instructions for the calibration of testing devices shall be maintained. A record of the calibration and testing of the diagnostic equipment shall be maintained by the health care staff.
4. When there is an order for diagnostic testing, the required test shall be performed at the next possible opportunity if being done on-site or an appointment in the community shall be arranged in a timely manner.
5. A notation shall be made in the resident's health care record that the order has been noted by the nursing staff.

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6. All diagnostic tests that have been ordered shall be documented and shall include the resident's name, the date the order was written, the date the test is scheduled for and the date the test is completed. For any diagnostic test that requires the health care authority's administrative approval, the date requested and the date the approval was given shall be documented.
7. When diagnostic procedures are scheduled to be done in the community, the resident may be informed that the required test has been scheduled but shall not be told when or where it shall take place, due to security reasons.
8. When diagnostic procedures are scheduled to be done in the community, designated security staff shall be notified by health care staff of the time and place so that security staff can arrange transport. Notification shall be given as soon as possible and, in a non-emergency situation, at least twenty-four (24) hours in advance. Off-site health care appointments may only be cancelled by health care staff or the facility Chief Administrative Officer.
9. The health care staff shall provide the transport staff with the Consultation Request Form to be completed by the community provider. The completed form shall be returned by the transport staff to the health care department immediately upon return to the facility. The completed form shall be reviewed and filed by appropriate health care staff.
10. The facility physician, physician assistant, nurse practitioner, dentist, or optometrist shall review, date, and sign all diagnostic test results and/or shall make a notation of the review in the progress notes. Appropriate health care staff shall review with the resident in a timely manner any clinically significant diagnostic test results.
11. Reports of results of all diagnostic tests shall be filed in the resident's health care record.

Procedure B: Dental Services

1. All residents shall have access to facility dental care services under the direction and supervision of a facility dentist. All residents shall receive timely emergency and routine dental treatment to include fillings, extractions, and, if determined appropriate by a facility dentist and approved by the Chief Administrative Officer, maintenance of orthodontic appliances and dentures.
2. Dental screening shall be conducted upon admission. An examination by a dentist shall be performed within fourteen (14) days of admission for intrasystem transfers, unless there is documentation of a dental examination within the last six (6) months. Preventive care by a dentist or dental hygienist shall be provided

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within fourteen (14) days of admission, unless there is documentation of dental preventive care completed within the last six (6) months.

3. Dental examination shall consist of, at a minimum, the following:
 - a. Review of dental history;
 - b. Charting of the condition of the teeth (see Attachment A);
 - c. Examination of the hard and soft tissue;
 - d. Examination of the oral cavity with a mouth mirror, explorer and adequate illumination;
 - e. Ordering of X-rays for diagnostic purposes, as necessary;
 - f. Determining the conditions for more frequent than annual dental follow up;
 - g. Development of an individualized treatment plan, as indicated for residents receiving dental care;
 - h. Consultation and referral to specialists, when necessary.
4. Oral hygiene, oral disease education and self-care instruction (See Attachment B) shall be provided at intake by health care staff.
5. In the case of a resident readmitted to the Department who has received a dental examination within the past six (6) months at a Departmental facility or who has been transferred from another Departmental facility, a new exam is not required, except as determined by the supervising facility dentist.
6. A Consent for Dental Surgical Treatment form (See Attachment C) shall be completed by a resident, who has attained the age of 18, prior to any dental surgical procedure. If a resident, who has attained the age of 18, has a legal guardian for health care decisions, the health care staff shall contact the resident's legal guardian to obtain consent.
7. Dental hygiene progress notes (Attachment D) shall be maintained in the resident's health care record.

Procedure C: Eye Care

1. All residents shall be provided eye care services under the direction and supervision of a facility optometrist, except for the visual screening, which may

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be performed by any health care staff. All residents shall receive timely emergency and routine optometric and ophthalmologic treatment and any other necessary health care in order to support healthy vision.

2. Visual screening shall be performed as part of the physical health assessment, utilizing the Snellen test. Based on the result of the Snellen test, a resident may be referred for follow-up care with the optometrist or a specialty consult with an ophthalmologist.
3. All residents with chronic medical problems that may affect vision or the health of the eye(s) shall be referred for an optometric or ophthalmologic exam annually or more often, as necessary.
4. The facility optometrist shall document the results of any eye exam conducted on a resident in the resident's health care record.
5. Corrective eyeglasses, or other reasonable accommodations, shall be provided as ordered by the facility optometrist or ophthalmologist, except that any order for accommodations other than corrective eyeglasses with clear lenses shall be referred to the Chief Administrative Officer for final determination, after review of any security concerns.
6. A resident prescribed eyeglasses shall be provided state-issued glasses as prescribed by a facility optometrist or ophthalmologist. The resident shall sign a receipt for each pair of eyeglasses received. (See Attachment E)
7. Detained residents using corrective contact lenses at the time of admission shall be allowed to retain them. Committed residents shall not be allowed to retain contact lenses, except as provided in 5. above. Health care staff shall determine, as soon as possible after admission, when a contact lens prescription expires and shall provide this information to the facility optometrist or ophthalmologist, who shall, as appropriate, schedule the resident for the provision of state-issued corrective eyeglasses. Contact lens prescriptions shall not be renewed, except as provided in 5. above.
8. The facility optometrist may order diagnostic testing and optometric treatment as necessary.

Procedure D: Detoxification and Withdrawal

1. Every resident shall be screened by qualified health care staff for the use and/or dependence on alcohol or drugs, as part of the admission health screening.
2. Any resident reporting or suspected of being under the influence of alcohol, opiates, stimulants, sedatives, hypnotics, or other legal or illegal substances at

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the time of the admission health screening shall be immediately evaluated by health care staff for their degree of intoxication and need for medical treatment for withdrawal from the substance.

3. Any necessary medical treatment for withdrawal and detoxification, including use of hospitalization, shall be carried out according to the written specific protocols approved by the Medical Director.
4. Residents in withdrawal from a substance or in detoxification shall be referred by health care staff for other necessary follow-up assessment, treatment, counseling, or referral, to include referral to substance abuse treatment staff.

Procedure E: Pregnancy Management Services

1. The facility shall ensure that obstetrical, gynecological, family planning, health education, and pregnancy management services are provided to female residents, as needed.
2. Pregnancy management services shall be available to all female residents. At a minimum, these services shall include:
 - a. Pregnancy testing,
 - b. Routine and high-risk prenatal care,
 - c. Management of the substance addicted pregnant resident,
 - d. Comprehensive counseling,
 - e. Postpartum follow-up, through community medical providers and in the facility, to include any necessary mental health care,
 - f. Assistance by facility social service staff, through referral to community resources, including, but not limited to, making arrangements for the issuance of birth certificate,
 - g. Off-site services, through community medical providers, and
 - h. Referral to community family planning services upon release, if requested.

Procedure F: Physical Therapy

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1. Physical therapy services shall be provided to a resident as ordered by the facility physician, physician assistant, or nurse practitioner. These services may be provided on-site or through the use of community-based resources.

Procedure G: Specialty Consultations

1. All residents shall have access to specialty consultation services as ordered by a facility physician, physician assistant, nurse practitioner, dentist, or optometrist and approved by the Medical Director.
2. These consultations shall be provided either at the facility or in the community.
3. When there is an order for a specialty consultation, the required consultation shall be performed at the next possible opportunity if being done on-site or an appointment in the community shall be scheduled in a timely manner.
4. A notation shall be made in the resident's health care record that the specialty consultation order has been processed by the nursing staff.
5. Logs of all specialty consultations that have been ordered shall be established and shall include the resident's name, the date the order was written, the date the approval of the Medical Director was given, the date the consultation is scheduled for, and the date the consultation is completed. For any specialty consultation that requires the health care authority's administrative approval, the date requested and the date the approval was given shall be documented.
6. When specialty consultations are scheduled to be done in the community, the resident may be informed that the required consultation has been scheduled but shall not be told when or where it shall take place, due to security reasons.
7. When specialty consultations are scheduled to be done in the community, designated security staff shall be notified by health care staff of the time and place so that security staff can arrange transport. Notification shall be given as soon as possible and, in a non-emergency situation, at least twenty-four (24) hours in advance. Off-site health care appointments may only be cancelled by health care staff or the facility Chief Administrative Officer.
8. The health care staff shall provide the transport staff with the Consultation Request Form to be completed by the community provider. The completed form shall be returned by the transport staff to the health care department immediately upon return to the facility. The completed form shall be reviewed and filed by appropriate health care staff.
9. The facility physician, physician assistant, nurse practitioner, dentist, or optometrist shall review, date, and sign all specialty consultation results and

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shall make a notation of the review in the progress notes. Appropriate health care staff shall review with the resident in a timely manner any specialty consultation results.

10. Reports of results of all specialty consultations shall be filed in the resident's health care record.

Procedure H: Hospital Services

1. Each facility shall have written arrangements for providing medical care in hospitals and specialized ambulatory care facilities that meet state licensure requirements. Each facility shall use statutory procedures for referral to hospitals that provide in-patient mental health treatment for juveniles. Each facility shall use statutory procedures for providing mental health hospitalization in state operated mental health institutes for residents who have attained the age of 18.

Procedure I: Continuity of Care

1. Facility health care staff shall assure continuity of a resident's health care, for all emergency and routine health care services, from the time of admission throughout the incarceration, through referral and consultation, as needed, including consultation when residents are transferred to another facility and upon release.
2. During incarceration, health care services shall be provided in accordance with an individualized treatment plan, which may include enrollment in a chronic care clinic or monitoring through the annual health assessment.
3. In preparation for the resident's release from the facility, facility health care staff shall inform facility social service staff of the need for coordinating continuity of health care through referral to community health care providers, to include referral to a family planning agency, when appropriate.
4. The medical health care staff shall complete a written health care discharge summary prior to the resident's release. (See Attachment F, Health Care Discharge Summary) The written health care discharge summary for a resident, who has attained the age of 18, and who does not have a guardian shall be signed by the resident. The resident shall be given a copy and the original shall be filed in the resident's health care record.
5. For all other residents, a copy of the written health care discharge summary shall be given to the resident's legal guardian, and the original shall be filed in the resident's health care record. If a person other than a resident's legal guardian is scheduled to pick up a resident for release, the legal guardian's

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permission must be obtained by the health care staff to release the health care discharge summary and, if applicable, medications to this person. Such permission shall be documented in the resident's health care record.

Procedure J: Care of Chronic Illness (Chronic Care Clinics)

1. Each facility shall have in place a plan for the treatment of residents with chronic conditions that require periodic care and treatment. The plan shall be approved by the facility physician or facility mental health authority and shall include, but not be limited to, medication monitoring, laboratory testing, the use of specialist consultation and review, as needed, and directions to health-care providers and other facility personnel regarding their roles in the care and supervision of the residents.
2. All residents diagnosed with chronic illnesses or conditions, (e.g. asthma, diabetes, and other diseases that require periodic care and treatment) shall be enrolled in the appropriate chronic care clinic to assure continuity of care and treatment.
3. All residents enrolled in a chronic care clinic shall be seen by the facility physician, physician assistant, or nurse practitioner at least every six (6) months or more frequently, as necessary.
4. All residents enrolled in the mental health chronic care clinic shall be seen by the facility psychiatrist at least every ninety (90) days or more frequently, as necessary.
5. The facility shall have in place a system to ensure that all residents that are enrolled in a chronic care clinic are seen at least every six (6) months.
6. All chronic care clinic visits shall be documented on the appropriate chronic care clinic form(s) in the resident's health care record.
7. The health care staff conducting the chronic care clinic shall review with the resident all decisions resulting from the clinic, including a decision to discharge the resident from the clinic.
8. If it is determined by the facility physician, physician assistant or nurse practitioner that the resident's condition no longer warrants follow-up in a chronic care clinic, a notation in the resident's health care record shall be made explaining the reason for this decision. For a resident enrolled in the mental health chronic care clinic, such a decision must be made by the psychiatrist.

Procedure K: Special Needs

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1. Residents with special needs may include but are not limited to the following:
 - a. Residents with chronic illnesses,
 - b. Residents with serious communicable diseases,
 - c. Residents with physical disabilities,
 - d. Residents who are pregnant,
 - e. Residents with terminal illnesses,
 - f. Residents with serious mental health needs,
 - g. Residents with developmental disabilities,
 - h. Residents on dialysis,
 - i. Residents who are suicidal,
 - j. Residents with chemical dependence.

2. The Chief Administrative Officer, or designee, shall consult with facility health care staff whenever action is initiated by any staff regarding a housing assignment, program assignment, disciplinary measure, work assignment, transfer to another facility, or placement on observation status for a resident identified as having special needs and the action might require an accommodation for the special needs. The consultation shall take place prior to any action being implemented. In an emergency, staff may take action immediately to protect safety or security. The consultation shall take place to review the appropriateness of the action as soon as possible but no later than 72 hours.

3. An individualized treatment plan shall be developed collaboratively with health care, security and program staff and approved by the facility physician, physician assistant or nurse practitioner. The plan shall be revised, as necessary, and monitored during the chronic care clinic or during the annual health assessment for the care of each special needs resident.

4. The plan shall include instruction about diet, exercise, adaptation to the correctional environment, and medication, diagnostic testing, referrals, and follow-up evaluations as applicable.

5. The plan shall identify short and long term goals as well as the methods by which these goals may be accomplished.

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6. The progress of residents with special needs shall be reviewed for compliance with and effectiveness of the plan at a minimum once each quarter. This review may be conducted in conjunction with the Chronic Care Clinic.
7. The care of a terminally ill resident shall include an individualized treatment plan, formulated by a multi-disciplinary team, to include, but not be limited to, pain management, consideration for release in accordance with Departmental policy and procedure, consideration for placement in community long term care facilities, and hospitals and/or hospice care facilities.
8. The health care staff conducting the chronic care clinic or annual health assessment shall review the treatment plan with the resident.

Procedure L: Observation Status

1. When a resident is placed on Observation status, the Juvenile Program Manager, or other security supervisor designated by the Chief Administrative Officer, shall immediately notify the facility Health Service Administrator (HSA), or designee.
2. The HSA, or designee, shall ensure that appropriate health care staff review the resident's health care record to determine if there is any health care condition that contraindicates the placement or that requires monitoring by the health care staff.
3. After reviewing the health care record, designated health care staff shall go to the housing unit to evaluate the resident immediately. The health care staff shall notify on-call mental health staff if not previously notified.
4. In any situation in which bodily injury is apparent or the resident complains of bodily injury related to the placement, the Juvenile Facility Operations Supervisor, or other designated supervisory staff, shall consult with appropriate health care staff immediately, unless safety or security considerations cause a delay.
5. At a minimum, daily rounds to residents on Observation status shall be made by health care staff once per shift to ensure the resident's access to appropriate health care.
 - a. The presence of the health care staff shall be announced to the residents.
 - b. The health care staff shall observe each resident and inquire of each resident as to the resident's well-being.

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- c. Rounds in each housing unit shall be documented by health care staff in the housing log and signed by the health care staff making the rounds.
 - d. For all checks by mental health care staff, the resident shall be escorted to a setting for confidential consultation, unless escorting the resident is determined by the Chief Administrative Officer, or designee, to create a risk to safety or security of the facility.
6. Health care staff shall accept sick-call slips, on a daily basis, from residents requesting non-emergency health care in any housing area that does not have a sick-call drop box.

Procedure M: Medical Orders

- 1. Treatment performed by nursing staff is pursuant to written or verbal orders given by health care staff authorized by law to give such orders.
- 2. Written orders shall be recorded on the Physician Orders sheet and shall include the signature of the person issuing the order and the time and date the order was given.
- 3. Verbal orders shall be recorded by the nurse on the Physician Orders sheet and shall include the name of the person issuing the order, the person accepting the order, and the time and date the order was given. The individual who issued the order shall sign and date it on his/her next visit to the facility.

Procedure N: Nursing Protocols

- 1. The health care authority shall develop nursing assessment and treatment protocols. All nursing protocols shall comply with the regulations of the State of Maine Board of Nursing.
- 2. The health care authority shall develop preventive medicine protocols.
- 3. The HSA, or designee, shall assure each nurse is trained in the nursing protocols at the facility, and each nurse shall sign and date the time of this training.
- 4. Unless otherwise ordered by the facility physician, physician assistant, or nurse practitioner in a specific case, all care provided by the nursing staff shall be in accordance with approved nursing protocols. Standing orders shall not to be used.
- 5. Protocols involving medication shall be limited as follows:

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- a. Protocols may allow treatment with prescription medication without a written or verbal order in the case of an emergency life threatening situation (e.g., nitroglycerin, epinephrine);
 - b. Protocols may allow the routine use of over the counter medications without a written or verbal order;
 - c. Administration of any medications, including over the counter medications, by nursing staff shall be documented in the Medication Administration Record.
6. At a minimum, the nursing pathway manual (containing nursing protocols) shall be reviewed, revised as needed, dated and signed annually by the HSA and the Regional Medical Director.

Procedure O: Clinic Space, Equipment and Supplies

- 1. The Chief Administrative Officer of each facility shall ensure that there is sufficient and suitable space, equipment and supplies to provide on-site health care services at that facility. When on-site health care services are provided, the space, equipment and supplies shall include:
 - a. Examination and treatment rooms for medical care large enough to accommodate the necessary equipment and fixtures and to permit privacy for the resident. Basic equipment available for examination and treatment shall include, but not be limited to:
 - 1. Hand sanitization,
 - 2. Examination table(s),
 - 3. A light capable of providing directed illumination,
 - 4. Scale(s),
 - 5. Thermometers,
 - 6. Blood pressure cuffs,
 - 7. Stethoscope,
 - 8. Ophthalmoscope, and
 - 9. Otoscope.

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- b. Prescribed and allowed over the counter medications.
 - c. Emergency response equipment, to include automatic external defibrillators (AEDs), and supplies for use by health care staff that health care staff inspect daily (appropriately documented).
 - d. Adequate office space providing secure storage of health care records.
 - e. Private interview and counseling space for medical and mental health care.
 - f. Appropriate areas for laboratory, radiological, or other ancillary services when they are provided on site.
 - g. Waiting areas for residents that have seats and access to drinking water and toilets, if residents are to wait more than a brief period for services.
 - f. Basic medical supplies and equipment that are inventoried at least quarterly.
2. At a minimum, inventories shall be conducted on a weekly basis of any items that pose a safety or security risk (e.g., syringes, needles, scissors, and other sharp instruments). All inventories shall be appropriately documented.

Procedure P: Elective Medical Treatment

- 1. The health care authority shall utilize a process, on an individual basis, for the provision of medical treatment to correct a significant functional deficit, pathological process, or condition that is not a serious threat to the resident's health.

Procedure Q: First Aid and Personal Protective Equipment Kits

- 1. The Health Services Administrator (HSA), or designee, shall, in conjunction with the Chief Administrative Officer, or designee, determine the locations and number of first aid and personal protective equipment kits for use by facility and community corrections staff.
- 2. The Health Services Administrator (HSA), or designee, shall determine the contents of the kits.
- 3. The Health Services Administrator (HSA), or designee, shall conduct a monthly inspection of the kits and restock the kits as necessary.
- 4. The inspections shall be documented.

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Procedure R: Medical Therapeutic Restraints

1. Therapeutic restraints authorized for a medical reason may be used only when the safety or health of the resident cannot be protected by less restrictive alternatives. The following provisions shall be adhered to any time therapeutic restraints are used in resident care:
 - a. Therapeutic restraints may not be used for punishment;
 - b. Therapeutic restraints may not be used to force unwanted treatment on a competent resident who has attained the age of 18;
 - c. If therapeutic restraints are used, the least restrictive restraints possible shall be used and only for the period of time necessary;
 - d. Therapeutic restraints may be ordered only by a facility physician, physician assistant or nurse practitioner. The documentation shall include the order, the medical reason for the order, the justification for using restraints (to include efforts for less restrictive treatment alternatives) and the justification for the type of restraints ordered;
 - e. A new order, including the reason for the continuation, must be written for every twelve (12) hour continuation in the use of therapeutic restraints; and
 - f. A facility physician, physician assistant or nurse practitioner shall personally examine the resident within twenty-four (24) hours of the initial use of therapeutic restraints, if the use has not been discontinued in the meantime.
2. If the purpose of the restraints is to provide necessary medical treatment to a resident age 18 or over who is refusing the treatment and who has a legal guardian, the following shall apply:
 - a. The Chief Administrative Officer, or designee, shall assign a staff person to speak with the resident in an effort to persuade the resident to accept the treatment.
 - b. If the resident continues to refuse the treatment, an attempt shall be made to contact the resident’s guardian for specific consent to provide the treatment and the attempt and the result of that attempt shall be documented.

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- c. If the resident continues to refuse the treatment, and the guardian has consented to the treatment, health care and security staff shall develop a plan for providing the treatment using only the degree of physical force necessary.
 - d. If the resident's guardian cannot be contacted and it appears that contact cannot be made in a reasonable period of time, the Chief Administrative Officer, or designee, shall contact the Department's legal representative in the Attorney General's Office to inquire about obtaining a court order or taking other appropriate action.
3. If the purpose of the restraints is to provide necessary medical treatment to a resident age 18 or over who is refusing the treatment and who does not have a guardian, the following shall apply:
- a. The Chief Administrative Officer, or designee, shall assign a staff person to speak with the resident in an effort to persuade the resident to accept the treatment.
 - b. If the resident continues to refuse the treatment, the resident shall be referred to the facility psychiatrist or psychologist for a determination of competence.
 - c. If the resident is determined to be competent, therapeutic restraints shall not be used.
 - d. If the resident is determined to be incompetent, the Chief Administrative Officer, or designee, shall contact the Department's legal representative in the Attorney General's Office to inquire about obtaining an emergency guardian or taking other appropriate action.
4. If the purpose of the restraints is to provide treatment to a resident who has not attained the age of 18 who is refusing treatment, the Chief Administrative Officer, or designee, shall assign a staff person to speak with the resident in an effort to persuade the resident to accept the treatment. If the resident continues to refuse the treatment, the Chief Administrative Officer, or Deputy Chief Administrative Officer, shall be contacted for specific consent to provide the treatment.
5. Unless the treatment is governed by an Advance Directive, in a health care emergency in which a resident is unable to consent to or refuse treatment (is unconscious, unable to communicate, or disoriented) and where it is necessary to provide treatment before consent can be obtained, necessary treatment shall be provided, using only the degree of physical force necessary.

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6. A therapeutic restraints order shall be obtained by health care staff prior to the initiation of the use of therapeutic restraints. In an emergency situation, to protect the health or safety of the resident, security staff may restrain the resident until the order for therapeutic restraints is obtained. In an emergency situation, security staff shall contact health care staff for authorization immediately after restraining the resident.
7. A therapeutic restraints order shall be documented by the health care staff in the resident's health care record.
8. Health care staff shall immediately inform the Juvenile Facility Operations Supervisor when therapeutic restraints have been ordered.
9. The application of the therapeutic restraints shall be done by security staff. Only the amount of force reasonably necessary may be used in the application of therapeutic restraints.
10. Only restraints that would be appropriate for use in hospitals shall be used for therapeutic restraints. These include, but are not limited to, fleece-lined leather, rubber, or canvas hand and leg restraints, and 2-point or 4-point ambulatory restraints. Metal or plastic devices, such as handcuffs and leg shackles, shall not be used as therapeutic restraints, except in an emergency situation.
11. A resident may be restrained in a hospital bed, stretcher, wheelchair, or restraint chair. A resident may not be restrained in an unnatural position or face down.
12. A resident placed in therapeutic restraints shall be observed by health care staff or security staff at least every fifteen (15) minutes and these observations shall be documented on the Therapeutic Restraint Sheet (Attachment H).
13. In all cases in which therapeutic restraints are used and bodily injury or compromise to health is apparent or the resident complains of bodily injury or compromise to health related to the use of the restraints, the security staff shall consult with appropriate health care staff immediately, unless safety or security considerations cause a delay.
14. Whenever therapeutic restraints are authorized, medical staff shall assess the resident as soon as possible and at least every two (2) hours thereafter, and the following shall be checked:
 - a. Circulation, movement, and sensation in extremities,
 - b. Respiratory status,
 - c. Mental status,

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- d. Vital signs,
 - e. That food, water, and use of the toilet has been offered as appropriate, and
 - f. That the resident has been offered the opportunity to have each limb removed separately from restraints for the purpose of movement every two (2) hours as appropriate.
15. During the resident's hours of sleep, health care staff may elect not to awaken the resident to complete the assessment.
 16. The results of the assessment shall be documented in the resident's health care record, including any reason for security staff not offering food, water, use of the toilet, or movement of restrained limbs. If health care staff elect not to awaken a sleeping resident, that fact shall be documented in the resident's health care record.
 17. The need for continued therapeutic restraints of the resident shall be reevaluated at least every four (4) hours by health care staff. If the health care staff determines that the use of therapeutic restraints is no longer necessary, the staff shall contact the facility physician, physician assistant, or nurse practitioner requesting an order to discontinue the use of the restraints.
 18. Health care staff shall immediately inform the facility Shift Commander when the discontinuation of therapeutic restraints has been ordered.
 19. The removal of the therapeutic restraints shall be done by security staff. Only the amount of force reasonably necessary may be used in the removal of therapeutic restraints.
 20. The Health Services Administrator, or designee, and the Chief Administrative Officer, or designee, shall be notified by health care staff as soon as possible of any order for the use of therapeutic restraints and of any order to discontinue the use of the restraints.
 21. The Chief Administrative Officer, or designee, shall arrange for a review of the use of therapeutic restraints following each incident, to include attendance by security and health care supervisory staff.
 22. Nothing in this policy precludes the use of security restraints to facilitate noninvasive measures designed to protect others from potential exposure to bodily fluids, including the involuntary application of bandages to wounds to prevent the spreading of bodily fluids.

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Procedure S: Medical Therapeutic Seclusion

1. Therapeutic seclusion authorized for a medical reason (e.g., respiratory isolation, contact precautions) may be used only when the safety or health of the resident or others cannot be protected by less restrictive means. The following provisions shall be adhered to any time therapeutic seclusion is used in resident care:
 - a. Therapeutic seclusion may not be used for punishment;
 - b. If therapeutic seclusion is used, it shall be used only for the period of time necessary;
 - c. Therapeutic seclusion may be ordered only by a facility physician, physician assistant or nurse practitioner. The documentation shall include the order, the medical reason for the order, and the justification for using seclusion;
 - d. A facility physician, physician assistant or nurse practitioner shall personally examine the resident within twenty-four (24) hours of the initial use of therapeutic seclusion, if the use has not been discontinued in the meantime.
2. The order shall be obtained by health care staff prior to the initiation of the use of therapeutic seclusion. In an emergency situation, to protect the health or safety of the resident or others, staff may isolate the resident until the order for therapeutic seclusion is obtained.
3. A therapeutic seclusion order shall be documented by the health care staff in the resident's health care record.
4. Health care staff shall immediately inform the Juvenile Program Manager, or if unavailable, the Juvenile Facility Operations Supervisor when therapeutic seclusion has been ordered.
5. The movement of the resident to therapeutic seclusion shall be done by security staff.
6. Log book entries shall include the name and title of the physician, physician's assistant or nurse practitioner authorizing seclusion, names and titles of all persons visiting the resident, records of time checks, the name of the health care staff authorizing release from seclusion and the time of release from seclusion.

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7. The need for continued therapeutic seclusion of the resident shall be reevaluated at least every twenty-four (24) hours by health care staff. If the health care staff believes that the use of therapeutic seclusion is no longer necessary, the staff shall contact the physician, physician assistant, or nurse practitioner for an order to discontinue the use of seclusion.
8. Staff having personal contact with the resident or entering the seclusion area shall follow all seclusion protocols as required by the Medical Director.
9. Residents on therapeutic seclusion shall be visited at least once each day by health care staff, unless health care is needed more frequently.
10. Health care staff shall immediately inform the Juvenile Program Manager, or if unavailable, the Juvenile Facility Operations Supervisor when the discontinuation of therapeutic seclusion has been ordered.
11. The movement of the resident from therapeutic seclusion shall be done by security staff.
12. The Health Services Administrator, or designee, and the Chief Administrative Officer, or designee, shall be notified by health care staff as soon as possible of any order for the use of therapeutic seclusion and of any order to discontinue the use of the seclusion.

VII. PROFESSIONAL STANDARDS

ACA:

4-JCF-3C-03 The following procedure is followed for any juvenile placed in room confinement:

1. Checked visually by staff at least every 15 minutes
2. Visited at least once each day by personnel from administrative, clinical, social work, religious, and/or medical units. Actual entry into the room of confinement with the juvenile or removal of the juvenile from the room for the purpose of discussion or counseling constitutes a visit.
3. A log is kept recording:
 - a. The name and title of the individual who authorized the confinement
 - b. Name and title of persons visiting the juvenile
 - c. Record of time checks
 - d. The person authorizing release from confinement
 - e. The time of release
4. Suicidal juveniles are under continuous one-to-one observations until evaluated by a mental health professional.

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- 4-JCF-4C-08** A written medical summary is required to maintain continuity of care when a juvenile is referred to a community-based health-care provider or released from the facility.
- 4-JCF-4C-10** (MANDATORY) Treatment by a qualified health professional is performed pursuant to written standing or direct orders by a health-care practitioner. Health-care practitioners, such as nurse practitioners and physician's assistants, practice within the limits of applicable laws and regulations.
- 4-JCF-4C-11** A decision-making process is in place that governs elective procedures or surgery for juveniles.
- 4-JCF-4C-13** (MANDATORY) Detoxification from alcohol, opiates, hypnotics, other stimulants, and sedative hypnotic drugs is conducted under direct medical supervision when performed at the facility or is conducted in a hospital or community detoxification center. Specific guidelines are followed for the treatment and observations of individuals manifesting mild or moderate symptoms of intoxication or withdrawal from alcohol and/or other drugs.
- 4-JCF-4C-15** Routine and emergency dental care is provided to each juvenile under the direction and supervision of a licensed dentist. There is a defined scope of available dental services, including emergency dental care, which includes the following:
1. Dental screening is conducted upon admission by a qualified health-care professional or health-trained personnel
 2. Dental examination by a dentist within 14 days of admission on intersystem transfers, unless documentation of dental examination completed within the last six months, and diagnostic x-rays, as necessary
 3. Preventive care by a dentist or dental-trained personnel within 14 days of admission, unless documentation of dental-preventive care completed within the last six months.
 4. Dentist determines the conditions for more frequent than annual dental follow-up
 5. Defined charting system that identifies the oral-health condition and specifies the priorities for treatment by category is completed
 6. Development of an individualized dental-treatment plan as indicated for juveniles receiving dental care
 7. Consultation and referral to dental specialists, including oral surgery, when necessary.
- 4-JCF-4C-16** A health-care treatment plan shall be developed for juveniles who require medical supervision for chronic and convalescent care. This plan includes directions to health-care providers and other facility personnel regarding their roles in the care and supervision of the juveniles. This plan is approved by the responsible health-care authority.
- 4-JCF-4C-17** Juveniles with chronic illnesses or conditions, such as asthma, diabetes, and other diseases, receive periodic care, and treatment that includes:
1. Medication monitoring
 2. Laboratory testing
 3. Specialist consultation, as needed

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4. Health-care practitioner review and examination, as indicated
- 4-JTS-4C-19 (MANDATORY) If female juveniles are housed, access to obstetrical, gynecological, family planning, health education, and pregnancy-management services are provided. Provisions of pregnancy management include the following:
1. Pregnancy testing
 2. Routine and high-risk prenatal care
 3. Management of chemically addicted pregnant juveniles
 4. Comprehensive counseling
 5. Postpartum follow-up care
- 4-JCF-4C-20 Medical and dental adaptive devices are provided when medically necessary as determined by the responsible health-care planner.
- 4-JCF-4C-07 Juveniles who need health-care beyond the resources available in the facility, as determined by the responsible health-care practitioner, are transported under appropriate security provisions to a facility where such care is provided. A written list of referral sources, including emergency and routine care, is available and reviewed/updated at least annually.
- 4-JCF-4C-46 When a juvenile is placed in seclusion/isolation, a qualified health-care professional or health-trained person shall be informed immediately and shall complete an assessment, as determined by the health authority. Unless medical attention is needed more frequently, each juvenile in seclusion/isolation receives a daily visit from a qualified health-care professional or health-trained person.
- 4-JCF-4C-47 (MANDATORY) Guidelines regarding the use of restraints on juveniles for medical and mental-health purposes at a minimum shall include:
1. Conditions under which restraints may be applied
 2. Types of restraints to be applied
 3. Identification of a qualified medical or mental health professional and health-care practitioner who may authorize the use of restraints after reaching the conclusion that less intrusive measures are not successful
 4. Monitoring procedures
 5. Length of time restraints are to be applied
 6. Less-restrictive-treatment-plan alternatives are developed and implemented as soon as possible
 7. After-incident review
- 4-JCF-4C-59 First aid kits and automatic external defibrillators (AEDs) are available in designated areas of the facility as determined by the health authority in conjunction with the facility or program administrator. The health authority shall establish procedures for the first aid kit and AED use by nonmedical staff. Monthly inspections of first aid kits and AEDs will occur.
- 4-JCF-4E-01 Juveniles with alcohol and other drug abuse problems are identified through a standardized assessment process. This assessment process is documented and includes, at a minimum, the following:

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1. Drug and alcohol screening at initial intake to include use, abuse and treatment history
2. Medical assessment for referral to a drug and alcohol crisis-intervention-program appropriate to the needs of the individual juvenile
3. Drug and alcohol assessment, when necessary, for program placement needs
4. Reassessment, if indicated clinically

4-JCF-4E-02 In a facility that offers a treatment program for alcohol and other drug-abusing juveniles, the clinical management includes, at a minimum, the following:

1. Standardized diagnostic-needs assessment administered to determine the extent of use, abuse, and dependency
2. Collaboration in the development of an individualized treatment plan developed by a substance abuse professional and the clinical team that may include medical, mental health, education, social service, recreation and unit staff, as deemed necessary
3. Involvement of the juvenile and, when possible, his/her family/guardian, in treatment, aftercare, and discharge planning

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