CHAPTER 9 — HEALTH CARE SERVICES

Effective June 16, 1995

ARTICLE 1 — RESERVED FOR MEDICAL SERVICES

ARTICLE 2 — MENTAL HEALTH SERVICES

Revised July 11, 1995
Updated March 9, 2015

91020.1 Policy
The Department shall receive, evaluate, house, treat, and/or refer all psychiatrically disturbed inmates who by virtue of their mental illness are unable to appropriately function within the constraints of the usual correctional processing or program assignments.

91020.2 Purpose
To provide for the detection, diagnosis, treatment, and referral of inmates with mental health problems and to assist each facility's Warden during all stages of each inmate's period of incarceration.

91020.3 Plan for Mental Health Programs
The Deputy Director, HCSD, shall maintain the delivery of mental health services and programs to inmates and parolees. Such services and programs shall include the following:

- Provisions for mental health care to all inmates and parolees with emphasis on identification of need while in reception and prerelease processing.
- Provision for diagnosis and treatment of voluntary patients.
- Provision for involuntary diagnostic and treatment services with appropriate safeguards against abuse and means for appeal and relief.
- POCs shall provide mental health services to parolees, reporting administratively to P&CS and, reporting professionally to the Deputy Director, HCSD.
- An ongoing program to assess the needs of current departmental population.
- Priorities for the use of limited resources and plans for improving existing programs or initiating new programs.
- Criteria for referring for services within the Department and to other agencies.
- A program review and evaluation activity.

91020.4 Services
Each institution shall provide staff, space, equipment, and supplies for the treatment and/or referral of inmates with mental disorders requiring care. Each institution shall provide 24-hour emergency service.

- All departmental staff, by their supervisors, shall apprise institutional management when this procedure and/or professional standards are not being followed or met.

91020.5 How Services are Obtained
Departmental employees may refer an inmate to an institution's mental health services or the inmate may submit a request for such services.

91020.6 On-Site Services
Inpatient psychiatric services shall be provided at the:
- CMF.
- CIM.

Outpatient services or arrangements for appropriate referrals shall be provided at all institutions.

91020.7 Routine Referrals
The treating physician at any facility may initiate a referral to any psychiatric resource by contacting the designated facility Chief Psychiatrist (CP) or equivalent. The referring facility shall arrange transportation. The receiving facility may request further evaluation prior to transfer.

Placement and assignment procedures for psychiatric treatment categories, including documentation and CSR endorsement, shall be as outlined in the DOM 62050 and 62080.

91020.8 Category "I"
A classification of Category "I" for males and "I" or "Psychotic" for females is assigned to inmates who are believed to be:
- Acutely psychotic, severely depressed, or suicidal.
- Mentally ill inmates who are management problems, providing the psychosis warrants treatment in a hospital setting.

91020.8.1 Category "I" Transfers
Category "I" care is provided at CMF or at the CIW. Category "I" designation shall only be made by CMF or CIW staff. Other institutions with inmates who appear to meet Category "I" criteria shall transfer such cases to CMF or CIW for psychiatric observation.

When an inmate believed to be mentally ill is transferred to a psychiatric program and later found not to be mentally ill, they shall be returned to the sending institution without CSR review.

The DMH provides inpatient services for inmates transferred from the Department in accordance with PC 2684 and at CMF by interdepartmental contract.

91020.8.2 Mental Health Evaluations
When an inmate is transferred for a comprehensive mental health evaluation by a multiple disciplinary mental health team, it shall take place within 14 days after the date of transfer. The evaluation shall include at least the following:
- Review of mental health screening and appraisal data.
- Collection and review of additional data from staff observation.
- Individual diagnostic interviews and tests assessing intellect and coping abilities.
- Compilation of individual's mental health history.
- Development and overall treatment/management plan with referrals.

91020.9 Off-Site Services
The Department maintains interdepartmental agreements to transfer mentally ill or mentally deficient inmates or parolees to DMH or the Department of Developmental Services for treatment.

91020.10 Records
Records for each inmate housed by DMH shall be maintained by the respective "hub" institution (refer to DOM 62030). The "hub" institution and P&CS staff shall make all contacts with the designated DMH facility to secure reports, schedule BPT hearings, and to process an inmate's parole or discharge. Any report needed for BPT hearings, Superior Court, or other such proceeding shall be requested of DMH to prepare the report or send the departmental staff person to the hospital to complete the report.

91020.11 Inpatient Facility
The psychiatric inpatient unit shall treat mentally disordered patients with any psychiatric illness or disease, whether functional or of organic origin, requiring inpatient-level care.

91020.11.1 Inpatient Facilities Requirements
The CP shall:
- Administer medical care and services for the unit, including all acts of diagnosis, treatment, prescribing, and ordering of drugs.
- Develop a plan for treating and/or referral of patients with emergency medical problems.
- Chair a committee to identify and recommend to administration necessary equipment and supplies.

91020.11.2 Psychiatrists
The psychiatrist shall:
- Prepare the diagnostic formulation for each inmate.
- Develop and implement individual treatment plans.
- Determine frequency of medical examinations.

Reports of all medical examinations shall be placed in the inmate's medical record file.

Only medical staff shall order an inmate removed from general housing status for medical or psychiatric reasons.

91020.11.3 Clinical Psychologists
Psychological services shall be provided by clinical psychologists. Clinical psychologists are members of the medical staff and shall have admitting privileges within departmental medical facilities.

91020.11.4 Social Worker Services
A social worker shall be used for the rendering of social services:
- At the request of the patient's attending physician.
- At the request of management staff.
91020.11.5 Psychiatric Nursing
A nurse with at least two years experience in psychiatric nursing shall provide the nursing management of the psychiatric unit. There shall be an RN with training and experience in psychiatric nursing on duty at all times in an institution having a psychiatric unit. There shall be sufficient nursing staff including RNs, MTAs, Licensed Vocational Nurses (LVN), and mental health workers to meet the needs of inmates. Nursing activity documentation shall be forwarded to the unit CP.

91020.12 Therapeutic Programs
Every inpatient unit shall:
- Provide and conduct organized programs of therapeutic activities in accordance with the interests, abilities, and personal and custodial needs of the inmate.
- Develop and record an individual evaluation and treatment plan which is correlated with the total therapeutic program.

Qualified therapists shall be employed to conduct the therapeutic activity program that may include:
- Occupational.
- Music.
- Art.
- Dance.
- Recreation.

91020.13 Inmate Patient Rights
Each inmate shall have the same rights as all other inmates unless the physician has good cause to deny an inmate any of the rights specified. The denial and reasons shall be entered in the inmate's medical record.

91020.14 Due Process for Psychiatric Patient Transfers to CMF
Due process for inmates transferred to CMF for psychiatric reasons shall be accomplished by CMF staff.
The inmate shall:
- Be given written notice indicating a hearing shall be held within seven days after arrival at CMF.
- Be assisted by his caseworker for and at the hearing which includes available documentation relating to the transfer.
- Have the information and/or justification for ordering the transfer disclosed at the hearing.
- Have the opportunity to present either oral or written testimony of witnesses.
- Be informed in writing of the decision.
The chairperson shall:
- Be an independent decision maker.
- Not be the treating psychiatrist at the referring or treating facility.
- Have the discretion to limit witnesses.
- Have the discretion to continue the hearing if additional information is needed.

91020.14.1 Appeal
The inmate may appeal the decision within 30 days using CDC Form 602, Inmate/Parolee Appeal Form.

Note: DOM 54060.15 through 54060.34 are now incorporated into DOM 91090.

91020.15 Control of Inmate
Revised August 17, 2011
Refer to the CCR, Title 15, Section 3268, Use of Force policy.

91020.15.1 Contained Situation
Contained or controlled situations (such as a recalcitrant inmate in a locked cell or room) with no apparent likelihood of immediate danger or injury to any person shall be evaluated and alternatives to the use of force, considered. In such controlled non-emergency situations, the use of force may be authorized only by personnel at the level of lieutenant or above. On psychiatric wards, the approval of a psychiatrist shall be required.

91020.16 Staff Responsibility
Staff persons shall:
- Orally report to the immediate supervisor all incidents where physical force is used to subdue, contain, or control an inmate.
- Fully document the incident prior to leaving the facility.

91020.16.1 Supervisor's Responsibility
Supervisors shall:
- Provide supervision of the incident, when possible, to ensure only minimum amount of force is used to control the situation.
- Not become actively involved in the use of force unless absolutely necessary.
- Report incident verbally and in writing to the immediate supervisor.

Supervisor in charge shall:
- Ensure medical attention and care is provided.
- Have personnel evaluated by medical staff and first-aid administered if required.
- Have injured inmates treated by medical staff and documented on a CDCR Form 7219.
- Have photographs taken of all persons involved and verify photographs are true depictions.
- Log and maintain negatives and pictures for two years before obliteration.

91020.17 Restraint and/or Seclusion
Application of mechanical equipment and/or seclusion for psychiatric reasons shall be:
- Used only to protect the inmate and others from injury.
- To prevent property damage.

Mechanical Equipment
An inmate shall:
- Be placed in restraint only by written order of a physician.
- Be placed in restraint at the discretion of a RN, MTA, or LVN and an oral order obtained, recorded, and signed by a physician.
- Be observed every 15 minutes by medical staff.
- Be easily removable in the event of fire or other emergencies.

A record of type of restraint, application, and removal shall be in the inmate's medical record.

Seclusion
An inmate placed in seclusion requires the same orders as mechanical equipment restraint.

91020.18 Electronic Control Device
Revised August 17, 2011
Procedures for the use of an Electronic Control Device (ECD) are contained in the Restricted Volume (55000 Series) of the DOM.

91020.18.1 Review of Medical/Psychiatric Records
Custodial Staff
A taser shall not be utilized until the following occurs:
- Custodial staff shall notify the CMO or designee that use of the taser is being considered on a particular inmate. Custodial staff shall identify the inmate to medical staff by name, CDC number, and housing location.

CMO
- The CMO or designee is responsible to review the medical and psychiatric sections of the inmate's health record to ascertain whether there are any medical conditions that preclude the use of the taser. Use of the taser is prohibited if the inmate received any psychotropic medication in the prior six weeks, is being treated for a cardiac arrhythmia, or has a pacemaker.
- If no prohibitive medical or psychiatric condition exists, medical staff shall inform the appropriate custodial authority that there are no medical/psychiatric factors which preclude the use of the taser on the inmate at this time.

91020.18.2 Documenting Review of Medical/Psychiatric Records
CMO
- The CMO or designee is responsible to document their findings in the general medical and psychiatric sections of the inmate's health record.

Facility Administrative Staff
- The facility administrative staff is responsible to document compliance with these procedures within the CDCR Form 837 series, Crime/Incident Report, which is submitted to the Institutions Division at headquarters.
See DOM 32010, Taser Certification/Recertification Requirements; 51030, Reportable Incidents; and 55050, Authorization/Use/Limitations and Storage, for additional information on the taser.

91020.19 Inmate in AD-SEG
When an inmate remains in AD-SEG beyond 30 days, a personal interview shall be conducted and a written report, CDC Form 128-C, shall be prepared by a psychologist or psychiatrist to evaluate any psychological sequel, need for medications, and/or reassurance about external circumstances. If the inmate confinement continues beyond three months, a psychological assessment shall be made every three months.

91020.20 Clinical Evaluation by Counselors
There may be occasions when large numbers of psychiatric referrals and limited psychiatric staff may require that qualified CC-IIs prepare clinical records in lieu of psychiatric evaluations for selected cases and under supervision of a psychologist or a psychiatrist. A psychiatric council shall be established to review such evaluations prepared by counselors. The council shall be comprised of:
- Chairperson: facility's chief or program psychiatrist/consulting psychiatrist.
- Clinical psychologist.
- PA, CC-III, or CC-II who prepared the evaluation.

91020.21 Inmates With Death Sentences
Three appointed psychiatrists shall:
- Conduct a psychiatric examination and submit a written report to the Warden in time for the report to be transmitted to the Governor at least 20 days prior to the scheduled execution date.
- Have all information available pertinent to the inmate's sanity.
- Prepare a report at least 20 days prior to scheduled execution to be submitted in triplicate to the Director.
- Evaluate the electroencephalogram examination with an interpretation of the results in lay wording.

91020.22 Psychiatric Serious Disciplinary Hearings
For serious disciplinary hearings in a psychiatric unit, a subcommittee shall include a psychiatrist or psychologist. A full disciplinary committee shall include a psychiatrist and a psychologist.

91020.23 Psychiatric/Psychological Evaluations—General Instructions
For efficient use of evaluations for BPT, Superior Court, etc., the psychiatric/psychological portion of the cumulative case summary shall:
- Be brief and concise.
- Use lay terminology and explanations.
- Avoid detailed recapitulation of material available elsewhere in the cumulative summary.
- If the previous report is virtually identical to the current evaluation, do not rewrite the entire report.
- Indicate the case has been reviewed, the previous report is still applicable, and there is no significant change.

91020.23.1 Content
The evaluation shall also indicate:
- Whether this is the first, second, etc., report to the authority.
- Length of time since the last report.
- What was the nature of author's contact with the inmate.
- If first report, note pertinent previous psychiatric history with a short digest of essential conclusions and treatment.
- Summarize current essential development and progress.
- Delineate the psychopathology present which supports the diagnosis and prognosis.
- Reevaluate previously reported psychiatric conclusions.
- Comments on causative factors, self-understanding, attitudes, motivation for change, emotional stability, social identification, sincerity, and rehabilitation.
- A neurological appraisal (or reference to prior appraisal or note that such appraisal is needed) if organicity is present.
- The observed effect of medication or note if not on medication.

91020.23.2 Conclusions
All evaluations shall list the reasons for general conclusions. The diagnosed psychopathology is related to criminal behavior:
- Directly, the offense or offenses were largely a function of the psychopathological state.
- Indirectly, the psychopathology directly and clearly predisposed to the offenses but did not determine them.
- No significant relationship, criminal behavior, and psychopathology have been unrelated. Continuation of the psychopathology does not substantially increase the likelihood of criminal behavior.

Observation in the Facility
During observation in the facility, the inmate has:
- Psychiatically improved slightly, moderately, greatly, or entirely.
- Psychiatically deteriorated slightly, moderately, or greatly.
- Psychiatically has shown no significant change.
- No conclusions may be drawn because of insufficient time and observation by evaluation.

Return to Community
In a less controlled setting such as return to the community, the inmate is:
- Considered likely to continue improvement.
- Considered likely to hold present gains.
- Considered in all probability to deteriorate because of (list reasons).

91020.23.3 Suggested Actions
From a psychiatric standpoint, the inmate should:
- Remain in present rehabilitation program as continued benefit is likely. State recommended specific treatment.
- Be removed from special (psychiatric evaluation) calendar because:
  - Psychopathology is not significantly related to future criminal behavior and psychiatric opinion will not contribute to release decision.
  - Two or more favorable psychiatric reports (having conclusions favorable for release) have been written within the last three years. The two favorable reports shall have been written by more than one examiner or had psychiatric council review.
  - There have been repeated psychiatric reports describing chronic mental pathology which cannot be expected to change. The conditions under which parole would be possible or become possible shall be spelled out with this recommendation.
- Be considered for transfer to DMH as needing treatment not available in the Department. Recommendations shall state whether it is anticipated that such treatment may result in the inmate being able to be returned to society.

91020.23.4 Parole and Release
If the inmate is to be paroled or released, consideration shall be given to the following:
- Violence potential outside a controlled setting in the past considered to have been serious (specify) and at present estimated to increase, decrease, or be comparable. In this context, violence is equated with inflicting physical harm on others or great emotional harm, as by creating fear.
- Conditions of parole such as outpatient clinic (parole or local), halfway house, no alcohol, and other special attention or special supervision needs. Indicate whether evaluator recommends:
  - Mandatory for parole from facility.
  - Necessary after release to parole.
  - Desirable.
- Continuation of medication on parole. Specify name of medication, dosage, frequency, and route of administration.

91020.23.5 Contingency Recommendations
Indicate recommendations to the classification committee if parole is denied. If a parole date is set, give pertinent information for the period in the facility prior to parole (e.g., whether further psychiatric evaluation should be made prior to release). Indicate basis for all recommendations.

91020.24 Progress Reports
After the report is written, new psychiatric developments in the case shall be reported on CDC Form 128-C and sent to the C&PR for inclusion in the report.
91020.25 Psychiatric Evaluations—Life Prisoners
A full psychiatric evaluation on life prisoners shall be prepared for all initial and subsequent parole hearings. An evaluation shall be prepared for any rescission hearing based on psychiatric problems or assaultive/sexual behavior. Inmates shall be retained on psychiatric referral status unless specifically removed by a BPT panel and the reasons specified in the hearing decision.

91020.25.1 Category X
Inmate cases ordered to category X shall be calendared to appear in one year, unless the panel specifically instructs that the inmate be calendared upon completion of the evaluation. Inmates who refuse to cooperate with a requested evaluation shall also be retained on psychiatric referral status and calendared on the one-year schedule.

91020.26 PC 1170(d) Evaluations
When a request for a PC 1170(d) is received, staff shall prepare a diagnostic study and recommendation. This report, together with the current psychological evaluation if indicated, and a transmittal letter shall be reviewed by the program's Associate Warden. If any staff recommendations are in conflict, the method by which this conflict was resolved shall be described in the transmittal letter to the court. Excluding reception centers and emergencies, inmates shall not be transferred until the PC 1170(d) report is completed.

91020.27 PC 273(a)(d) and 1203.03 Evaluations
Reception center staff shall prepare a psychiatric/psychological evaluation for each PC 1203.03 case and each inmate who, after observation or based on the information from the county, appears to have a psychiatric problem that may affect facility placement. Prisoners convicted of PC 273(a) (willful cruelty toward child/endangering life, limb, or health) and/or PC 273(d) (inflicting corporal punishment upon a child resulting in traumatic injury) shall undergo a psychiatric/psychological evaluation to determine whether counseling may be recommended as a condition of parole.

91020.28 Work/Training Incentive Program
An inmate with documented long-term medical/psychiatric work limitations shall be processed in the following manner:
• The inmate shall receive a psychiatric or psychological evaluation to determine the extent of the inmate's disability and to delineate the inmate's capacity to perform work and/or training programs for either a full or partial work day. If the inmate is deemed capable of working only a partial work program, they shall be awarded full-time credit for participation in such a program.
• The psychiatric or psychological evaluation shall be reviewed by the facility's classification committee.

91020.29 Revisions
The Director, DHCS, or designee is responsible for ensuring that the contents of this article are kept current and accurate.

91020.30 References
Revised May 6, 2015
PC §§ 273, 1170, 1203.03, 2600, 2602, 2684, 2685, 2690, 3002, 3501, 5068, and 5068.5.
CCR (15) (3) §§ 3342, 3362, 3364, 3364.1, and 3364.2.
CCR (22) §§ 70577 and 70579.
W&I §§ 5000 et seq., and 7301.
H&SC § 1316.5.
B&PC §§ 2900 - 2912.
Youngberg v. Romero.
DOM §§ 32010, 51030, 55050, 62030, 62050, and 62080.

ARTICLE 3 — RESERVED (DENTAL SERVICES)

ARTICLE 4 — NURSING SERVICES PROGRAM
Effective June 16, 1995

91040.1 Policy
Each facility shall plan for and provide quality nursing care that is commensurate with that provided in community health facilities. Each facility shall establish an organized nursing services department to ensure the provision of quality nursing care.

91040.2 Purpose
The nursing services department shall be an organized system for the provision of individualized patient care based upon established standards of care utilizing the nursing process, i.e., assessment, planning, intervention, and evaluation.
Each facility shall establish written standards of care, that are consistent with the Department’s Office of Health Care Services objectives and community care standards. These standards of care shall be utilized in planning, providing, and evaluating nursing care.

91040.3 Responsibility for Health Care Services
The CMO or other physician director shall be responsible for all health care services at each facility.

91040.4 Responsibility of the Director of Nursing Services
The nursing services department shall be directed by a qualified RN with training and experience in nursing administration and supervision.
• All Department general acute care hospitals shall be under the direction of a Supervising Nurse II/III. The Supervising Nurse II/III shall not serve as charge nurse.
• All Department infirmaries may be directed by either a Supervising Nurse II or an SRN as determined by patient care needs.
The nurse services director shall have authority and responsibility for all nursing services in the facility. The responsibility and accountability of the nursing services to the medical staff and administration shall be defined.

91040.5 Nursing Services Licensure and Certification
Each facility shall establish a method for verifying the current licensure of each RN, LVN, and MTA. Only those with current licensure shall be assigned patient care duties in hospitals or infirmaries.
Nurses working in expanded roles, i.e., nurse practitioners and nurse anesthetists, shall maintain current, appropriate certification.

91040.6 Nursing Services Organization
Nursing services shall be organized and staffed to ensure the supervision and coordination of nursing care by an RN.
All provisions of nursing care shall be under the supervision of an RN.
A sufficient number of RNs and MTAs shall be on duty at all times to provide nursing care according to patient needs.

91040.7 Nursing Services Organizational Plan
An organizational chart shall be developed defining lines of authority and accountability for each level and service of nursing staff.

91040.8 Nursing Services Procedures
Each facility shall develop and maintain written policies and procedures for the safe and effective provision of quality nursing care.
Nursing policies and procedures shall be developed in coordination with all departments and established for every patient service area.
Policies shall be approved by the governing body. Procedures shall be approved by the medical staff and administration.
Each nursing service employee shall be trained in the policies and procedures during orientation and whenever new policies or procedures are established.
Nursing policies and procedures shall be reviewed annually and revised as required to reflect current standards of nursing practice.

91040.8.1 Nursing Services Procedural Guidelines
Each nursing policy and procedure shall:
• Be established in writing.
• Identify the classification of staff approved to perform the procedure.
• Include a list of required equipment/supplies.
• Indicate any precautions or required special observations.
• Provide an easily understood, detailed, step-by-step procedure.
• State medical record and other documentation requirements.
• Include the dates of approval and revision.

91040.9 Nursing Scope of Practice
Each RN shall perform their duties according to the scope of practice as stated in the B&PC 2725, “Practice of Nursing Defined.”
Specifically selected and trained RNs may perform beyond the normal scope of practice only by utilizing standardized procedures as defined in B&PC 2725(d)(2). Each standardized procedure shall be developed and supervised by a committee on interdisciplinary practice. Each standardized

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procedure shall be developed according to the California Board of Registered Nurses, “Standardized Procedure Guidelines.”
Each MTA shall perform their duties according to the "Scope of Regulation," B&PCC Article 2, 2959.
MTAs may perform patient care activities only under the direction of a physician or an RN.

91040.10 Nursing Services Staff Development Program
Each facility shall plan and conduct an ongoing nursing staff development program to ensure appropriate training of all nursing staff.

91040.10.1 Components of a Nursing Services Staff Development Program
Each staff development program shall include the following:
- Written attainable educational goals and objectives.
- An annual training plan.
- An orientation program for all newly hired nursing staff which includes orientation to all applicable institutional policies and procedures, to the medical services areas, and to the specific job assignment.
- Continuing IST based upon identified educational needs.
- An annual or more frequent review for all nursing staff of cardio-pulmonary resuscitation and infection control procedures.
- Specific area training for nursing staff required to work in specialized patient care areas, i.e., surgery, emergency, psychiatry, and hemodialysis.
- Training of nursing staff who are required to perform procedures which require additional training, i.e., intravenous fluid administration, cardiac monitoring, standardized procedures.
- An annual evaluation of the nursing education program for compliance with the standards of care and educational goals and objectives.

91040.10.2 Nursing Services Continuing Education Courses
Nursing staff shall participate in outside educational programs when required training cannot otherwise be obtained. Records of such training should be retained by the nursing services director or nurse instructor.
Facilities that employ a qualified nurse instructor may obtain approval from the Board of Registered Nurses and Board of Vocational Nurse and Psychiatric Technician Examiners to provide continuing education credit for nursing staff training.

91040.10.3 Nursing Services Training Documentation
Records of all orientation and IST shall be maintained which include:
- Date and time of presentation.
- Name and title of presenter.
- Course title and objective.
- Summary of course content.
- Signatures of staff attending.

91040.11 Nursing Services Reference Materials
Each facility shall maintain current reference materials including textbooks, journals, and periodicals to complement the training and staff education program.

91040.12 Psychiatric Nursing Services
Psychiatric nursing policy and procedures shall be established at all facilities providing inpatient and/or outpatient care for mentally disordered inmates.

91040.12.1 Psychiatric Nursing Services Requirements
An RN with training and experience in psychiatric nursing shall be immediately available whenever a patient is admitted to an inpatient unit for psychiatric care.
Nursing staff shall participate in psychiatric treatment planning.
Psychiatric nursing service policies and procedures shall be developed in consultation with other appropriate health professionals and administration.

91040.13 Nursing Services Job Descriptions
A written job description shall be established for each nursing position specifying performance standards, delineating functions, responsibilities, and specific qualifications.

91040.14 Nursing Services Staffing Requirements
Sufficient registered nursing personnel shall be provided to assure the direction and provision of nursing care at all times.
Each hospital nursing unit shall have an RN immediately available at all times.

An RN with training and experience in operating room techniques shall be responsible for operating room service.
An RN with training and experience in post-anesthesia nursing care shall be responsible for the nursing care in the hospital post-anesthesia unit.
An RN with training and experience in emergency room procedures shall be immediately available at all times to provide emergency nursing care in facilities providing emergency care.
MTAs may be utilized as needed to supplement RNs in ratios appropriate to patient needs.
Each infirmary shall have at least one RN immediately available 24 hours a day, seven days a week.

91040.15 Nursing Services Staffing Based on Patient Classification System
Each general acute care hospital shall establish and implement a patient classification system to ensure adequate and appropriate staffing based on patient needs.
The patient classification system shall include the following patient assessments:
- The patient's ability to care for themselves.
- The patient's degree of illness.
- The patient's requirements for special nursing activities.
- The skill level required by staff for their care.
- The patient's placement in the nursing unit.
The methodology used in making determinations shall be established and maintained in writing.
Written staffing records shall include the total number of nursing staff, the available nursing care hours for each nursing unit, and the categories of nursing staff available for patient care and shall be retained for a minimum of six months.
Each facility shall maintain a record for every nursing staff employed from an outside agency that includes the following:
- Documentation of orientation to facility policies and procedures and duties as assigned.
- Verification of current licensure with documentation of license number and expiration date.
- Records of dates and hours worked.

91040.16 Assignment of Nursing Services Patient Care: Inpatient Units
Each patient's nursing care shall be planned, supervised, and evaluated by an RN.
An RN shall assess the care needs of each patient admitted to a hospital or infirmary prior to assigning nursing staff.
Nursing staff shall only be assigned to duties that are commensurate with their training, experience, and skill.

91040.17 Assignment of Nursing Services Patient Care: Outpatient Services
An RN shall be responsible for the nursing care provided in the outpatient setting.

91040.18 Nursing Services Process: Patient Care Plan
Nursing process is a title used to describe a system of providing patient care that includes assessment, planning, implementation, and evaluation.
Patient care planning is the utilization of the nursing process for the provision of individual patient care.
A written patient care plan shall be initiated upon admission and developed within seven days in coordination with the total health team for each hospital and infirmary patient. The patient care plan shall be the basis for the provision of nursing care.

91040.19 Nursing Services Patient Assessment
Each patient upon admission to an inpatient unit shall be assessed by an RN for the identification of patient care needs.
The patient assessment shall include:
- Medical history.
- Physical condition.
- Social status.
- Emotional status.
- Knowledge deficit.
The nursing patient assessment shall be completed in writing, shall be included in the patient's medical record, and shall be used to identify patient care needs.

A continuing assessment of patient care needs shall be maintained throughout the patient's admission.

91040.19.1 Nursing Services Psychiatric Patient Assessment
An RN with training and experience in psychiatric nursing shall assess the mental health status, using behavioral terminology where appropriate, of all patients admitted to an inpatient psychiatric unit.

91040.19.2 Nursing Services Patient Assessment Guidelines
- The following guidelines should be utilized in performing the initial patient assessment.
- Conduct a patient interview in an area affording privacy and freedom from interruption if possible.
- Inform the patient that the requested information shall be used in planning their care.
- Inquire as to the patient's medical history and reason for admission to the unit. Assess their knowledge of their medical condition.
- Inquire as to the patient's emotional/spiritual condition. Are they angry, anxious, afraid?
- Be alert to the patient's non-verbal responses, mood changes, or hesitancy in answering. These may indicate social, emotional, or educational needs.
- Observe the patient's physical condition including vital signs, weight, height, nutritional state, skin condition, physical limitation, vision, hearing, injuries, wounds, infections, and other. Utilize a body systems approach. Document in detail in the patient's medical record all observations and findings.
- Document on the patient care plan all patient care needs identified by the patient assessment.

91040.20 Nursing Services Diagnosis
A nursing diagnosis is a clinical diagnosis made by an RN to describe actual or potential health problems which nurses, by virtue of their education and experience, are capable of and licensed to treat.

Nursing service departments may use nursing diagnoses or may describe patient needs in other terms.

91040.21 Nursing Services Patient Care Planning
A plan of care shall be developed in writing for every identified patient need. The plan of care shall include realistic, attainable goals for each identified patient need. The plan of care shall include specific patient care activities designed to attain the goals. Each patient care plan shall include the anticipated date for goal attainment and the staff member responsible for each element of patient care.

91040.22 Nursing Services Patient Care Plan Implementation
All nursing staff shall review the patient care plans of their assigned patient daily to ensure the provision of patient care as planned. Nursing staff shall provide all patient care consistent with the patient care plan. Medical record nursing notations shall reflect the implementation of the care plan.

91040.23 Nursing Services Patient Care Plan Evaluation
All patient care plans shall be maintained current. A review and updating of the plan is required when any of the following occur:
- A change in patient condition.
- A change in the physician's plan of care.
- A failure of the current plan to accomplish the identified goals.
- A failure of the patient to accept or respond to the plan.
- The identification of any additional patient care needs.
The date anticipated for goal attainment has been reached.

91040.24 Nursing Services General Documentation Guidelines
All medical record documentation shall be consistent with the following guidelines:
- All entries shall be timely, dated and signed, including title, by the person making the entry.
being discharged to a general housing unit, the summary may be limited to discharge instructions and the patient shall receive a copy of these instructions. A copy of the summary shall be retained in the patient's medical record.

- Food intake and patient personal hygiene shall be documented as provided.

91040.26 Nursing Services Outpatient Documentation Guidelines

Nursing documentation shall be included in the patient's outpatient medical record upon every patient visit. The documentation shall be consistent with the inpatient documentation guidelines. Nursing outpatient medical record documentation shall include:

- Date, time, and location of patient visit.
- Patient complaints.
- Observations of patient's condition.
- Vital signs whenever the patient complains of illness, major injury, or other acute symptoms.
- Notification of the physician if the physician is not present.
- Noting of physician's orders.
- Documentation of all medications, treatments, and procedures administered.
- Documentation of patient discharge instructions.

91040.27 Nursing Services Audit

Each nursing services department shall establish a nursing medical record audit procedure to evaluate the quality of medical record documentation on a regular ongoing basis. The identified medical record documentation deficiencies shall be incorporated into the nursing staff development program.

91040.28 Nursing Services Staff Committee

A nursing committee or committees shall be established to assist in the planning, development, and evaluation of the nursing service. The nursing committee shall be composed of RNs and MTAs. The nursing committee shall meet as often as necessary, but at least every two months, to identify problems in the provision of nursing care and to develop and implement solutions to these problems. A written, systematic method shall be developed and implemented for evaluating the quality of nursing care. Minutes shall be recorded at each nursing committee meeting indicating the names of the members present, date, subject matter discussed, and actions taken. The nursing staff committee may perform the nursing audit procedure.

91040.29 Responsibility of Nursing Services Toward Infection Control

An RN with training and experience in infection control shall be assigned to surveillance and monitoring for infection control. The RN shall be a member of the hospital or infirmary infection control committee.

91040.30 Revisions

The Deputy Director, HCSD, or designee is responsible for ensuring that the contents of this article are kept current and accurate.

91040.31 References

CCR (22) §§ 70213-70215, 70706(2), 70719(c)(2), and 70721(a)(6).
California Correctional Association Standards, 2-2101, 2-4079, 2-4084, 2-4088, 2-4091, 2-4401, 2-4271, 2-4276, and 2-4283.
B&PC Chapter 6, Article 2, §§ 2732-05 and 9958; Chapter 6, § 2725; and Chapter 6-5, §§ 2859 and 2873.6.

ARTICLE 5 — LABORATORY SERVICES

Effective June 16, 1995

91050.1 Policy

Each Department health care facility shall provide appropriate space, equipment, supplies, and personnel for the performance of clinical laboratory tests for the examinations, care, and treatment of inmates. Provisions shall be made for 24-hour emergency clinical laboratory services.

91050.2 Purpose

Clinical Laboratory Services shall provide operational guidelines for clinical laboratory practices consistent with the Department's administrative directives, ACA Standards, CCR, and B&PC.

91050.3 Responsibility of the Clinical Laboratory Services Staff

The clinical laboratory staff are responsible for:

- Developing policies and procedures to ensure the satisfactory collection, processing, and disposal of laboratory specimens.
- Developing procedures for the provisions of prompt and accurate examinations for each test to be performed.
- Developing procedures to ensure the safety and protection of all personnel.
- Providing consultation to clinicians in the interpretation of diagnostic tests/results.
- Participation in continuing education health care and infection-control programs.
- Maintaining accurate and complete records.
- Developing an effective communication system between the clinical laboratory and infirmary staff.
- Developing a peer review process to ensure that adequate laboratory standards are maintained.
- Demonstrating satisfactory performance in an ongoing proficiency testing program, as required by Laboratory Field Services.

91050.4 Clinical Laboratory Services Operational Requirements

To accomplish its purpose effectively and safely, each clinical laboratory shall have:

- An area large enough to accommodate laboratory equipment and staff movement.
- A preventive maintenance schedule for each piece of equipment.
- Clutter-free testing areas.
- Toilet facilities adjacent to or in the immediate vicinity.
- Sufficient area for storing supplies, filing data, and properly disposing of refuse.
- Twenty-four-hour emergency coverage.
- If tests are to be performed on outpatients, outpatient access to the laboratory shall not traverse an inpatient nursing unit.

91050.5 Clinical Laboratory Services Provided On-Site

A list of services provided on-site shall be available to all medical staff. These services are laboratory procedures generally considered routine and may include, but not be limited to, the following:

- Urinalysis.
- Complete blood counts.
- Blood typing.
- Blood cross-matching.
- Chemistry.
- Microbiology.
- Serology.
- Hematology.
- Toxicology.
- Bacteriology.
- Specimen collection/processing/disposal.

91050.6 Clinical Laboratory Services Provided Off-Site

Clinical laboratory services are contracted if they require special equipment and/or specialized personnel unavailable on-site.

91050.6.1 Clinical Laboratory Services Off-Site Criteria

For services that are not provided on-site, each health facility shall make contractual arrangements for services to be provided off-site. When necessity dictates clinical laboratory services to be provided off site, the contract shall specify:

- The contracted laboratory is licensed to operate in California and conform to the requirements of the B&PC and CCR (17).
- Time frames for regular and emergency pickup service.
- Time limits for the return of clinical laboratory reports for regular and emergency service.
• Access to clinical laboratory director for interpretation of reports.
• Competitive fee schedule.
• All other requirements necessary in the formulation of State contracts.
• DOM 22040, discusses contracts in detail.

91050.7 Clinical Laboratory Services Director
The pathologic and clinical laboratory shall be directed by a physician who is qualified to assume professional, organizational, technical, and administrative responsibility for the unit and the services rendered. The physician shall be certified or be eligible for certification in clinical pathology and/or pathologic anatomy by the American Board of Pathology. If a full-time or regular part-time employee is unavailable to fill this position, a consultant with comparable qualifications shall be retained on a contractual basis to provide these services as often as required.

91050.7.1 Clinical Laboratory Services Technologist
The clinical laboratory technologists shall be licensed by the State of California. They shall display their valid license in a conspicuous area of the laboratory.

91050.7.2 Performance of Technical Clinical Laboratory Activities by Unlicensed Persons
CCR (17) explains in some detail the limited activities allowed unlicensed persons working in licensed clinical laboratories. Questions have arisen, however, related to some activities not specifically mentioned. The following are some of these activities:
• Unlicensed persons (including phlebotomists) shall not perform:
  • Bleeding times.
  • Urine dipstick tests.
  • Hematocrit tests.
  • Sedimentation rates.
  • Glucose testing by any method.
  • Any other clinical laboratory test.
• Unlicensed persons shall not make any decision related to the reading of standard or control results for any test procedure, automated or not.
• CCR (17) requires that all laboratory results shall be, “critically reviewed and verified for accuracy, reliability, and validity” by a duly licensed person prior to sending out any reports.

91050.7.3 Performance of Clinical Laboratory Medical Tasks by Inmates
Inmates shall not be permitted to perform duties such as:
• Obtaining blood samples.
• Administering blood.
• Introducing or discontinuing intravenous infusions.
• Any other task identified as medical or nursing functions.

91050.8 Authority for Clinical Laboratory Services
Clinical laboratory examinations shall only be conducted pursuant to the order of a person lawfully authorized to give such an order.

91050.9 Procedures for Clinical Laboratory Specimen Collection/Disposition of Data
Each clinical laboratory shall establish procedures to ensure that:
• Specimens are collected, processed, and disposed of in a medically acceptable manner.
• Examinations are performed accurately.
• Results are reported promptly upon completion of test.
• All clinical laboratory reports shall remain an integral part of the patient’s health record. See also 91050.9.1.
• Each hospital shall maintain blood storage facilities in conformance with the provisions of CCR (17). Such facilities shall be inspected at appropriately short intervals every day to ensure fulfillment of the statutory requirements.

91050.9.1 Requirements for Retention of Clinical Laboratory Services Records
The following is a summary of the record retention requirements of the Department, Medi-Cal, and Medicare programs:
• All inmate and QC records shall be retained for two years except cytologic reports which shall be kept for ten years. Cytology slides shall be kept for five years.
• The Medi-Cal program requires all patient and QC records be retained for three years. This includes all written requests for laboratory tests.
• 42 CFR related to the Medicare program requires all patient and QC records be kept for two years.

91050.9.2 Requirements for Retention of Clinical Laboratory Services Printouts
For automated equipment where results of standards, controls, reaction limits, and patient information are recorded on printouts, these printouts along with all other records shall be retained for 90 days.

91050.10 Information Required on Clinical Laboratory Forms
Only standardized departmental forms shall be used when requesting and recording any medical data. The request for a test shall identify the following information:
• The person making the request.
• The inmate.
• The test required.
• Time the request reached the laboratory.
• Date and time the specimen was obtained.
• Time the laboratory completed the test.
• Any special handling required.
• Name and address of laboratory.

91050.11 Clinical Laboratory Guidelines for AIDS, ARC, HIV, and Hepatitis
Employees having needle stick exposure (the accidental breaking of the skin by an exposed hypodermic syringe) to suspected HIV, AIDS, ARC, and Hepatitis shall be reported to the facility CMO and ongoing records maintained for the staff exposed. The employee shall be treated by his or her own physician as a work-related injury.

All clinical laboratory specimens shall be labeled to allow for special handling. They shall be handled by trained personnel wearing gloves.

91050.12 Clinical Laboratory Services Infection Control Program
A formal infection control program shall be adopted and shall conform to the guidelines in the most recent edition of “Infection Control in the Hospital” published by the American Hospital Association.

91050.12.1 Clinical Laboratory Membership on the Infection Control Committee
A qualified staff member of the clinical laboratory service shall be a member of the hospital's infection control committee.

91050.13 Clinical Laboratory Services QC System
A QC system designed to assess functional efficiency in all facets of clinical laboratory operations, and to ensure reliability and proper handling of the data generated shall be established. QC activities shall be conducted on an ongoing basis.

91050.13.1 Staff Evaluation of Clinical Laboratory Services
In accordance with hospital bylaws, at least annually, a committee of hospital staff shall evaluate services provided and make appropriate recommendations to the medical executive committee and the health facility administration.

91050.14 Revisions
The Deputy Director, HCSD, or designee is responsible for ensuring that the contents of this article are kept current and accurate.

91050.15 References
PC §§ 5054 and 5058.
CCR (15) (3) §§ 3350 and 3354.
CCR (17) §§ 1002 and 1030 through 1057.
CCR (22) §§ 70055(a)(9), 70241, 70243, 70245, 70247, 70251, 70253, 70255, 70257, 70259, 70739, and 70837.
42 CFR.
H&SC § 25100 et seq.
B&PC Rules 1200 through 1322.
ACA Standards 2-4271, 2-4274, 2-4275, 2-4277, 2-4282, 2-4284, and 2-4310.
DOM § 22040.
ARTICLE 6 — RADIOLoGICAL SERVICES
Effective June 16, 1995

91060.1 Policy
Each Department health care facility shall provide appropriate space, equipment, supplies, and personnel for the performance of radiological services for the examinations, care, and treatment of inmates. Provisions shall be made for 24-hour emergency radiology services.

91060.2 Purpose
Radiological Services shall provide operational guidelines for radiological services consistent with the Department's administrative directives, ACA, and California Radiation Control Regulations.

91060.3 Radiological Services
Radiological service means the use of x-ray, other external ionizing radiation, and/or thermography, and/or ultrasound in the detection, diagnosis, and treatment of human illnesses and injuries. Ultrasound, although properly the province of physical medicine, may be considered part of the radiological service.

91060.4 Responsibility of Radiological Services
To achieve its purpose, the radiological unit shall:
- Take, process, and interpret radiographs and fluoroscopes.
- Establish and implement policies and procedures to ensure protection to all personnel in contact with radiation.
- Provide consultation and advice to clinicians.
- Interpret roentgenological findings.
- Plan and implement diagnostic x-ray procedures.
- Make additional postmortem examinations to complete records.
- Participate in hospital's educational program.
- Maintain and keep accessible, accurate, and complete records.
- Provide sufficient space, equipment, supplies, and personnel.
- Provide 24-hour emergency service.

91060.5 Radiological Services Provided On-Site
A published list of services provided on-site shall be available to all staff. These services are diagnostic radiological services up to and including fluoroscopic examinations.

91060.6 Radiological Services Provided Off-Site
The radiology unit shall make contractual arrangements for services to be provided off-site if these are specialized radiological procedures requiring staff and equipment unavailable on-site.

91060.7 Director of Radiological Services
A physician shall be responsible for the radiological service. The physician shall be a certified radiologist or eligible for certification by the American Board of Radiology. If such a person is not available on a full-time or regular part-time schedule, a physician with equivalent qualifications shall be retained on a contractual basis to provide supervision and direction for the service.

91060.8 Radiological Services Technologists
All radiology technicians shall be personnel licensed by the State of California as certified radiology technicians. All radiology staff licenses shall be valid and posted in a conspicuous place in the radiological unit.

91060.9 Requirements for Radiological Services
All radiological studies shall be performed under the order of the licensed physician or other licensed health professional lawfully authorized to prescribe the procedure.

91060.10 General Radiological Services Requirements
Written policies and procedures shall be developed and maintained by the person responsible for the service.
- The responsibility and accountability of the radiological service to the medical staff and administration shall be defined.
- A technologist shall be available to the unit during operational hours.
- The monitoring of radiology personnel and monthly recording of the cumulative radiation exposure of each individual shall be performed.
- The director shall be responsible for verifying the qualifications and capabilities of all radiological personnel.

- A QC program shall be maintained to minimize the unnecessary duplication of radiographic studies, and to maximize the quality of diagnostic information available.
- Positive proof of collimation (cut-off margins on radiographs) and gonad shielding (mark visible on radiographs) shall be present on all radiographs if gonadal shielding is indicated.
- Film shall not be “double exposed.”
- Manufacturer's recommended guidelines shall be followed for the use and periodic maintenance of all equipment.
- Inmate's records shall be properly filed and retained for the same period as other parts of inmate's medical record.
- Sign-out procedures shall be stringently adhered to.

91060.11 Radiological Services Forms/Records
Only standardized departmental forms shall be used when requesting and recording radiological data. The request shall include:
- Proper identification of the requesting physician.
- Proper identification of the inmate.
- A history pertinent to the examination requested.

Radiological services staff shall maintain accurate and complete records/reports that shall be incorporated into the inmate’s medical file and a copy maintained in the radiology unit. When an inmate is transferred to another facility, all x-rays shall be forwarded to the receiving health facility.

91060.12 Radiological Services Safety Procedures
Radiation protection for all staff and inmates shall be strictly enforced during all radiological examinations. Lead aprons and/or other safety devices shall be utilized to ensure maximum available protection.

The use, storage and handling of all radiation machines and radioactive material shall comply with the California Radiation Control Regulations and CCR. All diagnostic equipment shall be calibrated annually. A physicist shall be available as needed for consultation.

91060.13 Infection Control Program for Radiological Services
A formal infection control program shall be adopted to conform to the guidelines addressed in the most recent edition of “Infection Control in the Hospital” published by the American Hospital Association. Activities of this program shall include:
- Ongoing surveillance of patients and staff.
- Prevention techniques.
- Treatment/referral.
- Documenting infection related incidences expeditiously.
- Reporting any occurrence which threatens the welfare, safety and/or health of inmates, staff, and/or visitors.

91060.14 Infectious Waste in Radiological Services
Infectious waste containers shall be provided for all:
- Examining rooms.
- Emergency care rooms.
- Dental operators.

All infectious wastes, as defined in H&SC 25117.5, shall be handled and disposed of in accordance with the Hazardous Material Control Law, Chapter 6.5, Division 20, 25100 et seq., H&SC and the regulations adopted thereunder.

91060.15 Radiological Services Audits/QC
Refer to DOM 93053.13.

91060.16 Revisions
The Deputy Director, HCSD, or designee is responsible for ensuring that the contents of this Article are kept current and accurate.

91060.17 References
PC §§ 5054 and 5058.
CCR (15) (3) §§ 3350 and 3354.
CCR (17) §§ 1002 and 1030 - 1057
91070.1 Policy
The medical record service shall maintain medical records that are documented accurately, in a timely manner, are readily accessible, and permit prompt retrieval of information and statistical data.

91070.2 Purpose
To serve as a basis for planning patient care.
To provide documentary evidence of the course of the patient's medical treatment.
To document interdisciplin ary communication regarding patient care.
To protect the legal interest of the Department, hospital, patient, and provider.
To provide data for research, education, and evaluation of medical services provided.

91070.2.1 Documentation Principle
Each facility shall maintain health records for all patients treated by the facility. The records shall contain information to identify the patient, justify the diagnosis, to describe the patient's treatment and care, and to provide for continuity of medical care. The record shall serve as an accurate database for the evaluation of the quality of care provided, to provide documentation for business purposes, and to defend legal interests.

91070.2.2 Record Completion
Records shall be complete, legible, typed or in ink, signed, dated, and in compliance with licensing requirements in CCR (22).
Correctable deficiencies are those that can be completed by the individual responsible for the entry or in the absence of the responsible person by another member of the clinical staff with knowledge of the recorded events.
Non-correctable deficiencies are entries where it is not possible to determine if the staff member responsible provided care and treatment.

91070.2.3 Charting Guidelines
All entries in the medical record should be accurate, timely, objective, specific, concise, and descriptive. Only approved abbreviations shall be used. Additional information recorded on subsequent pages shall have "Continued" indicated. Entries are to be recorded consecutively, not leaving blank spaces for additions.
Error corrections are made with a single line drawn through the entry making certain not to obliterate the information. The word error is to be written with the date and writer's initials. An asterisk (*) next to the date of the incorrect entry and another to indicate location of the correction should be used for large corrections. For small corrections continue writing.
"White-out" or any other form of obliteration on hand or typewritten entries is not to be used. All entries are to be written in permanent ink.
All pages in the health record shall contain the patient's full name, CDC inmate number, and name of the facility where treatment or care is provided.
Signatures shall consist of the writer's first initial, last name, and professional title. Countersignatures are to be used when a facility's policy and procedure require such. Initials may be used where called for on specific forms.
Amendments to a record are additions that provide additional facts not available at the time the original entries were made. They provide evidence that the information originally recorded is in error or incorrectly represents the facts. Amendments also explain or clarify missing or incomplete entries.
For late entries, insert (*) in the margin or between lines to correspond with observation, action, or event.

91070.3 Services Defined
The medical record service shall maintain the inmate's health record in a system which allows for easy retrieval, shall assist in locating records on new arrivals, shall answer requests for medical information from other agencies, and shall transcribe various medical reports.

91070.4 Services Provided
Each departmental health care facility shall have a medical record service staffed by medical records personnel. The medical record service shall be conveniently located and adequate in size and equipment to facilitate the accurate processing, checking, indexing, and filing of all medical records.

91070.5 Centralized Outpatient Health Records
An outpatient health record shall be created and maintained for each inmate admitted to the Department. The outpatient health record shall contain both medical and psychiatric information. The reception centers shall initiate the record except in the case of condemned male inmates. SQ shall initiate the record on condemned male inmates.

91070.6 Inmate Access
Inmates shall not be used as workers in medical record services or in areas that would allow the inmate access to health records. An inmate shall not review or be given access to another inmate's health record.

91070.7 Supervision Health Records
In departmental health care facilities with a hospital, the medical records service shall be under the supervision of a registered record administrator or accredited record technician. In all other facilities, the medical record service shall be under the supervision of either a health record technician or a medical records director. When the services of either cannot be obtained on a full-time basis, consultation services shall be obtained.

91070.7.1 Health Record
The inmate's health record, including x-ray films, shall be the property of the Department and shall be maintained for the benefit of the inmate, the medical staff, the health care facility and the Department. The health care facility shall safeguard the information in the record against loss, defacement, tampering, or use by unauthorized persons.
Note: If a hospital ceases operation, DHS shall be informed within 48 hours of the arrangements made for safe preservation of inmate patient records.

91070.7.2 Accountability
A written statement defining the accountability of the medical records service staff and administration shall be available and shall include an organizational chart.

91070.7.3 Service Evaluation
Periodically an appropriate committee of the medical staff shall evaluate the services provided and make recommendations to the medical executive committee and administration of the health care facility.

91070.8 Confidentiality and Release of Information
All health records, either as originals or accurate reproductions of the content of such originals, shall be maintained in such form as to be legible and readily available upon the request of admitting physician; the non-physician granted privileges pursuant to CCR (22) 70706.1; the hospital, its medical staff, or any authorized officer, agent, or employee of either authorized representatives of DHS; or any other person authorized by law to make such a request.

91070.8.1 Valid Authorization
A valid authorization for the release of an inmate's health care record shall follow these guidelines:

- Be handwritten by the person who signs it or is in typeface no smaller than 8-point type.
- Be clearly separate from any other language present on the same page and be executed by a signature which serves no other purpose than to execute the authorization.
- Be signed and dated by the inmate. If the inmate is deceased or incompetent, the legal representative, spouse or registered domestic partner of inmate or person responsible for the inmate, or the beneficiary or personal representative of the deceased inmate may sign the authorization.
- State the specific uses and limitation on the types of medical information to be disclosed.
- State the name or functions of the provider of health care that may disclose the medical information.
- State the name or functions of the persons or entities authorized to receive the medical information.
- State a specific date after which the provider of health care is no longer authorized to disclose the medical information.

Revised March 11, 1993
Revised September 25, 2007
• Advise the person signing the authorization of the right to receive a copy of the authorization.
• Statement of revocation.

91070.8.2 Requests From Outside Agency/Facility

Verbal Requests
Upon receipt of a valid written authorization, health information shall be copied and sent to the requesting hospital, physician, or other agency. Verbal requests for health information shall be referred to the medical records director, medical records supervisor, correctional health services administrator, CMO, or chief psychiatric officer if the request is for psychiatric information.

Within Department
It is not necessary to have a valid authorization when releasing health information to another facility within the Department or when releasing information to consulting health care personnel within the Department.

91070.8.3 Requests From State AG’s Office
Copies of health records shall be made available for review at each facility at the request of the State AG’s Office.

91070.8.4 Inmate's Request
Inmates have the right to review and receive copies of their own health record. This review shall take place in the presence of a health services staff member. A charge shall be made for all pages copied at rates specified in the DOM 13030. Inmates totally without funds and/or a pay number shall be provided copy service without charge.

An inmate shall not review or be given access to another inmate's health record.

91070.8.5 Requests From Inmate's Attorney
Upon receipt of a valid authorization from the inmate's attorney, health information can be copied and sent to the attorney. Representatives of the attorney shall have the same degree of access as the attorney providing the attorney designates so in writing. Designated representatives of an attorney are limited to licensed investigators, attorney-sponsored law students, a State Bar certified paraprofessional, or a full-time employee of the attorney. No charge shall be made to the attorney. (See DOM 71020 for more details.)

91070.8.6 Subpoenas
The "Protocol for Subpoenas" published by the California Medical Record Association shall be followed in preparing the records in response to a subpoena.

91070.8.7 Drug Abuse
Health records containing information of drug abuse subsequent to March 21, 1972 and alcohol abuse subsequent to May 14, 1974 are covered by federal laws, 42 CFR C and D. Valid authorization shall indicate that the patient knows that drug and/or alcohol abuse information shall be released if there is any in the record.

91070.8.8 Psychiatric Records
Valid written authorization shall indicate that the patient knows that psychiatric information shall be released if there is any record. Records shall be released by subpoena only if it directs the release of the information to the judge of the court and a subsequent court order is obtained when information is admitted as evidence. Records shall be released by court order. (W & I 5328 and 5328.19.)

91070.8.9 AIDS and AIDS-Related Condition (ARC) Information
Valid authorization shall indicate that the patient knows that AIDS and/or ARC information shall be released if there is any in the record.

91070.9 Coding
The most recent edition of the International Classification of Diseases shall be used for coding. In those facilities with psychiatric units, the most recent edition of the Diagnostic Statistical Manual shall be used for psychiatric diagnostic coding. Coders shall have completed an approved basic coding course.

91070.10 Indexing
Medical records shall be cross-indexed according to patient by:
• Disease.
• Operation.
• Physician.

94010.11 Standardized Health Services Forms
All forms filed in the inpatient or the outpatient health record shall be approved departmental forms.

91070.12 Inpatient Health Record
The inpatient record shall be in the following order:
• Patient identification.
• Face sheet/admitting form/patient identification.
• Narrative discharge and transfer summary.
• Death reports.
• Report of death.
• Coroner's report (autopsy).
• Medical reports.
• Refusal of examination and treatment.
• Emergency room reports (also known as ER reports).
• Medical history.
• Physical examination.
• Consultant reports.
• Informed consent.
• Human Immunodeficiency Virus (HIV) consent.
• Notice of transfer/transfer summary.
• Operative reports.
• Consent of surgical operation.
• Preop check list.
• Prenesthesia check list.
• Anesthesia report.
• Postanesthesia report.
• Report of operation.
• Pathology report.
• Physician's reports.
• Physician's progress notes.
• Doctor's orders.
• Psychiatric treatment plan.
• Material from outside facilities (same order):
  • Staff reports.
  • Laboratory reports.
  • X-ray reports.
  • Electrocardiograms (also known as EKGs).
  • Other diagnostic reports.
  • Physical therapy reports.
  • Respiratory therapy reports.
  • Social services.
  • Occupational therapy.
  • Dietary assessment.
  • Nursing reports.
  • Medication records.
  • Graphic charts.
  • Intake & output records.
  • Intravenous flow charts (also known as IV flow charts).
  • Diabetic record.
  • Weight record.
  • Nursing assessment.
  • Bedside records (nursing notes).
  • Patient care plan.
  • Record of daily activities.
  • Medical report of injury or unusual occurrence.
  • Telegram.
  • Suicide watch.
  • Chronos.
  • Miscellaneous.

91070.13 Discharge Analysis
Qualitative analysis shall be performed on all inpatient records. Each inpatient medical record shall consist of at least the following items:
• Identification sheets shall include, but are not limited to, the following:
• Name.
• Address on admission.
• Identification number.
• Age.
• Sex.
• Marital status.
• Religion.
• Date of admission.
• Date of discharge.
• Name, address, and telephone number of person or agency responsible for patient.
• Name of patient's admitting physician.
• Initial diagnostic impression.
• Discharge or final diagnosis.
• History and physical examination.
• Consultation reports.
• Physician Order to Admit/Discharge including medication, treatment, and diet orders.
• Progress notes including current or working diagnosis.
• A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, the condition on discharge, and the recommendations and arrangements for future care.

Nurses' Notes

• Nurses' notes shall include, but not be limited to, the following:
  • Concise and accurate record of nursing care administered.
  • Record of pertinent observations including psychosocial and physical manifestations as well as incidents and unusual occurrences and relevant nursing interpretation of such observations.
  • Name, dosage, and time of administration of medications and treatment. Route of administration and site of injection shall be recorded if other than by oral administration.
  • Record of type of physician-ordered restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints used for support and protection of the patient or required for seclusion for custody reasons.
  • Vital sign sheet.
  • Reports of all X-ray examinations performed.
  • Consent forms when applicable.
  • Anesthesia record including preoperative diagnosis if anesthesia has been administered.
  • Operative report including preoperative and postoperative diagnosis, description of findings, technique used, tissue removed or altered if surgery was performed.
  • Pathological report or laboratory report if tissue or body fluid was removed.
  • Labor record if applicable.
  • Delivery record if applicable.
  • Nursing care plan.
  • Psychiatric treatment plan if applicable.

91070.14 Incomplete Inpatient/Outpatient Medical Records

Medical records shall be completed promptly and authenticated or signed by a physician, dentist, or podiatrist within two weeks following the patient's discharge.

91070.15 Transfer of Inpatients to Different Levels of Care

Within the Same Facility

The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital that has a distinct partially skilled nursing or intermediate care service.

91070.15.1 Transfer to Outside Facilities

A transfer summary shall accompany the patient upon transfer to another health facility. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan. The transfer summary shall be signed by a physician. A copy of the transfer summary shall be retained in the inpatient record.

Note: Patients transferred to an outside community health facility shall be considered discharged from the CDC health care facility. The inpatient record shall be closed and a discharge summary completed. Upon return of the patient, a new record shall be established. The history and physical from the outside community health facility may be used if the attending physician makes a notation that the history and physical has been reviewed.

91070.15.2 Transfers to Other Facilities

A narrative discharge summary or transfer summary shall accompany inmates who transfer from one acute care service in one health care facility to another within the Department.

91070.16 Filing System for Inpatient/Outpatient Health Records

All inpatient/outpatient records shall be filed by the inmate's prison identification number. The records shall be filed in numerical order by the last two digits and then in order by the first three digits. The alphabetical prefix is utilized only when two numbers are identical.

91070.16.1 Retention of Inpatient/Outpatient Records

Patient records including X-ray films or reproduction thereof shall be preserved safely for a minimum of seven years following discharge of the patient from a departmental health care facility.

91070.17 Outpatient Health Record

Documents are to be filed behind appropriate divider in reverse chronological order (most recent on top). The outpatient record shall be maintained in the following order:

Left Side of Folder

• Outpatient medication record.
• Daily diabetic record.
• Consultation/inpatient reports section (yellow).
  • Consultation reports–most recent on top.
  • Inpatient reports.
  • Consent to operate–outpatient surgery.
  • Operative reports–outpatient surgery.
  • Refusal of treatment.
• Miscellaneous section (blue).
  • Reports from other (nondepartment) facilities.
  • Medical report of injury or unusual occurrence.
  • Requests for medical information from Department to outside facilities.
  • Receipts from inmate for receiving copies of records.
  • Memos.
  • Correspondence.
• Laboratory/pathology section (orange).
  • Laboratory reports–full page.
  • Laboratory reports.
  • Pathology reports.
• X-ray section (brown).
  • X-ray reports.
  • X-ray reports from nondepartment facilities.
  • Computerized Axial Tomography Scans (also known as CAT Scans).
• Other diagnostic section (pink).
  • Electrocardiograms.
  • Electroencephalograms.
  • Hearing tests.
  • Eye refractions.
  • Physical therapy.

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• Outpatient medical record.
• Physician orders for outpatient services.
• Chronos section (green).
  • CDC Form 128-C, Medical/Psychiatric/Dental Chronos.
The following statistics shall be maintained monthly and forwarded to the HCSD:
- Total admissions.
- Average daily census.
These statistics shall be maintained for all health care facility patients, all patients at outside hospitals, and all non-medical personnel housed in a health care facility.

91070.19.3 Death Log
The following information shall be maintained on all deaths:
- Inmate's full name.
- Inmate's number.
- Date of death.
- Cause of death.
- Place of death.
This log shall also include inmates who expire outside the facility.

91070.19.4 Master Patient Index
A master patient index shall be maintained on all patients. For patients previously hospitalized, current information shall be added to the master index.

The following information shall be maintained on each master patient index:
- Full name of inmate (last name, first name, middle initial).
- Inmate prison identification number.
- Social security number.
- CI&I fingerprint identification number.
- Race.
- AKA.
- Date of birth.
- Age.
- Comments.
- Date of admission.
- Date of discharge.
- Physician.
- Final diagnosis on discharge.
This is a permanent file and shall never be destroyed.

91070.20 Medical Staff Committees
The medical record service responsibilities to medical staff committees are:
- To submit statistical information as requested by the committee.
- To act as a resource.
- To obtain data at the request of the committee for their review.

91070.21 Approved Abbreviation List
Only those abbreviations approved by the Chief of DHS or the CMO shall be used in the inpatient or outpatient health record.

91070.22 Revisions
The Deputy Director, HCSD, or designee shall be responsible for ensuring that the contents of this article are kept current and accurate.

91070.23 References
PC §§ 5054 and 5058.
CCR (15) (3) § 3350.
CCR (22) §§ 70703(d), 70747(a), 70747(b), 70749, 70751(a), (b), (c), (d), (g), (h), (i), and 70753.
42 CFR §§ C and D.
W&I §§ 5328 and 5328.19.
Privacy Act of 1977.
ACA Standards 2-4271, 2-4274, and 2-4288.
DOM §§ 13030 and 71020.

ARTICLE 8 — INMATE TUBERCULOSIS ALERT SYSTEM
Effective April 21, 1993

91080.1 Policy
The Inmate Tuberculosis (TB) Alert System is a critical component of the Department overall efforts to identify an inmate's TB status and to control TB within CDC.
Components

- Provide a rapid method for Medical Care Services, Classification Services, Case Records, and CDC Transportation staff to determine the most current TB status of an inmate.
- Provide a rapid method for Medical Care Services staff to identify inmates that require ongoing TB treatment at the receiving facility.
- Allow CDC Transportation, C&PR, and/or the CC-III to schedule transportation by the most appropriate method given the inmate's TB status.
- Provide reports that will assist facilities in the tracking and control of TB.

91080.3 Definition

TB is an infectious airborne disease that is a serious public health problem in correctional facilities around the country. The control of TB requires a program that emphasizes testing, treatment, and tracking.

**Testing**

CDC facilities have established TB testing programs to ensure that inmates are tested on an annual basis, as well as when circumstances warrant additional testing. The testing program ensures that inmates with TB are identified as quickly as possible.

**Treatment**

Control of TB requires aggressive and continuous treatment for extended periods of time. TB can be broadly divided into two stages: TB Infection and TB Disease. Unlike the sound of its name, TB Infection is not infectious. During this early stage of TB, the individual has been infected but has no symptoms. Without treatment, 10 percent of the individuals infected with TB will develop the more severe stage-TB Disease.

With treatment, only 2 to 5 percent will develop TB Disease. It is extremely important to control that individuals with TB Infection undergo a full course of treatment. Treatment for TB Infection requires regularly administered oral medications for up to 12 months. Interruptions in therapy can cause a multiple drug resistant strain of TB requiring more aggressive and expensive therapy. Inmates with TB Infection can be moved; however, the Medical Care Services staff at the receiving facility shall be notified that an inmate requiring continuous TB treatment has been transferred to the facility.

TB Disease is initially infectious. After diagnosis and initial treatment, it becomes noninfectious but requires aggressive treatment for up to 24 months. Inmates with TB Disease cannot be moved without respiratory precautions until the disease is noninfectious. Medical staff at the receiving facility must be notified prior to the inmate with TB Disease being transferred to the facility.

**Tracking**

Controlling movement of the inmate population is critical to TB control. The Inmate TB Alert System addresses the need to control this movement. No inmate shall move on regular CDC transportation if the inmate's TB status has not occurred since endorsement. This policy requires that the CDC Form 128-C, Medical/Psychiatric/Dental Chrono, or CDC Form 128-C-1, Reception Center Medical Clearance/Restriction Information Chrono, documenting the inmate's TB Alert Code be filed in the inmate's C-File at the time of endorsement. The inmate shall not be endorsed for movement if the C-File lacks a CDC Form 128-C or CDC Form 128-C-1 documenting the inmate's TB Alert Code.

**Special Transportation Requirements**

- Inmates with special transportation restrictions shall not be moved on regular CDC transportation. Inmates that have an unknown TB status shall not be transported on regular CDC transportation. These inmates, as well as infectious inmates, require special transportation using respiratory precautions. Special transportation is other than regularly scheduled CDC bus transportation which is normally arranged by the sending facility and provides medical respiratory precautions where required by the referring physician. Respiratory precautions require that masks are worn by those who come close to the patient, hands are washed after touching the patient or potentially contaminated articles and before taking care of another patient, and articles contaminated with infective material be discarded or bagged and labeled before being sent for decontamination and reprocessing.

**Medical Advance Transfer Notice**

- The CDC Form 7343, Medical Advance Transfer Notice, shall contain the most current TB Alert Code and TB Alert Transportation Instruction for each inmate. The TB status of all inmates scheduled for movement shall be reviewed by the facility's Medical Care Services staff prior to movement. This is to ensure that changes in TB status have not occurred since endorsement.

**Transfer Record**

- The CDC Form 135, Transfer Record, shall contain the most current TB Alert Code and TB Alert Transportation Instruction for each inmate. CDC Transportation Sergeants shall be required to review the TB Alert Transportation Instruction of each inmate. Any inmate without a Clear for Transportation Instruction shall not be allowed to board the bus.

**Telephone Alert System**

Each facility shall be required to implement a telephone alert system that allows Medical Care Services staff to quickly alert Classification and Custody staff of the need to schedule an inmate for special transportation. When Medical Care Services staff determine that an inmate is going to be moved inappropriately, a medical hold process shall be in place to allow the scheduled movement to be delayed or postponed. Since inmates can move at odd hours, a telephone alert procedure shall be rapid and responsive to the need in stopping inappropriate inmate movement.

The reports associated with the Inmate TB Alert System shall provide Medical Care Services staff with information necessary for immediate follow-up on inmates with unknown TB status. Medical Care Services staff's access to DDPS bed assignments should make reading TB tests more efficient. The transfer endorsement policy and the inclusion of the TB Alert Transportation Instruction for each inmate on the CDC Form 135 and the CDC Form 7343 shall provide additional security in stopping the transmission of TB through inappropriate inmate movement.

91080.5 The TB Alert Code

The current DDPS and ATS are used to collect information, transfer data, and track inmates throughout the CDC system. The DDPS is updated every day and selected information is downloaded to the ATS as required. When an inmate transfers to another facility, the DDPS information follows the inmate within 24 hours. The Inmate TB Alert System is an enhancement to the DDPS and ATS.

The Inmate TB Alert Code is a two-digit code that shall be entered in the Inmate TB Alert System daily by Medical Care Services staff. The code shall then be printed on the CDC Form 7343 and the CDC Form 135, along with the TB Alert Transportation Instruction for each inmate. DDPS shall also generate two reports that will be useful to Medical Care Services staff in monitoring testing activities and tracking inmates with TB Infection and TB Disease.
Determining the TB Alert Code

Every inmate at any CDC facility shall be assigned a TB Alert Code to identify their TB status. When an initial TB Alert Code is established and every time the code changes, it shall be documented on a CDC Form 128-C or CDC Form 128-C-1.

TB Alert Code Descriptions

Revised January 18, 1994

The TB Alert Codes are described below:

**Code _ _**

Status Unknown

No entry has been made into the Inmate TB Alert System. This code indicates the TB status of an inmate is unknown. Blank codes require immediate action of the Medical Care Services staff designated as the facility's Inmate TB Alert System Coordinator.

Inmates arriving at CDC reception centers can remain Code _ (blank) until the initial Mantoux Purified Protein Derivative (PPD) skin test has been read. The Code _ (blank) remains until the skin test has been read/interpreted. After test interpretation, the Code _ (blank) becomes either a Code 21 or Code 22. An inmate's TB Alert Code should not remain blank for over 72 hours.

Since an inmate entering the reception center shall be a Code _ (blank) until the PPD is read, it is imperative that designated Medical Care Services staff administer and interpret the Mantoux PPD skin test within 72 hours of inmate arrival. Failure to promptly administer, read, and document the PPD result could result in serious inmate movement problems.

TB Alert Transportation Instruction: Transfer and endorsement shall be deferred. Please refer to DOM 91080.16.

**Code 11**

Status Unknown/PPD Test Performed.

Code 11 denotes that the PPD skin test has been administered, but not yet read and/or interpreted. The inmate's TB status is unknown. Inmates should remain a Code 11 no more than 72 hours. This code is used when an inmate with an already established TB Alert Code has a subsequent skin test. The inmate must be coded as a Code 11 after the skin test is administered to assure that the inmate is not moved and to document the change in TB Alert status. After the PPD is read/interpreted, the inmate shall be assigned one of the appropriate TB Alert Codes: 21 or 22.

Code 11 is used when:

- Inmates with a Code 22 receive their annual PPD skin test.
- When an inmate is given a PPD skin test as part of a case contact investigation.
- Any time an inmate with an existing TB Alert Code is given a skin test or becomes unknown status.

As specified under Code _ (blank) above, mandatory use of Code 11 in newly arriving reception center inmates is no longer required.

TB Alert Transportation Instruction: Inmates with unknown TB status shall be transported/moved by special transportation using respiratory precautions.

**Code 21**

TB Screening Test Result Significant--Inmate Under Diagnosis.

A Code 21 is used when the clinician has determined that an inmate requires diagnostic TB testing. While this is generally done in response to a significant PPD skin test, any time a clinician considers an inmate "under diagnosis" for TB, the inmate should be coded as a Code 21.

A Code 21 is used when:

- An inmate has a PPD skin test induration of 10 mm or more.
- An inmate has a PPD skin test induration of 5 mm or more and risk factors specified in the CDC TB Guidelines exist.
- An immunosuppressed inmate is determined skin test positive (without regard to the mm induration) based on anergy testing.
- An inmate with a previously significant PPD (prior history of TB Disease or TB Infection) is undergoing annual or other periodic TB evaluation. Inmates with a prior history of TB Disease or TB Infection should be evaluated once a year. At the time the inmate is ducated for evaluation, the inmate's TB Alert Code should be changed to Code 21.

It should remain a Code 21 until the medical evaluation is completed and the inmate is determined free from the disease.

A Code 21 is used only until appropriate diagnostic procedures establish a subsequent TB Alert Code. After diagnostic procedures, the inmate shall be assigned one of the appropriate TB Alert Codes: either 31, 32, or 33.

Movement from Code 21 to Code 31:

Inmates should be coded 31 any time a clinician suspects infectious TB Disease, based on either symptoms, sputum smears, x-rays, or any combination. The inmate should be changed from Code 21 to Code 31 as soon as the clinician suspects that the inmate could be infectious. For example, if a sputum smear for Acid Fast Bacilli (AFB) returns as positive and the inmate is considered a suspect for infectious TB Disease, they should be immediately coded as a Code 31. It is not appropriate for the inmate to remain a Code 21 while awaiting confirmatory results of the culture and sensitivity.

Movement from Code 21 to Code 32:

Inmates should be moved from a Code 21 to a Code 32 when:

- Written documentation establishes that the positive skin test is the result of a prior exposure and the inmate does not require current prophylactic treatment.
- A clinician determines that a new exposure will not receive prophylactic treatment due to medical contraindications.

Movement from Code 21 to Code 33:

Inmates should be moved from a Code 21 to a Code 33 after the initiation of TB Infection prophylactic medication or upon a signed refusal by the inmate to take prescribed medications. Inmates with a negative chest X-ray must remain a Code 21 until the medical evaluation is complete and the medication initiated or refused.

TB Alert Transportation Instruction: Inmates with a Code 21 shall be transported/moved by special transportation using respiratory precautions.

**Code 22**

PPD Test Result Non-significant.

Code 22 is used when the PPD skin test is not significant and no follow-up treatment is required. Inmates with a Code 22 require annual PPD skin testing or testing upon exposure.

TB Alert Transportation Instruction: Inmates with a Code 22 shall be transported/moved by regular CDC transportation.

**Code 31**

Infectious TB Disease Suspected.

A Code 31 is used when an inmate is suspected of having infectious TB Disease. An inmate should be made a Code 31 as soon as the clinician suspects infectious TB Disease. The inmate should remain a Code 31 until they have received appropriate treatment and are no longer considered infectious.

Inmates that are considered a Class V TB case would immediately be coded as a Code 31. The inmate would remain a Code 31 until the clinician determines they are no longer infectious. After the inmate has been placed on TB Disease treatment and is no longer considered infectious, the inmate should be coded as a Code 43. (Please note that the inmate is still a Class V TB case until culture confirms the diagnosis. In most cases, however, the inmate's TB code would change to a Code 43 several weeks before obtaining the culture results.) The inmate should not remain a Code 31 until culture confirmation of the case. They should be coded as a Code 43 (TB Disease-On Medication) as soon as the inmate is no longer considered infectious.

Inmates with a significant PPD reaction from prior exposure to TB have a significant PPD reaction from prior exposure to TB with no medical contraindication. After the inmate has been placed on TB Disease treatment and is no longer considered infectious, the inmate should be coded as a Code 43. (Please note that the inmate is still a Class V TB case until culture confirms the diagnosis. In most cases, however, the inmate's TB code would change to a Code 43 several weeks before obtaining the culture results.) The case should be coded as a Code 43 (TB Disease-On Medication) as soon as the inmate is no longer considered infectious.

Inmates with a Code 31 shall be transported/moved by special transportation using respiratory precautions.

**Code 32**

PPD Test Result Significant From Prior Infection/Disease--Noninfectious.

A Code 32 is used when:

- An inmate has a significant PPD reaction from prior exposure to TB that has already been prophylactically treated.
- An inmate has a significant PPD reaction from a prior case of TB Disease and the inmate has completed the required treatment.
- An inmate has a diagnosis of TB Infection, but after medical evaluation, is not receiving prophylactic treatment due to medical contraindications.

TB Alert Transportation Instruction: Inmates with a Code 32 shall be transported/moved by regular CDC transportation.
Code 33
TB Infection—Noninfectious, On Medication.

Code 33 is used when:

- An inmate has a diagnosis of TB Infection and is receiving prophylactic treatment.
- TB medication has been prescribed but the inmate refused the medication.
- TB medication has been prescribed but the inmate is only intermittently or partially compliant with the treatment regimen.
- HIV inmates receiving multiple medication as prophylactic treatment for TB Infection.

When an inmate completes the course of prophylactic treatment for TB Infection, the inmate's TB Alert Code should be changed to Code 32.

**TB Alert Transportation Instruction:**

Inmates with a Code 33 shall be transported/moved by regular CDC transportation. Medication shall be transported on the bus or Medical Care Services staff shall ensure the medication is available at the receiving facility.

**Code 43**

TB Disease, Not Infectious.

Code 43 is used for inmates currently under treatment for TB Disease when the inmate is no longer considered infectious. Inmates shall remain Code 43 through the entire treatment period for this episode of TB Disease. Upon completion of TB curative treatment, the inmates shall be coded Code 32.

Inmates receiving curative treatment for TB Disease should be coded Code 43 while the result of the culture is pending. If the culture result confirms TB Disease, the inmate will remain a Code 43 throughout the treatment period. If the culture rules out TB Disease, the inmate should, at that time, be coded Code 33 to reflect the inmate's TB Infection status. If the inmate is diagnosed with atypical Mycobacterium infection, the code should be changed to either Code 32 if the PPD status is positive or Code 22 if the PPD status is negative.

Code 43 is used for:

- Confirmed cases of TB Disease currently receiving curative treatment.
- Suspected cases of TB Disease (awaiting culture confirmation currently receiving curative treatment and not infectious.
- Extrapulmonary TB Disease (confirmed Mycobacterium TB in other than a pulmonary site).

Upon completion of treatment for TB Disease, the inmate shall be coded as Code 32.

**TB Alert Transportation Instruction:**

Inmates with a Code 33 shall be transported/moved by regular CDC transportation. Medication shall be transported on the bus or Medical Care Services staff shall ensure the medication is available at the receiving facility.

91080.8 Documenting the TB Alert Code and Entering the TB Alert Code in the DDPS

Every time an inmate's TB Alert Code changes, Medical Care Services staff shall complete a CDC Form 128-C or CDC Form 128-C-1. This shall be done within 24 hours of reading the PPD skin test results and diagnosing the inmate's TB status.

If the TB Alert Code is 31, the TB Alert Code shall be documented on the CDC Form 128-C or CDC Form 128-C-1 by the end of the shift in which the diagnosis was made.

The TB Alert Code shall be identified on the CDC Form 128-C or CDC Form 128-C-1. Medical Care Services staff shall input the inmate's TB Alert Code into the DDPS file within 24 hours of reading the PPD skin test results, diagnosis, or any change in the TB Alert Code.

If the TB Alert Code is 31, the TB Alert Code shall be entered into the DDPS by the end of the shift in which the diagnosis was made.

91080.9 Routing and Filing the CDC Forms 128-C and 128-C-1, Mainline Facilities:

- Medical Care Services staff in mainline facilities shall route the CDC Form 128-C documenting the TB Alert Code to Medical Records by the end of the shift in which the PPD skin test result was read, diagnosis made, or any change to the TB Alert Code.
- Medical Records in mainline facilities shall file the CDC Form 128-C in the inmate's Medical Record within 24 hours of receipt (or by the end of the next business day if received on a weekend or holiday) from Medical Care Services staff.
- Medical Records in mainline facilities shall route the CDC Form 128-C to Case Records within 24 hours of receipt (or by the end of the next business day if received on a weekend or holiday) from Medical Care Services staff.
- Case Records in mainline facilities shall file the CDC Form 128-C in the inmate's C-File as soon as possible. The CDC Form 128-C must be filed prior to transfer endorsement.

91080.10 Reviewing Scheduled Inmate Movement on the CDC Form 7343, Medical Advance Transfer Notice

**General Requirements**

A CDC Form 7343 generated at each facility shall contain the TB Alert Transportation Instruction for every inmate listed. The facility's Associate Information System Analyst (AISA) routinely extracts (downloads) information from the DDPS and enables the ATS access to this information during the generation of the CDC Form 7343. ATS reads each inmate's TB Alert Code from the extracted information, generates the appropriate TB Alert Transportation Instruction based on the TB Alert Code, and prints the TB Alert Transportation Instruction on the CDC Form 7343.

Medical Care Services staff shall review the CDC Form 7343 to ensure the appropriate TB Alert Transportation Instructions have been identified and medications are prepared for transfer if appropriate.

**CDC Form 7343 Medical Advance Transfer Notice Distribution Instructions**

The Inmate TB Alert Coordinator shall walk to Case Records and obtain a copy of the CDC Form 7343 as soon as it is printed and as subsequent changes occur.

**CDC Form 7343 Review Instructions**

Medical Care Services staff shall review the CDC Form 7343. It is not necessary to compare the TB Alert Transportation Instruction with the DDPS TB Alert Code or documentation in the medical record. A visual check of the names and TB Alert Transportation Instructions printed on the CDC Form 7343 along with Medical Care Services staff’s knowledge of inmates who are in the infirmary, quarantine, etc., shall be sufficient. This review is intended to ensure all inmates have a Clear For Transportation status and to identify that any recent change in the TB Alert Code not yet entered in DDPS can be identified and arrange transportation arrangements, if necessary.

Medical Care Services staff shall follow instructions for placing Special Transportation Requirements, as described in DOM 91080.11, for any inmate who is TB Alert Code 31, Infectious TB Disease.

Medical Care Services staff shall be responsible for securing medications for inmates who are TB Alert Code 33, TB Infection, Noninfectious, On Medication; or TB Alert Code 43, Diagnosis of Noninfectious TB Disease, On Multiple Medication.

Medical Care Services staff shall be responsible for ensuring transfer medications are at Receiving and Release (R&R) at the time of inmate transfer. If medications are not transferred on the bus, Medical Care Services staff shall telephone Medical Care Services staff at the receiving facility that medications did not transfer with the inmate.

If a TB Alert Code requires change, Medical Care Services staff shall contact Case Records before the end of the shift and document the name of the person contacted and the date of the contact next to the inmate's name on the CDC Form 7343.
Upon completion of review, Medical Care Services staff shall sign the CDC Form 7343 denoting approval and route the CDC Form 7343 to Case Records.

If Medical Care Services staff does not have 24 hours to review the CDC Form 7343, changes and approvals shall immediately be communicated with the appropriate staff by telephone.

91080.11 Special Transportation Requirements

General Requirements

Every inmate who has been diagnosed as Code 31, TB Disease, Infectious, shall have a medical hold pending special transportation arrangements. Medical Care Services staff shall place a telephone call to the C&PR, the CC-III, or their designee during regular business hours (the Administrator on Duty [AOD] or their designee during non-business hours) and:

- Identify the inmate as currently infectious.
- Require that the inmate be transferred using special transportation and using respiratory precautions until further notice.

Document the TB Alert Code as described in the DOM 91080.8.

Enter the TB Alert Code as described in DOM 91080.8.

Route and file the documentation as described in DOM 91080.9.

Placing A Medical Hold Pending Special Transportation Arrangements

Every inmate who has been coded with a TB Alert Code 31, TB Disease, Infectious, shall have a medical holding pending special transportation arrangements. Medical Care Services staff shall place a telephone call to the C&PR, the CC-III, or their designee during regular business hours (the Administrator on Duty [AOD] or their designee during non-business hours) and:

- Identify the inmate as currently infectious.
- Require that the inmate be transferred using special transportation and using respiratory precautions until further notice.

Document the TB Alert Code as described in the DOM 91080.8.

Enter the TB Alert Code as described in DOM 91080.8.

Route and file the documentation as described in DOM 91080.9.

Removing A Medical Hold Pending Special Transportation Arrangements

When an inmate is no longer Code 31, TB Disease, Infectious, the special transportation requirement shall be removed. Medical Care Services staff shall place a telephone call to the C&PR, the CC-III, or their designee during regular business hours (the AOD or their designee during non-business hours) and:

- Identify the inmate as no longer infectious.
- Remove the special transportation requirement.

Document the TB Alert Code as described in the DOM 91080.8.

Enter the TB Alert Code as described in DOM 91080.8.

Route and file the documentation as described in DOM 91080.9.

91080.12 Inmate TB Alert System Reports

The Inmate Alert System provides two reports, 1) Medical Alert List by Arrival Date and 2) Medical Alert List by Medical Code and two screens 1) Medical Information Screen History--Diagnosis and 2) Medical Information Screen History--Movement. The reports and screens are useful in monitoring an inmate's TB status.

Medical Alert List By Arrival Date

The user of the Inmate TB Alert System selects the desired inmate arrival date. The selected date may be either one single day or a sequence of many days.

The Medical Alert List by Arrival Date Report provides the following data elements for every inmate in the facility by date of arrival:

- Bed/Cell--Most current housing status.
- CDC Number.
- Inmate Name.
- Birth Date.
- Age.
- Medical Code.

The Medical Alert List by Arrival Date Report may be generated daily and used for:

- Inmate Tracking--Immediate action shall be taken if the inmate's TB Alert Code remains 11 after 72 hours.
- Case contact investigation information.
- Identification of inmates with TB Alert Code 22 who require annual PPD skin testing.
- Identification of inmates with TB Alert Code 31, 32, 33, or 43 who require yearly evaluations for symptoms of coughing, night sweats, fever, and weight loss.
- Assistance with identifying inmates who require Directly Observed Therapy.
- Assistance in Confidential Morbidity Report and Verified Case Report card generation.

Medical Alert List by Medical Code

The Medical Alert List by Medical Code Report provides a list of every inmate grouped by TB Alert Codes. The report may be generated by selecting one or a combination of TB Alert Codes.

This report, sorted by medical alert code and description of code, provides the following data elements for every inmate in the facility:

- Bed/Cell--Most current housing status.
- CDC Number.
- Inmate Name.
- Birth Date.
- Age.
- Arrival.

The Medical Alert List by Medical Code Report may be generated daily and used for:

- Follow-up of inmates with a TB Alert Code 11 that should have progressed into another code.
- Data surveillance on a daily, weekly, monthly, and annual basis.
- Expediting follow-up care on inmates with TB Alert Code 21, 31, or 32.

Screen:

The Medical Information Screen History--Diagnosis.

Medical Information Screen History Diagnosis

The user will read information regarding the inmate's TB history provided on the Medical Information Screen History--Diagnosis screen. Refer to the Medical Alert System User's Manual for detailed instructions.

This screen provides the following data elements for every inmate in the facility:

- CDC Number.
- Inmate Name.
- Bed/Cell--Most current housing status.
- Current TB Alert Code.
- Previous medical diagnosis and date of entry.

Uses of the Medical Information Screen History--Diagnosis screen include:

- Current TB Alert Code and date entry.
- Previous medical diagnosis history.

Once this screen is displayed on the DDPS terminal, a screen print may be executed on the printer. Refer to the Medical Alert System User's Manual for detailed instructions.

Medical Information Screen History Movement

The user will read information regarding an inmate's movement history provided on the Medical Information Screen History--Movement screen. Refer to the Medical Alert System User's Manual for detailed instructions.

This screen provides the following data elements for every inmate in the facility:

- CDC Number.
- Inmate’s Name.
- Bed/Cell--Most current housing status.
- Current TB Alert Code.
- Transaction Message.
- Facility.
- Cell.
- Location.
The TB Alert System can assist facilities to manage case contact investigations. As soon as a diagnosis of Infectious TB Disease is reasonably established on hospital admission, the facility's AISA automatically captures the diagnosis on the DDPS. The TB Alert Code 11, 21, or 31. Any TB Alert Code changes follows the procedures specified in DOM 91080.8 and 91080.9.

91080.16 TB Documentation for Transfer Endorsement

General Requirements
An inmate's transfer endorsement shall be deferred if the TB Alert Code is not documented on a CDC Form 128-C or CDC Form 128-C-1, Medical/Psychiatric/Dental Chorine, and filed in their C-File at the time of endorsement. The C&PR or CC-III (for DPU cases) shall be responsible for deferring endorsement of any case with incomplete TB status information. The inmate's C-File shall have a documented TB Alert Code of 21, 22, 31, 32, 33, or 43. The C&PR or CC-III shall notify Medical Care Services staff of any missing documentation.

Medical Care Services staff is responsible for reviewing the inmate's Medical File, completing or providing the appropriate copy of the CDC Form 128-C or CDC Form 128-C-1 and forwarding it to Case Records within 24 hours from the date of notice by the C&PR or CC-III. Case Records shall file the CDC Form 128-C or CDC Form 128-C-1 in the inmate's C-File within 24 hours.

Classification Referral Instructions
As is current practice, the C&PR, CC-III, or their designee shall audit all files prepared for CSR review and endorsement to ensure proper casework. No case shall be presented for CSR action without a valid TB Alert Code of 21, 22, 31, 32, 33, or 43 documented on a CDC Form 128-C or CDC Form 128-C-1 in the inmate's C-File. The C&PR, CC-III, or their designee shall notify the Inmate TB Alert System Coordinator in Medical Care Services of the missing CDC Form 128-C or CDC Form 128-C-1 within 24 hours of review. The inmate TB Alert System Coordinator shall provide the CDC Form 128-C or CDC Form 128-C-1 within 24 hours of notification. Should a case inadvertently be presented to a CSR for transfer endorsement and lack a valid TB Alert Code of 21, 22, 31, 32, 33, or 43 documented on a CDC Form 128-C or CDC Form 128-C-1, the case shall be deferred. The CSR shall notify the C&PR, CC-III, or their designee of the missing information that same day. The C&PR, CC-III, or their designee shall follow step two above.

Special Transportation Instructions
If an inmate with a TB Alert Code of 11, 21, or 31 requires movement, special transportation arrangements are required. A CDC Form 128-C or CDC Form 128-C-1 shall document a doctor-to-doctor agreement for appropriate housing, type of transportation, and any medical concerns and restrictions per DOM 62080.16. Following transfer endorsement by a CSR, transportation arrangements shall be coordinated by the C&PR, CC-III, or their designee. The C&PR or CC-III shall refer to DOM 91080.19 for specific guidelines. If an emergency transfer of an inmate is required for other than medical reasons and the TB Alert Code does not authorize a normal move, the C&PR, CC-III, or their designee shall contact Medical Care Services staff during regular business hours (the Medical Officer on Duty [MOD] during non-business hours) and receive verbal TB Alert Code verification for inclusion on the CDC Form 135, Warden's Check-out Order. If the transfer takes place after regular working hours, arrangements shall be made through the Watch Commander, AOD, MOD, and Supervising RN (SRN) if applicable. Transportation precautions shall be taken accordingly. Within 24 hours of verbal verification, Medical Care Services staff shall provide appropriate documentation on a CDC Form 128-C or CDC Form 128-C-1 to Case Records for inclusion in the inmate's C-File and update the TB Alert Code in DDPS if required. They will also contact the receiving facility's Medical Care Services staff with any relevant medical information pertaining to the transferred inmate.
A description of the TB Alert Transportation Instructions can be found in DOM 91080.19.

**CDC Form 7343 Using ATS**
AISA shall download DDPS to ATS before the CDC Form 7343 is generated.
Follow the normal process to generate the CDC Form 7343.

**CDC Form 7343 Distribution Instructions**
The Inmate TB Alert System Coordinator shall walk to Case Records and obtain a copy of the CDC Form 7343 as soon as it is printed and as subsequent changes occur.

**CDC Form 7343 Review Instructions**
Medical Care Services staff shall immediately notify Case Records of any TB Alert Transportation Instruction changes by telephone.
Upon completion of review, Medical Care Services staff shall sign the CDC Form 7343 denoting approval and route the CDC Form 7343 to Case Records.
If Medical Care Services staff do not have 24 hours to review the CDC Form 7343, changes and approvals shall immediately be communicated with the appropriate staff by telephone.

**91080.18 Deletion of Inmates From the CDC Form 7343**
Medical Care Services staff shall notify Case Records if an inmate's TB Alert Code has changed.
Inmates remaining on the CDC Form 7343 with a TB Alert Code of 11, 21, or 31 shall not be moved on regular CDC transportation. The inmate's name shall be deleted from the CDC Form 7343 by telephone request. See DOM 91080.4 for additional information.
If it is necessary to move the inmate, a CDC Form 128-C or CDC Form 128-C-1, documenting the special transportation instructions, shall be requested from Medical Care Services staff.

**91080.19 TB Alert Transportation Instructions**
The TB Alert Transportation Instructions shall be found on the CDC Form 135. A description of each TB Alert Transportation Instructions is as follows:
- **TB Alert Transportation Instruction: Med Alert Sp Trans 11.**
  - **Meaning:** TB status unknown.
  - **Action:** Inmates with Code 11 have an unknown TB status, either because their screening test has not yet been performed or has not been read and interpreted. These inmates pose a high risk of transmitting TB Infection and cannot be put on regular CDC transportation, including buses and transportation used to move inmates from CDC facilities to CCFs. These inmates shall be transferred by special transportation using respiratory precautions.

- **TB Alert Transportation Instruction: Med Alert Sp Trans 21.**
  - **Meaning:** The inmate's PPD was significant and the inmate is being diagnosed for suspected TB Disease.
  - **Action:** Inmates with Code 21 had a significant PPD and remain under diagnosis. These inmates pose a high risk of transporting TB Infection and cannot be put on regular CDC transportation, including buses and transportation used to move inmates from CDC facilities to CCFs. These inmates shall be transferred by special transportation using respiratory precautions.

- **TB Alert Transportation Instruction:** Clear For Transportation 22.
  - **Meaning:** Inmates with Code 22 had a non-significant PPD and are not infectious. These inmates shall be transported by regular CDC transportation.

**91080.20 Review of Inmate TB Alert Transportation Instructions by the Transportation Sergeant**
The CDC Transportation Sergeant shall be required to review the TB Alert Transportation Instructions of each inmate before boarding the bus. Inmates with TB Alert Codes of 11, 21, or 31 shall not be put on regular CDC transportation, which includes movement from CDC facilities to CCFs. These inmates shall be transferred by special transportation using respiratory precautions.

**91080.21 Review of Inmate TB Alert Transportation Instructions by the Receiving and Release Staff**
If an inmate arrives at the receiving facility with a TB Alert Code 11, 21, or 31, R&R staff shall immediately notify Medical Care Services staff. The inmate shall be placed in a separate cell until Medical Care Services staff move the inmate to the facility's infirmary.

**91080.22 Coordinating With Medical Services-Special Circumstance Moves**
If an emergency transfer of an inmate is required for other than medical reasons and the TB Alert Code does not authorize a normal move, the CDC Transportation Sergeant, or their designee shall contact Medical Care Services staff during regular business hours and receive verbal TB Alert Code verification for inclusion on the CDC Form 135 or Warden's Check-out Order. If the transfer takes place after regular working hours, arrangements shall be made through the Watch Commander, AOD, MOD, and SRN if applicable. Transportation precautions shall be taken accordingly. Within 24 hours of verbal verification, Medical Care Services staff shall provide appropriate documentation on a CDC Form 128-C or CDC Form 128-C-1 to Case Records for inclusion in the inmate's C-File and update the TB Alert Code in DDPS if required. They will also contact the receiving facility's Medical Care Services staff with any relevant medical information pertaining to the transferred inmate.

**91080.23 Revisions**
The Deputy Director, HCSD, or designee shall be responsible for ensuring that the contents of this article are kept current and accurate.

**91080.24 References**
PC §§ 3053, 5054, 5058, 6006, 6007, and 6008.
W&I § 1768.10

**ARTICLE 9 — INVOLUNTARY PSYCHIATRIC MEDICATIONS**

**Revised May 6, 2015**

**91090.1 Policy**
The Department may administer involuntary psychiatric medication to an inmate only if the procedures in Penal Code (PC) Section 2602 are followed.

**91090.2 Purpose**
The purpose of this article is to set forth CDCR’s operational procedures and expectations of its employees concerning all aspects of involuntary psychiatric medication, including proper pre-court and post-court documentation, criteria for initiation, criteria for renewal, scheduling, initiation, renewal, non-renewal, interface with the inmate’s attorney, interface with the Office of Legal Affairs (OLA), interface with the Office of Administrative Hearings (OAH), inmate post-hearing remedies, and proper use of electronic charting resources to document assessments, both what is observed and court results.
91090.3 General Provisions
Involuntary psychiatric medication should not be used in a psychiatric context:

- To control behavior that is not related to a diagnosable psychiatric disorder.
- When an inmate is capable of giving informed consent and objects to such medication, unless the inmate is a danger to self or others.
- Unless called for in a medical emergency as defined in CCR, Title 15, Section 3351, (a).
- In doses other than that for which the drug is approved by the Food and Drug Administration (FDA) or by community standards of professional practice or by nationally recognized guidelines or by legitimate scientific and medical opinion.
- In doses that diverge widely from appropriate dose recommendations, as defined by CCHCS care guidelines, nationally recognized guidelines, legitimate scientific and medical opinion, and by parameters provided by the FDA. Fonnulary decisions should conform to the CCHCS statewide formulary.

91090.4 Long-Acting Medication
When filing an emergency initial petition, clinical staff may not administer involuntary medication beyond the initial 72-hour emergency period.

When filing an emergency initial petition, clinical staff should administer no medications involuntarily that have substantial, clinically relevant actions due to the fact that they stay in the bloodstream longer than 10 calendar days, including the initial 72-hour emergency period. The medication or medications that cause the least restrictive effects yet accomplishes their purpose should be chosen. After the conclusion of the administrative hearing, if the court order is granted, clinical staff may administer long-acting medication.

91090.5 Medication Supervision and Observation
A physician, psychiatrist, licensed vocational nurse, registered nurse, licensed psychiatric technician, or psychiatric nurse practitioner should be physically present to observe the emergency administration of involuntary medication. That person should create a note in a health record, which should include:

- Personnel administering medication.
- Observation.
- Physical room or setting in institution where medication was administered.
- Resistance.
- Reason for medication.
- Time.
- Date.
- Form of medication (tablet, liquid, injection) and dosage.
- Injury.
- Force.
- Reaction.

If the inmate is not already in an inpatient setting, the inmate should be observed twice per day by a health care staff to monitor for side effects until the inmate is deemed at low risk for side effects by a psychiatric physician, medical physician, or nurse practitioner. Observations will be noted in appropriate health records.

Anytime force is observed or used by health care staff, the procedures and documentation requirements referenced in DOM Chapter 5, Article 2, Section 51020.17.6 must be followed.

91090.6 Documenting Evidentiary Factors

Danger to Self
Clinical and custody staff has an obligation to observe inmates and to note, document, and promptly report to their superiors, behavior that could be classified as a danger to self. Danger to self means the inmate has made a credible threat or has attempted to inflict, or made a credible threat of inflicting physical harm upon the person of another, and as a result of a serious mental disorder, the inmate presents a demonstrated danger of inflicting physical harm upon others. Demonstrated danger may be based on an assessment of the inmate’s present mental condition, including consideration of the inmate’s historical course of serious mental disorder, to determine if the inmate currently presents an elevated chronic risk or an imminent risk to his or her own safety. If these signs or symptoms of dangerousness to self are observed by any employee at any time, an immediate mental health referral should be made and the patient should be observed until a clinician makes an assessment. If a licensed clinician evaluates the inmate and believes there is an emergency, elevated chronic risk, or an imminent risk, psychiatry personnel should be contacted, psychiatric medication should be considered, and if it is thought that medication will help but the patient refuses these medications and is expected to continue to refuse medications, a CDCR MH-7363, Involuntary Medication Notice, or CDCR MH-7368, Renewal of Involuntary Medication Notice, should be started with inputs from any staff member familiar with, or observing, the inmate’s behaviors. Referral to the crisis bed should be considered.

Danger to Others
Clinical and custody staff has an obligation to observe inmates and to note, document, and promptly report to their superiors, behavior that could be classified as a danger to others. Danger to others means the inmate has inflicted or attempted to inflict, or made a credible threat of inflicting physical harm upon another. Demonstrated danger may be based on an assessment of the inmate’s present mental condition, including consideration of the inmate’s historical course of serious mental disorder, to determine if the inmate currently presents an elevated chronic risk or an imminent risk of harming another person. If these signs or symptoms are observed by any employee at any time, an immediate mental health referral should be made. If a licensed clinician evaluates the inmate and believes there is an emergency, elevated chronic risk, or an imminent risk, psychiatry personnel should be contacted, psychiatric medication should be considered, and if it is thought that medication will help but the patient refuses these medications and is expected to continue to refuse medications, a CDCR MH-7363 or CDCR MH-7368 should be started with inputs from any staff member familiar with, or observing, the inmate’s behaviors.

Grave Disability
Clinical and custody staff has an obligation to observe inmates and to note, document, and promptly report to their superiors, behavior that could be classified as gravely disabled. Photographs of trash in the cell, organic material on walls or windows, flooding of the cell, or unflushed toilets should be taken, if there is suspicion of grave disability. If a psychiatrist, medical physician, psychologist and/or social worker suspects that a patient is gravely disabled he or she must order relevant recording of information which may include: logs of missed showers, records of weights and weight loss, documentation of catatonic behavior, documentation of the patient being taken advantage of by others, and/or other recording of relevant behavior or speech that corroborates grave disability. If the inmate is being victimized, or subject to being victimized, due to diminished cognitive capacity or due to mental health issues that diminish appropriate responses, being Developmentally Disabled (DD) or due to other diminished mental capacity, the circumstances demonstrating the lack of capacity, the ensuing dangerous victimization should be documented and steps should be taken to prevent victimization. Gravely Disabled means there is a substantial probability, due to a serious mental disorder and incapacity to accept or refuse psychiatric medication, that serious harm to the physical or mental health of the inmate will result. Serious harm means significant psychiatric deterioration, debilitation, or serious illness as a consequence of his or her incapacity to function in a correctional setting without the supervision or assistance of others, inability to satisfy his or her need for nourishment, and/or inability to attend to needed personal or medical care, seek shelter, and/or attend to self-protection or personal safety. The probability of harm to the physical or mental health of the inmate requires evidence that the inmate is presently suffering adverse effects to his or her physical or mental health, or evidence that the inmate has previously suffered these effects in the historical course of his or her mental disorder and that his or her psychiatric condition is again deteriorating. The fact that an inmate has a deteriorating mental disorder does not alone establish probability of serious harm to the physical or mental health of the inmate. If these signs or symptoms are observed by any employee at any time, an immediate mental health referral should be made. If a licensed clinician evaluates the inmate and believes there is an emergency, elevated chronic risk, or an imminent risk, psychiatry personnel should be contacted, psychiatric medication should be considered, and if it is thought that medication will help but the patient refuses these medications and is expected to continue to refuse medications, a CDCR MH-7363 or CDCR MH-7368 should be started with inputs from any staff member familiar with, or observing, the inmate’s behaviors.

Elevated Chronic Risk
Elevated chronic risk means the serious and persistent presentation of clinical factors that suggests an inability to adequately navigate within society or
inability to effectively navigate within a structured environment such that, based on historical course of mental disorder, there is a reasonably foreseeable elevated risk of self-harm, violence, or grave disability.

**Imminent Risk**

Imminent risk means the presence of clinical and situational factors that suggest a significant risk of violence toward others, self, or grave disability and requires immediate intervention.

**Determination of Capacity or Lack of Capacity**

Clinicians must make a good faith attempt to engage the inmate to determine the inmate’s capacity to voluntarily consent to medication, which requires capacity, other than in an emergency situation. Capacity should be evaluated by reviewing the inmate’s (a) ability to communicate a choice; (b) ability to understand relevant information; (c) ability to appreciate the nature of the situation and its likely consequences; and (d) ability to use the information rationally.

**Reporting Serious Mental Illness**

Clinical and custody staff has an ethical obligation to observe inmates in all treatment and custody settings and to note, document, and promptly report to their superiors, behavior that aligns with the description of a serious mental disorder, danger to self, danger to others, or grave disability, as defined above.

A serious mental disorder means an illness or disease or condition that substantially impairs the person's thought, perception of reality, emotional process, or judgment; or which grossly impairs behavior; or that demonstrates evidence of an acute brain syndrome for which prompt remission, in the absence of treatment, is unlikely. Qualifying behaviors include, but are not limited to, clinical and custody staff observation of delusional behavior, catatonia, responding to internal stimuli, auditory or visual hallucinations, and paranoia.

When an inmate exhibits the above symptoms, an immediate mental health referral should be made. If a medical emergency, elevated chronic risk, or imminent risk exists, psychiatric medication should be considered if there are no less restrictive alternatives, and if it is thought that medication will help but the patient refuses these medications and is expected to continue to refuse medications a CDCR MH-7363 should be started with inputs from anyone familiar with the inmate’s behaviors.

**Consent and Refusal**

Involuntary psychiatric medication should not be given to an inmate who has the capacity to consent to medication. Clinical staff should document the offer of medication and an inmate’s refusal to consent to medication before proceeding to the involuntary medication process under PC 2602, except in the case of a medical and/or psychiatric emergency.

**Initiation Proceedings**

Initiation of involuntary medication is accomplished by completing a CDCR MH-7363 (initial petition) and CDCR MH-7366, Inmate Rights Notice – Involuntary Medication, and serving the inmate, the inmate’s attorney, the OLA, and the OAH via electronic transmission. The OLA will maintain a master calendar of the available inmate calendar for PC 2602 hearings and the attorney rotation for the various high-volume institutions. Institutions that have only an occasional need for hearings should coordinate with the OLA first to arrange for attorney coverage to avoid calendar conflicts.

**Staff Disclosure of Prior Case Activity within Past 60 Days**

If an institution is re-filing on a specific inmate who was the subject of a court proceeding in the immediately preceding 60 calendar days (court denial, withdrawal, request for dismissal), either the doctor filling out the CDCR MH-7363 or the OLA shall disclose this in one of the pleadings so that all parties are aware of the history of the case.

**Alert of Ex Parte Request and Medication Order in Health Records**

If the institution submits an emergency initial petition asking for authority to administer involuntary medication pending the administrative hearing, the Medication Court Administrator (MCA) must scan the CDCR MH-7363 and Ex Parte Request (included in CDCR MH-7363) into the health records the same day it is filed so that physicians and pharmacists are aware of the pending request. The MCA must then follow-up within ten calendar days and scan in the resulting order from the OAH either granting, or denying, interim medication authority, so that physicians and pharmacists will know the status of the case.

**Supplemental Petitions**

The OLA will prepare a Supplemental Initial Petition for each case submitted by an institution, and may add or drop cases based upon legal review of the health records. This document should be served on the OAH and upon the inmate’s attorney no later than three business days prior to the scheduled hearing, but optimally ten business days before the hearing.

**Ending A Case**

Every case currently pending or filed in the future should terminate with either (1) a court order signed by an Administrative Law Judge (ALJ), (2) a Withdrawal Notice prepared by the OLA, (3) a Request for Dismissal prepared by the OLA, or (4) a CDCR MH-7370, Notice of Non-Renewal of Involuntary Psychiatric Medication form completed at the institution and submitted to the OLA documenting the reasons the case was not renewed.

Institutions who know an inmate is paroling or moving to Mentally Disordered Offender (MDO) status should complete the necessary forms documenting why a case is not being renewed before the inmate departs.

**Renewal Proceedings**

No later than 90 calendar days before a court order authorizing the administration of involuntary medication is due to expire, the clinical staff of the facility where the inmate is currently housed should assign the matter to a psychiatrist to interview the inmate and determine if the filing of a CDCR MH-7368 is warranted. Renewal is appropriate if the inmate, even after administration of psychiatric medication, has documented insufficient insight regarding his/her mental illness, refuses to accept that he or she has a mental illness, states that he or she knows that a court order is required to ensure medication compliance, or if it is clear from documented behaviors or statements over thirty-six month that the inmate, but for the medication, would become a danger to self or others, or gravely disabled and lacking capacity to accept or refuse psychiatric medication.

If a determination is made to renew involuntary medication, a CDCR MH-7368 and CDCR MH-7366 should be prepared and served on the inmate, the attorney for the inmate, the OAH, and the OLA no later than 30 calendar days before the current order expires.

If an individual psychiatrist does not want to renew the involuntary medication order, the institution should convene an Interdisciplinary Treatment Team (IDTT) and pursue the process described in DOM Section 91090.9, below.

**Non-Renewal Process**

Every case currently pending needs to either be renewed or not-renewed. Legitimate reasons not to renew a case include, but are not limited to, that the inmate has gained insight that he or she has a mental illness and is willing to reliably take medication, or that the inmate is transferring to another program that will take over the court order, such as an MDO program.

The starting point for a non-renewal is the treating psychiatrist, if available, who must fill out a CDCR MH-7370 documenting the reasons that non-renewal is being considered. The treating psychiatrist can recommend the non-renewal take effect immediately or upon the natural expiration of the existing court order. If the inmate transfers to a new institution prior to the effective date of the CDCR MH-7370, the receiving institution may independently review the case factors and may elect to rescind it based on the inmate’s psychiatric case factors and presentation.

**IDTT Review**

If an individual psychiatrist does not believe that renewal of an involuntary medication order is beneficial to the overall health of the patient, he or she should consult with treatment team members.

If there is disagreement amongst treatment team members, additional consultation from mental health statewide leadership can be sought, but ultimately the final decision about renewal or non-renewal lies with the evaluating psychiatrist.

**Health Records**

The non-renewal shall be recorded in the electronic health record. This is accomplished using one of two methods A CDCR MH-7370 is considered local to the institution that adopted it. That institution can make the non-renewal effective immediately, in which case the CDCR MH-7370 must be scanned into the health records and central file within 24 hours. Alternatively, an institution can make the non-renewal effective at the natural end date of
the PC 2602 court date. In such cases, the CDCR MH-7370 shall be filed as of the effective date of the expiration.

91090.9.3 Office of Legal Affairs
If an institution’s IDTT approves a CDCR MH-7370, and deems it active and ready to be scanned into the health records and central file, a copy should immediately be sent to the OLA. This form is not to be sent to the OAH.

91090.10 Hearings
Attendance and Timing
Every inmate scheduled for a hearing will be contacted by a sworn correctional officer or sworn MCA on the day of the hearing to determine if the inmate wishes to attend the hearing, refuses to attend, or to meet with their attorney. The inmate’s capacity to engage in the conversation should be documented by the custody officer going to the cell on the OLA PC 2602 Refusal form or an institution equivalent refusal form. An inmate’s request to meet with his/her attorney on the day of the hearing will be honored by facilitating an attorney client meeting. An attorney’s request to force or impose a visit upon an inmate who has already waived the right to a hearing on the day set for the hearing will be evaluated by the ALJ, who will take into account the data pertaining to the inmate’s waiver or refusal, as well as institutional security and operation. If the need arises and the ALJ agrees, the hearing may be conducted at cell side.

If an inmate lacks capacity to attend, the hearing should be conducted cell side or continued due to the inmate’s medical inability to participate, and the reasons for the continuance should be documented on the record by a doctor or psychiatrist familiar with the inmate’s condition.

The attorney for the inmate should meet with the clients in advance of the date set for the hearing so that hearings start at the scheduled time.

Institutions must permit attorneys to meet with clients in advance of the PC 2602 hearing. This is a due process requirement for the inmate and must be accommodated separate and apart from any legal visiting program. Attorney-client meetings should be handled according to local institution operating protocol, generally in a legal visiting room and not at cell side. If an inmate refuses to meet with the attorney, it will be documented and can be reviewed by the ALJ on the day of the hearing. If an inmate appears to be unable to communicate or attend to activities of daily living on the day of the attorney’s visit, or on the day of the hearing, the attorney should be informed.

Recording
The attorney from the OLA should bring the necessary equipment into the institution and record each proceeding. Those recordings should be maintained in digital archives by CDCR for a minimum period of five years, provided to the OAH annually, or individually upon request.

Copies of Filings
Legal filings with the OAH are deemed public documents and are not filed under seal.

Transcripts
Paper transcripts of administrative hearings are not prepared. Inmates may purchase paper transcripts from the OAH with funds from their inmate trust account or request alternative accommodation upon proof of indigence. Other parties may obtain copies of transcripts under the policies and pricing structure the OAH prescribes upon request.

Facilities
Each institution should provide a room, or rooms, on the day of the hearing that can accommodate an administrative hearing with seven to ten persons, including correctional officer escorts, with adequate room to maneuver and adequate space to provide security for the judge and attorneys.

Custody Escorts
Each institution should provide at least two correctional officers to bring inmates to and from the hearing room, or to and from the holding cells outside the hearing room. At least one correctional officer should stay in the room with the inmate during the hearing.

Telepsychiatry Declarants and Testimony
If an inmate’s psychiatric care has been primarily assigned to a telepsychiatrist for delivery of care, and specifically if a telepsychiatrist is the declarant on a CDCR MH-7363 or CDCR MH-7368, then the Department should coordinate any hearing for the inmate so that said telepsychiatrist is available to present the involuntary medication case. This presentation occurs via remote video or telephone connection into the hearing room on the day set for the hearing. The telepsychiatrist shall be available and prepared for cross-examination. The institution shall make every attempt to schedule on a day when the presenting witness is available. If the assigned telepsychiatrist is not able to appear, the ALJ has the discretion to grant up to one continuance not to exceed 14 calendar days to allow a new clinician at the inmate’s institution to review the inmate’s central file, health records, meet with the inmate, and prepare to present the case.

Notification of Next-of-Kin
The inmate’s next-of-kin will not be notified of the hearing unless the inmate requests to have the specified individuals audit the hearing. The inmate will submit the request in writing and complete a waiver of confidentiality. The inmate will be responsible for supplying an address where the next-of-kin in the first-degree or second-degree can be contacted. The MCA will send a notice to the identified next-of-kin stating the type of hearing, date and time of hearing. Any questions regarding the upcoming hearing will be referred to the inmate’s appointed attorney.

Requests by an inmate to have next-of-kin attend the hearing will be contingent upon those individuals completing a gate clearance packet and the subsequent approval of the gate clearance by the Chief Deputy Warden’s office. Only the identified next-of-kin in the first or second-degree will be considered for approval. These individuals will be escorted directly to the hearing room by the MCA (or designee) when their relative’s case is ready to begin. The next-of-kin will not be allowed to speak during the hearing unless directed by the ALJ to give sworn testimony. The inmate and next-of-kin will not be allowed to exchange any property. If these conditions are breached, the next-of-kin will be removed from the hearing by a custody escort. Upon completion of the hearing, the next-of-kin will be escorted out of the institution.

Appointment of Attorney
For every scheduled hearing, the MCA should assign an inmate attorney from the rotation calendar available from the OLA and the OAH, unless one of the following situations occurs:

- If the inmate desires to retain an attorney or has retained an outside attorney, the MCA will verify that the outside attorney is in fact taking the case, and then serve the paperwork accordingly on the outside attorney.
- If the inmate desires to appear in propria persona (as their own representation), the MCA should assign an inmate attorney from the rotation calendar available from the OLA and the OAH, and the matter of the inmate’s capacity to engage in self-representation will be brought up at the first hearing with the ALJ.

91090.11 Documentation of Legal Paperwork
Pre-Hearing
Institutions should provide supporting documentation to independently verify what is alleged in either the CDCR MH-7363 or CDCR MH-7368. The CDCR MH-7363 and CDCR MH-7368 are not evidence, and must be independently supported by health records, chronos, photographs, or other documentary evidence of the criteria alleged.

Such supporting documentation should be securely uploaded as a PDF to a secure Sharepoint or other secure site within three business days of the filing of either an initial or renewal petition, unless there is a justifiable business reason for not doing so. If the discovery cannot be provided to headquarters staff, to the inmate attorney within three business days of the filing of the CDCR MH-7363 or CDCR MH-7368, the institution should make a workstation available to the inmate’s attorney to review the discovery on site, unless other arrangements are made with the inmate attorney for delayed electronic discovery.

Discovery will include six months of CDCR 7230 Interdisciplinary Progress Notes, any recent discharge summaries from the Department of State Hospitals, six months of psychiatrist progress notes, six months of primary clinician progress notes, recent suicide risk assessments, six months of relevant nursing notes documenting observations of behavior that could be classified as danger to self, danger to others or grave disability, any relevant Triage and Treatment Area or Mental Health Crisis Bed admission notes, and any relevant refusals of medication, food, showers, etc. Additionally, as relevant to the case(s) alleged, items from the central file may include a probation officer’s report, Rules Violation Reports, CDC 128-G, Classification Chrono, or CDC-114A, and Isolation Log. Photographs will be provided, where relevant.

Institutions may supply discovery to the inmate attorney on CD-R media, or via secure electronic transmission media.

Post-Hearing
All court orders resulting from a hearing before an ALJ should be forwarded to the OLA either electronically as individual PDF files or by overnight mail within 24 hours of the conclusion of the hearing.

All court orders resulting from a hearing before an ALJ should be scanned into both the health records and the central file within 24 hours, with the
appropriate alert sheet. This includes the ex-parte interim court ruling from the OAH, as well as continuance orders.

If the court has denied a case, the order for involuntary medication must be discontinued from the electronic record as soon as possible and the order for discontinuation added to all available charting resources and health records within 24 hours.

91090.12 Medication Court Administrator

The MCA is the liaison between the institution and headquarters OLA, the inmate attorney, and the OAH for all matters pertaining to involuntary administration of psychiatric medications to inmates pursuant to PC 2602. Each institution shall maintain a local operating procedure or duty statement setting forth the duties and responsibilities of the Medication Court Administrator to ensure that Penal Code section 2602 matters are timely served and filed pursuant to statutory mandate and in conjunction with the requirements set forth by the OLA and the OAH.

Pre-Hearing

Prior to the day of hearings, the MCA is responsible for completing or monitoring the following:

- Knowing which inmates at the institution need renewal notices started (assign renewal to psychiatrist 90 days before expiration of current order).
- Giving assignments to psychiatrists and tracking progress.
- Helping psychiatrists initiate new proceedings.
- Tracking whether an emergency petition has been submitted within the 72-hour deadline with ex parte request properly filled out.
- Checking that fillable CDCR MH-7363/CDCR MH-7366/CDCR MH-7368 forms are filled out correctly and completely.
- Helping obtain and print declarations created through central dictation as part of the CDCR MH-7363/CDCR MH-7368; service of papers on inmates.
- Determining if an inmate needs assistance responding to CDCR MH-7363 within two business days of being served.
- Determining if Ex Parte Request for Interim Medication Order has been granted or denied within three business days after the inmate’s time period has run and promptly notifying pharmacy whether or not emergency medication can be continued.
- Filing all needed paperwork with OAH.
- Selecting inmate counsel based on master calendar sent by headquarters; properly using the statewide list created by OLA.
- Using the Sharepoint site maintained by OLA.
- Supplying timely copies of all petitions to headquarters staff the same day they are sent to OAH and inmate counsel.
- Supplying health records and ERMS information noted in DOM Section 91090.11 (Documentation of Legal Paperwork, Pre-Hearing), to inmate counsel and to headquarters staff, with available copy to testifying psychiatrist.
- Arranging for inmate counsel to meet confidentially with the inmate before the hearing.
- Ensuring, in cases where the inmate has private counsel, that private counsel sees the inmate, receives all discovery, and integrates seamlessly into the PC 2602 process.
- Tracking which CDCR MH-7363 and CDCR MH-7368 were sent to OAH (and the date), and knowing which have been completed by OLA (Supplemental Petition) and which have had Notice Setting Hearing (NSH) issued by OAH.
- Monitoring arrivals and departures from the institution, per the Strategic Offenders Management System (SOMS) Daily Movement Report, for any inmate on PC 2602 order. If an inmate departs, it is the responsibility of the sending institution’s MCA to notify the receiving institution of the PC 2602 inmate and forward the most recent CDCR MH-7368 and order.
- Contacting headquarters and arranging to move up the PC 2602 hearing, if an inmate on emergency interim medication is deteriorating and needs to go to a higher level of care, rather than transfer the inmate.
- Placing a “hold” on an inmate, if the inmate is stable and is scheduled to move before a hearing date, unless medical conditions, or Coleman considerations, justify moving the inmate elsewhere.
- Notifying an institution of any inmate transfers if an inmate, with a case in process, transfers to another institution, and sending all supporting documentation to the receiving institution.
- Taking the lead and immediately gathering required material if an ALJ orders document production.

- Processing change orders timely when a hearing date or location needs to be changed.
- Monitoring psychiatry assignments to ensure psychiatric consults are completed on time and submitted to OAH/OLA within specified timelines to avoid a procedural default. Contacting, if necessary, the Chief of Psychiatry or a Senior Psychiatrist at the institution.
- Maintaining a current weekly log of all PC 2602 inmates for psychiatric staff, and monitoring as needed, to generate information necessary for Coleman reports.
- Responding to headquarter requests for information for copies of a missing order or other documents.
- Assisting with Probate 3200 service of documents and collection of medical documentation on patients as needed.
- Arranging for esoteric hearings, such as cell side hearings or hearings at a local hospital.
- Monitoring inmate’s medical and dental appointments to ensure the inmate is present on the date scheduled for a hearing. Consulting with psychiatry and primary care providers to ensure the inmate is not subject to side-effects of other medications.

Day of Hearing

On the day of the administrative hearing, the MCA is responsible for monitoring or completing the following:

- Arranging for proper entry and clearance for the judge and inmate attorney (including requisite number of copies for gate passes).
- Arranging for proper and timely queuing of inmates.
- Checking accuracy of hearing results on the written court order, both on the day of hearing and subsequently on the statewide list, ensuring the results are properly recorded.
- Arranging to have necessary and late-developing documentation present.
- Filling out alert sheets correctly after a hearing and properly placing alert sheets in the electronic medical record health records and electronic ERMS promptly after the hearing.
- Inputting data and the scanning of records as needed.
- Updating the inmate’s Unit Health Record (UHR) immediately and accurately to properly reflect PC 2602 status (i.e. emergency petition filed, non-emergency petition filed/do not medicate/do not extract, hearing date, ex parte order granted, etc, ALJ order granted, ALJ order denied).
- Preparing packets for psychiatrists to use for testifying in court.
- Arranging schedules and assignments to ensure psychiatrists are present in court for the hearing at the appointed time.
- Investigating, if an inmate is not attending a hearing, the reason for not attending, via inmate interview, and preparing a statement of reasons for the judge.
- Testifying as a special investigator for all refusals and non-attending inmates with detailed information on the inmate’s medical, verbal, and behavioral responses as to capacity.
- Obtaining physician prescription orders sent to pharmacy/UHR for renewal of psychiatric medications on granted petitions and stop orders for denied hearings from psychiatrists.
- Ensuring Notice Setting Hearing and Proposed Order is printed for ALJ to sign for each case.
- Facilitating patient consent forms on dropped petitions.
- Notifying pharmacy and yard staff on the day of hearings when petitions are dropped or denied to ensure an inmate is not involuntarily medicated when there is no involuntary medication order.
- Scanning all court orders to PDF, filling out alert sheets and emailing to headquarters and delivering to health records personnel.
- Sending all court orders to headquarters staff within 24 hours as PDF files.

91090.13 Inmate Review and Appeal of PC 2602 Proceedings

Inmates seeking superior court review of a PC 2602 order should be directed to file a petition for habeas corpus or petition for writ of mandate in their local superior court. Inmates seeking to have the same ALJ take another look at the case should be provided a form CDCR MH-7369 Penal Code 2602 Reconsideration form. The inmate is responsible for filling out the form and returning the form to OAH.

91090.14 Revisions

The Division of Health Care Services, and the Office of Legal Affairs, or designee is responsible for ensuring that the contents of this article are kept current and accurate.
91100 Policy
The California Department of Corrections and Rehabilitation (CDCR) recognizes that an inmate has the fundamental right to control decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn. The CDCR shall provide general information to all inmates about the use of Advance Directives (AD).

91100.1 Purpose
The purpose of this Article is to inform inmates that they have the right to make decisions about their health care; may use advance directives to document these decisions; may execute a power of attorney for health care; and may appoint an eligible person to make health care decisions for them should they become incapacitated.

91100.2 Definitions
The following definitions shall apply to this Article.

“Advance Health Care Directive” or “Advance Directive” means either an individual health care instruction or a power of attorney for health care.

“Agent” includes a successor or alternate agent.

“Capacity” means a person’s ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its implications.

“Conservator” means a court appointed conservator having the authority to make a health care decision for a patient.

“Do-Not-Resuscitate Order” means a written order, which directs that resuscitation efforts (i.e., intubations and assisted mechanical ventilation, cardiac compression, defibrillation, and administration of cardio- tonic drugs) not to be initiated in the event of cardiac and/or respiratory arrest.

“Effective Communication” is the means by which information is translated and is understood by the intended party through speech, signals, or writing. The method of communication, which may include auxiliary aids, shall be determined on a case-by-case basis and shall be documented when utilized for health care contacts.

“Health care” means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient’s physical or mental condition.

“Health care decision” means a decision made by an inmate-patient, or the inmate-patient’s agent, conservator, or surrogate, regarding the inmate-patient’s health care, including the following:

- Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication.
- Directions to provide, withhold, or withdraw artificial nutrition, hydration, and all other forms of health care, including cardiopulmonary resuscitation (CPR).

“Health care provider” means an individual licensed, certified, or otherwise authorized or permitted by the law of this State to provide health care in the ordinary course of business or practice of a profession.

“Individual health care instruction” means a patient’s written or oral direction concerning a health care decision for the patient.

“Inmate” means an adult inmate under the jurisdiction of the CDCR.

“Licensed health care facility” means a health care facility licensed by the California Department of Health Services, and includes Correctional Treatment Centers (CTC), Skilled Nursing Facilities (SNF), and General Acute Care Hospitals (GACH), and other facilities included in California Health and Safety Code § 1250.

“Patient” means an adult inmate whose health care is under consideration, and includes a principal under a power of attorney for health care and an adult inmate who has given an individual health care instruction or designated a surrogate.

“Physician” means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California.

“Primary Care Physician” means a physician, nurse practitioner, or physician assistant designated to have primary responsibility for the patient’s health care or, in the absence of a designation or if the designated physician is not reasonably available or declines to act as primary physician, a physician who undertakes the responsibility.

“Principal” means an adult who executes a power of attorney for health care.

“Power of Attorney for health care” means a written instrument designating an agent to make health care decisions for the principal.

“Reasonably available” means readily available to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient’s health care needs.

“Supervising health care provider” means the Chief Medical Officer or other designated Physician Manager.

“Surrogate” means an adult, other than an inmate-patient’s agent or conservator, authorized to make a health care decision for the inmate-patient.

91100.3 Promoting the use of Advance Directives.
Information and forms concerning AD will be provided/available to the inmate population in designated locations in the institutions (e.g., clinics, law library, CTC).

91100.4 Designation of Agents
The inmate-patient may choose a family member as defined in Section 3000 of the Title 15 or close friend who is available and agreeable to assume the responsibility as an agent. If possible, the inmate-patient should get the consent of the potential agent before that person is designated and discuss his or her wishes with the agent in advance.

Supervising health care providers and CDCR employees (unless related to the inmate-patient by blood, marriage, or adoption, or is a registered domestic partner of the inmate-patient), may not serve as an inmate-patient’s agent.

91100.4.1 Consent to Disclosure
A person then authorized to make health care decisions for an inmate-patient has the same rights as the inmate-patient to request, receive, examine, copy, and consent to the disclosure of any medical or other health care information as long as:

- The information is necessary to carry out his/her duties.
- The person is not specifically excluded in an AD from doing so.

91100.4.2 Priority of Agents
An available agent has priority over any other person in making health care decisions, except where a surrogate has been designated. If a surrogate has been designated, the surrogate has priority over any other person, including a designated agent. If a court appoints a conservator for an inmate, CDCR shall comply with applicable court orders and/or mandates.

91100.4.3 Agent Revocation
An inmate-patient, having capacity, may revoke the designation of an agent by a signed writing or by personally informing the supervising health care provider.

91100.5 Designation of Surrogates
An inmate-patient may designate another adult as a surrogate to make health care decisions by personally informing the supervising health care provider. The health care provider shall promptly record the oral surrogate designation in the inmate-patient’s health care record. A surrogate designation is only effective during the course of treatment for an illness or during the stay in the licensed health care facility when the designation is made or for sixty days, whichever period is shorter.

Supervising health care providers and CDCR employees (unless related to the inmate-patient by blood, marriage, or adoption, or is the registered domestic partner of the inmate-patient) may not serve as an inmate-patient’s surrogate.

A surrogate must act in accordance with the inmate-patient’s known desires or the surrogate’s determination of the inmate-patient’s best interests.

91100.5.1 Surrogate Revocation
An inmate-patient, having capacity, may disqualify another person at any time, including a member of the inmate-patient’s family, from acting as the inmate-patient’s surrogate by a signed writing or by personally informing the supervising health care provider of the disqualification.

91100.6 Revocation of an AD
An inmate-patient having capacity may revoke all or part of an AD in any manner that communicates intent to revoke, except the designation of an
agent, which must be revoked in writing or by personally informing the supervising health care provider of the disqualification.

91100.7 Non-original copies of an AD
A copy of a written AD, revocation, or designation/disqualification of a surrogate, has the same effect as the original.

91100.8 Conflicting Advance Directives
A later AD that conflicts with an earlier AD revokes the earlier AD to the extent of the conflict.

91100.9 Verbal Health Care Decisions or Instructions
When an inmate-patient verbally expresses a health care decision or instruction to a health care staff person, the health care staff person shall ensure that the specific decision or instruction is documented appropriately.

Additionally, the health care staff person shall inform the inmate-patient of the AD process. If the inmate-patient wishes to complete an AD, the health care staff person shall provide the inmate-patient with the CDCR Form 7421, Advance Directive, and assist the inmate-patient in its preparation as necessary.

91100.10 Declining to comply with an Advance Directive, Health Care Decision, or Instruction
Health care providers may decline to comply with an inmate-patient’s AD, health care decision, or health care instruction for such reasons as:

- Reasons of conscience.
- The AD health care decision or instruction is contrary to the CDCR policy.
- The AD health care decision or instruction requires medically ineffective health care and is contrary to health care standards.

A health care provider that declines to comply with an AD health care instruction or health care decision shall do all of the following:

- Promptly inform the inmate-patient, if possible, and any agent or surrogate authorized to make health care decisions for the inmate-patient of the decision.
- Document the decision in the inmate-patient’s health record.

91100.11 Health Care Providers Responsibility
Health care providers caring for an inmate-patient shall:

- Request a copy of the AD for inclusion and maintenance in UHR.
- Communicate the health care decision and the identity of the person making the decision to the inmate-patient prior to implementation, if possible.
- Record the existence of an AD, revocation, or designation of a surrogate in the inmate-patient’s UHR.
- Comply with an inmate-patient’s health care instruction.
- Comply with the reasonable interpretation of the health care decisions made by the person authorized to make those decisions on behalf of the inmate-patient.

91100.12 Institution Staff Responsibility
The responsibilities of institutional staff concerning an AD are as follows:

Health Care Manager (HCM) or Chief Medical Officer (CMO) or designee shall ensure CDCR Form 7421 and instructions are provided for each inmate-patient as part of the admission procedure to any CDCR licensed health care facility.

Health Care Staff shall ask upon admission of an inmate-patient to a CDCR licensed health care facility, if an AD has ever been completed, either in California or any other state.

- If an AD has been completed, the health care staff shall:
  - Verify whether a current copy is in the UHR.
  - Notify the primary care provider.
  - Review the AD with the inmate-patient to determine if it is still current.
  - File a copy of the document in the inmate-patient’s inpatient health care chart and ensure that the original document is filed in the inmate-patient’s UHR.
- If an AD has not been completed the health care staff shall:
  - Explain the benefits of completing an AD.
  - If the inmate-patient wishes to complete an AD, the health care staff person shall give the inmate-patient the CDCR Form 7421.
  - Provide assistance to the inmate-patient, if necessary, for completion and understanding of the CDCR Form 7421.

- Notify the physician staff of the CDCR Form 7421.
- File a copy of the CDCR Form 7421, in the inmate-patient’s inpatient health care chart and ensure that the original document is filed in the inmate-patient’s UHR.

If the inmate-patient chooses not to complete an AD, health care staff shall document the offering and explaining the AD to the inmate-patient in the UHR.

91100.13 Screening for Effective Communications, Mental Health, Developmental Disability, and Physical Disability
For CDCR Form 7421 submitted by inmate-patients housed in a non-licensed bed, the HCM or designee shall review and screen the AD submitted by inmates as follows:

- HCM/designee will review the institutions’ roster of inmates who have Effective Communication (EC) needs.
- HCM/designee will complete the screening portion of CDCR Form 7421 identifying the inmate as one of the following:
  - No EC assistance needed.
  - Identify the type of EC assistance needed.
  - Mental Health, identified level of care.
  - Developmental Disability, identify designation.
  - Physical Disabilities, identify disability.

- If during screening it is determined that assistance is necessary, the HCM/designee will interview the inmate-patient with the CDCR Form 7421 to determine whether or not they understand the form. The HCM/designee shall document his/her findings.
  - If through the interview, the HCM/designee determines the inmate needs assistance with understanding the medical aspects of the CDCR Form 7421, the HCM/designee shall provide the needed assistance and will document the assistance provided on the form.
  - If the inmate-patient understands the medical aspects of the CDCR Form 7421, the HCM/designee shall forward the document to the Health Records Technician II (HRT-II).
  - If the inmate-patient does not understand the CDCR Form 7421, due to mental health concerns, the HCM/designee shall refer the inmate-patient to the Chief Psychiatrist or designated mental health care professional. The Chief Psychiatrist or designated mental health care professional will duetate the inmate patient, meet with him/her to determine whether or not the inmate has the mental capacity to make a decision regarding future health care, advise the inmate-patient of their decision, and document it on the CDCR Form 7421.
  - Upon completion, the mental health care professional will return the CDCR Form 7421 to the HRT-II.
  - If the mental health care professional determines that the inmate does have the mental capacity to make the decision, the mental health professional will return the CDCR Form 7421. The HRT-II will then forward the form to the institution notary for further processing (i.e. verification of inmate identity and signature, notary public signature, and placement of official seal). If the mental health care professional determines that the inmate does not have the mental capacity, the HRT-II will file the copy in the UHR, stamping the CDCR Form 7421 as INVALID in red ink, without further processing.

The HRT-II will process the CDCR Form 7421, as follows:

- The HRT-II shall maintain a tracking log of all AD.
- If no assistance is required to the inmate submitting an AD, the HRT-II shall request notary services to notarize the inmate-patient signature on the CDCR Form 7421.
- Upon completion, the notary will return the CDCR Form 7421 to the HRT-II who will log its receipt and place it in the inmate-patient’s UHR.
- The HRT-II shall process the CDCR Form 7421 within 30 days of receipt.

91100.14 Prerequisites for a Valid Written CDCR Form 7421
All of the following criteria must be met in order for a CDCR Form 7421 to be legally sufficient:

- The AD must be signed by the inmate-patient.
91100.15 Filing the AD in the UHR

Upon receipt of a valid AD, health records staff shall file it in the health record, flag the health record by stamping the cover “ADVANCE DIRECTIVE,” and inserting a yellow sheet of paper in the green section labeled “Medico-Legal.” The yellow sheet shall be clearly marked in red ink with the statement “This Record Contains an Advance Health Care Directive.” A copy of the document shall be filed in the most current volume of the UHR.

91100.16 Do Not Resuscitate Order

A DNR order shall be initiated in all cases of cardiac and/or respiratory arrest except when a valid Do Not Resuscitate (DNR) order has been properly documented in the inmate-patient’s UHR.

If an inmate-patient has capacity and wishes to have resuscitation measures initiated, that desire shall be followed. If an inmate-patient has capacity and decides to have resuscitation measures withheld, that desire should be followed. If an inmate-patient does not have capacity, a decision regarding the use of CPR shall be made by an agent or surrogate based on previously expressed desire of the inmate-patient. The treating physician shall seek the concurrence of the inmate-patient or the agent or surrogate before writing a DNR order.

A DNR order may be written in the UHR when, in the treating physician’s judgment, an inmate-patient is terminally ill and no reasonable treatment for the underlying disease process remains available. The decision to write a DNR order shall be made by the treating and/or designated physician and shall be based on:

- The right of the patient or his/her surrogate decision-maker to refuse medical care, even when it could prolong life; and
- The medical judgment that the potential benefits of resuscitation, assessed in context of the inmate-patient’s total medical condition, no longer justify initiation of resuscitation efforts.

A DNR order shall be implemented with the understanding that every effort shall be made to relieve the patient’s suffering and maintain comfort. A DNR order does not imply that other therapeutic measures necessary to promote comfort should not be provided (e.g., palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions).

The treating physician shall be responsible for determining whether an inmate-patient is capable of making health care decisions and discussing the possibility of cardiopulmonary arrest. The physician shall describe the procedures performed during CPR, including the likelihood of success and the potential adverse consequences, and encourage the inmate-patient to express whether he/she would prefer resuscitation to be performed. These discussions should be initiated as early as possible during hospitalization or placement in a CDCR licensed health care facility. If there is a question concerning an inmate-patient’s capacity to make informed health care decisions, the treating physician shall request a psychiatric consult.

If the inmate-patient is unable to communicate informed health care decisions, or lacks capacity to make health care decisions, and has not designated an agent or surrogate either orally or via an AD, the treating physician shall work with the Office of Legal Affairs to identify an appropriate surrogate. The physician shall advise the surrogate of the inmate-patient’s diagnosis and prognosis, and request that a decision be made on behalf of the inmate-patient regarding the initiation of CPR.

91100.16.1 Documentation

The treating physician shall write the DNR order on the Physician’s Order sheet in the inmate-patient’s UHR, and briefly state the inmate-patient’s terminal diagnosis. Additionally, the physician shall document the following in the patient progress notes:

- The medical diagnosis and prognosis at the time the order is written.
- The current mental and physical status of the inmate-patient at the time the order is written.
- The name of the agent or surrogate (if designated) and the relationship to the patient.
- A statement indicating the benefits, burdens, and risks of CPR, as well as the probable chances of successful outcome were discussed with the inmate-patient (or agent or surrogate if appropriate).
- Documentation of consultations with other physicians.
- A statement indicating the patient, or the agent, or surrogate concurs with the decision to withhold CPR in the event of cardiac and/or respiratory arrest.

If an inmate-patient requests that resuscitation measures be limited to specific interventions, the physician shall identify the intervention to be withheld, as well as the interventions to be initiated, on the Physician’s Order sheet in the inmate-patient’s UHR.

91100.16.2 Telephone Orders

Physician telephone orders to withhold CPR are acceptable when witnessed by one Registered Nurse and one other health care staff person who is not related to the inmate-patient. Both staff persons must sign the telephone order. Within 24 hours, the physician giving the telephone order shall co-sign the order sheet and document in the inmate-patient’s progress notes the rationale for the DNR order, and that the decision was discussed with the inmate-patient or surrogate decision-maker prior to writing the order. If the telephone order is not co-signed by the treating physician within 24 hours of issuance, it shall automatically be discontinued.

91100.16.3 Periodic Review

In licensed CDCR beds the treating physician shall review the DNR order at least monthly and whenever a change in the inmate-patient’s condition occurs. In those cases where the inmate-patient’s condition or prognosis improves, the treating physician shall reopen discussion with the inmate-patient, agent, or surrogate and update or reverse the DNR order in accordance with the inmate-patient’s wishes. The physician shall document any modification to the DNR order and supporting rationale in the inmate-patient’s UHR.

91100.16.4 Anesthesia and Surgery

In CDCR licensed beds, the treating physician or other designated Primary Care Physician (PCP), shall be responsible for discussing and documenting whether a DNR order is to be maintained, or completely or partially suspended, during anesthesia and surgery. Discussions with the inmate-patient, agent, or surrogate should include:

- The goals of surgery.
- The possibility of cardiopulmonary arrest.
- A description of the procedures performed during CPR.
- Possible outcomes with and without CPR.

The treating physician shall document the inmate-patient’s decision regarding the continuation or suspension of the DNR order during anesthesia and surgery in the UHR and communicate the inmate-patient’s wishes to all health care providers potentially involved in the surgical procedure. If the inmate-patient requests that the DNR order be suspended during anesthesia and surgery, the physician or designated PCP, shall document when the order is to be reinstated.

91100.16.5 Accepting a DNR Order from another CDCR Institution

If a terminally ill inmate-patient with a DNR order transfers to another CDCR institution, the receiving institution may accept the sending institution’s DNR order on a temporary basis. A physician at the receiving institution must discuss the resuscitation status with the inmate-patient within 72 hours of the inmate-patient’s arrival and rewrite the DNR order to the inmate-patient’s desires.

91100.16.6 Rescinding a DNR Order

The inmate-patient or surrogate decision-maker may rescind a DNR order at any time by simply informing health care staff of the desire to cancel the order. The cancellation becomes effective as soon as the inmate-patient, agent, or surrogate communicates his/her desire to rescind the order to health care staff. Health care staff who receive notification of an inmate-patient’s desire to cancel a DNR order shall notify the treating physician immediately. The treating physician shall make a notation regarding the cancellation of the order on the Physician’s Order sheet and patient progress notes in the inmate-patient’s UHR. Following cancellation of a DNR order, full CPR shall be initiated in the event of cardiac and/or respiratory arrest.

91100.16.7 DNR Instructions Given to a Non-Health Care Staff Person

Any non-health care staff person (i.e., clerical staff, administrative staff, correctional officer, etc.) who receives oral or written DNR instruction from an inmate-patient shall promptly notify the Supervising Registered Nurse. The Supervising Registered Nurse shall confirm the patient’s request and
immediately notify the patient’s primary care provider, the physician on call, the Medical Officer of the Day, or the Health Care Manager/designee. The notified health care staff member shall ensure that a DNR order is promptly implemented or rescinded in accordance with the inmate-patient’s wishes. Health care staff shall document all DNR instructions in the inmate-patient’s UHR. This includes oral instruction given to a non-health care staff person concerning the use of resuscitation measures and designation of a surrogate.

91090.17 Authorizing Anatomical Gifts

Inmate-patients or their appointed agents may authorize post-mortem (after death) tissue or organ anatomical gifts. The HCM or CMO shall promptly notify the local donor agency of the decision to authorize tissue or organ anatomical gifts.

CDCR shall not be responsible for any costs associated with the organ donation process.

91090.18 Revisions

The Director of the Division of Health Care Services or designee is responsible for ensuring that the contents of this Article are kept current and accurate.

91090.19 Reference

Family Code, §7002.
Health & Safety Code § 1250.
Probate Code, §§3200, 3201, 4605, 4607, 4609, 4617, 4621, 4623, 4629, 4643, 4674(c)(1), 4701(5.3), and 4711.
Welfare and Institutions Code §5325.
CCR, (15) (3), §§3000, 3351 and 3353.1.