POLICY TITLE: HEALTH CARE POLICY NUMBER: 18.5 CHAPTER 18: HEALTH CARE SERVICES		PAGE 1 OF 28
STATE of MAINE DEPARTMENT of CORRECTIONS Approved by Commissioner:		PROFESSIONAL STANDARDS: See Section VIII
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I. AUTHORITY

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

II. APPLICABILITY

All Departmental Adult Facilities

III. POLICY

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

IV. DEFINITIONS

1. Four-point restraints - a four-point restraint totally immobilizes the resident by securing a resident's arms and legs (four points), e.g., by using a restraint bed or gurney. This definition does not include the use of handcuffs, leg irons, and connecting chain used during the transport or internal movement (escort) of residents. This definition does not include the use of stationary restraints.
2. Five-point restraints - a five-point restraint totally immobilizes the resident by securing a resident's arms, legs, and head, chest or thigh (five points), e.g., by using a restraint chair or a restraint bed or gurney. This definition does not include the use of handcuffs, leg irons, and belly chains used during the transport or internal movement (escort) of residents. This definition does not include the use of stationary restraints.
3. Posey vest - a type of medical restraint used to restrain a patient to a bed or chair. The vest is placed on the patient, and mesh straps extending from each

corner are tied either individually to each side of the bed or together to the back of a chair.

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VI. ATTACHMENTS

Attachment A: Oral Hygiene and Preventive Education Sheet
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VII. PROCEDURES

Procedure A: Health Care Services, General

1. The Commissioner, or designee, shall ensure that health care services provided to adult residents by the Department are approved by the Department's contracted health care services provider as set out in Department Policy (AF) 18.1, Governance and Administration.

2. Each facility's health care services program shall include, but not be limited to, the following services:

   a. screening for health problems on admission;

   b. outpatient services for the detection, diagnosis, and treatment of illness and other health problems, to include medication management and/or health education, as appropriate;

   c. emergency medical services;

   d. therapeutic diets;

   e. accommodations for residents with disabilities or other special needs;

   f. elective and preventive treatment, where resources permit;

   g. pregnancy prevention and pregnancy management services, if applicable;

   h. provision for referral and admission to the Department's infirmary or to a hospital for residents whose medical needs exceed the treatment capability of the Department;

   i. processes for obtaining and documenting informed consent; and

   j. follow-up with residents who return from a hospital.

Procedure B: Diagnostic Services

1. All adult residents shall have access to diagnostic services, either on site or in the community (e.g. radiology, laboratory testing, EKG, glucose testing, peak flow testing, pregnancy testing) as ordered by the facility physician, physician assistant, nurse practitioner, dentist, or optometrist.

2. Each facility shall maintain a current list of the types of diagnostic services that are available and whether they are available on site or in the community. At a minimum, there shall be available on-site dipstick urinalysis, blood glucose testing, peak flow testing, and stool blood testing. For a facility housing female residents, pregnancy testing shall also be available.

3. All diagnostic equipment located at the facility shall be maintained to meet factory specifications and applicable state regulations. Instructions for the use of any diagnostic equipment and the instructions for the calibration of testing devices shall be maintained. A record of the calibration and testing of the diagnostic equipment shall be maintained by the health care staff.

4. When there is an order for diagnostic testing, the required test shall be performed at the next possible opportunity if being done on-site or an appointment in the community shall be arranged in a timely manner.

5. A notation shall be made in the resident's electronic health care record that the order has been noted by the nursing staff.

6. All diagnostic tests that have been ordered shall be documented and shall include the resident's name, the date the order was written, the date the test is

scheduled for and the date the test is completed. For any diagnostic test that requires the Department's contracted health care services provider's approval, the date requested and the date the approval was given shall be documented.

7. When diagnostic procedures are scheduled to be done in the community, the resident may be informed that the required test has been scheduled but shall not be told when or where it shall take place, due to security reasons.

8. When diagnostic procedures are scheduled to be done in the community, designated security staff shall be notified by health care staff of the time and place so that security staff can arrange transport. Notification shall be given as soon as possible and, in a non-emergency situation, at least twenty-four (24) hours in advance. Off-site health care appointments may only be cancelled by health care staff or the facility Chief Administrative Officer, or designee, in consultation with the facility Health Services Administrator.

9. The health care staff shall provide the transport staff with a Consultation Request Form to be completed by the community provider. The completed form shall be returned by the transport staff to the health care department immediately upon return to the facility. The completed form shall be reviewed and scanned into the resident's electronic health care record by appropriate health care staff.

10. The facility physician, physician assistant, nurse practitioner, dentist, or optometrist shall review, date, and sign all diagnostic test results and/or shall make a notation of the review in the progress notes. Appropriate health care staff shall review with the resident, in a timely manner, any clinically significant diagnostic test results.

11. Reports of results of all diagnostic tests shall be scanned into the resident's electronic health care record.

Procedure C: Dental Services
5-ACI-6A-19

1. An initial dental screening shall be performed on each adult resident upon intake to the reception facility as part of the admission health screening required by Department Policy 18.4, Health Screening and Assessment.

2. Oral hygiene, oral disease education, and self-care instruction (Attachment A) shall be provided at intake by health care staff.

3. All residents shall have access to emergent, urgent, and routine dental care services under the direction and supervision of a facility dentist. *5-ACI-6A-19-1*

4. A full dental examination shall be performed within thirty (30) days of admission to the Department by a licensed dentist to assess any dental pain, infection, disease, or impairment of function and establish the overall dental/oral condition.

5. The examination shall include:
    a. a review of the resident's dental and medical history, including medications;
    b. an examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination;
    c. appropriate uniform dental record using a numbered system such as the Federation Dental International System;
    d. Periodontal Screening and Recording (PSR) or a recognized periodontal health assessment;
    e. radiographs (x-rays) for diagnostic purposes, as necessary;
    f. consultation and referral to appropriate specialists when medically necessary; and
    g. ordering of other dental treatment, as necessary.

6. The facility dentist shall document the results of any dental exam conducted on a resident and any orders made as a result of the exam in the resident's electronic health care record.

7. In the case of a resident readmitted to the Department or who has been transferred from another Departmental facility and who has received a dental examination within the past six (6) months at a Departmental facility, a new exam is not required, except as determined by the supervising dentist.

8. Routine dental care includes fillings, extractions and, if determined necessary by a facility dentist, maintenance of orthodontic appliances and dentures.

9. A Consent for Dental Surgical Treatment (Attachment B) shall be completed prior to any dental surgical procedure and shall be scanned into the resident's electronic health care record. If a resident has a legal guardian for health care decisions, the health care staff shall contact the resident's legal guardian to obtain consent.

10. Treatment priority shall be based on the clinical and professional judgment of the facility dentist.

11. Provision of dentures for residents shall be in accordance with recommendation made by the facility dentist. *5-ACI-6A-40*

Procedure D: Eye Care

1. All adult residents shall be provided eye care services under the direction and supervision of a facility optometrist, except for the visual screening, which may be performed by any health care staff. All residents shall receive timely emergency and routine optometric and ophthalmologic treatment, and any other necessary health care, in order to support healthy vision.

2. Visual screening shall be performed as part of the physical health assessment for a resident within fourteen (14) days of intake to the reception facility by health care staff, utilizing the Snellen test. Based on the result of the Snellen test, a resident may be referred for follow-up care with the optometrist or a specialty consult with an ophthalmologist.

3. All residents with chronic medical problems that may affect vision, or the health of the eye(s) shall be referred for an optometric or ophthalmologic exam annually or more often, as necessary.

4. The facility optometrist shall document the results of any eye exam conducted on a resident and any orders made as a result of the exam in the resident's electronic health care record.

5. Corrective eyeglasses, or other reasonable accommodations, shall be provided as ordered by the facility optometrist or ophthalmologist, except that any order for accommodations other than corrective eyeglasses with clear lenses shall be referred to the Regional Medical Director for determination of medical necessity in consultation with the facility Chief Administrative Officer, or designee, to address any security concerns.

6. A resident prescribed eyeglasses shall be offered one (1) pair of state-issued glasses per prescription or one pair every two (2) years when indicated (e.g., scratched lens) or more often, if authorized by the Chief Administrative Officer, or designee. Unless exempted under Department Policy 18.1, Governance and Administration, the resident shall pay a co-pay for each pair of state-issued eyeglasses.

7. Each facility shall offer a variety of eye wear from the approved vendor. A resident may choose any style from the frame selection offered by the facility vendor. A resident shall not be allowed to obtain eye wear through any other means than the facility vendor, except as permitted by the Chief Administrative Officer.

8. If applicable, a resident shall be required to return existing eyeglasses in order to receive replacement eyeglasses. The resident shall sign a Receipt of Eyeglasses Form (Attachment C) when each pair of eyeglasses is received, which shall be scanned into the resident's electronic health care record.

9. The facility optometrist may order diagnostic testing and optometric treatment as necessary.

Procedure E: Withdrawal and Detoxification

5-ACI-6A-41

1. Every adult resident shall be screened by qualified health care staff for the use of and/or dependence on alcohol or drugs as part of the admission health screening.

2. Any resident reporting or suspected of being under the influence of alcohol, opiates, stimulants, sedatives, hypnotics, or other legal or illegal substances at the time of the admission health screening shall be immediately evaluated by health care staff for his or her degree of intoxication and need for medical treatment for withdrawal from the substance and/or detoxification.

3. Any necessary medical treatment for withdrawal and/or detoxification, including use of hospitalization, shall be carried out according to written specific protocols approved by the Regional Medical Director.

4. Any resident in withdrawal from a substance or in detoxification shall be referred by health care staff for other necessary follow-up assessment, treatment, counseling, or referral, to include referral to substance abuse treatment staff.

5. If a resident exhibits opioid withdrawal or there is another indication that any resident has an opioid use disorder, the resident shall be referred by health care staff for Medication-Assisted Treatment (MAT) screening in accordance with Department Policy 18.24 (AF), Medication-Assisted Treatment.

Procedure F: Provider Orders

1. Treatment performed by nursing staff is pursuant to written or verbal orders given by health care staff authorized by law to give such orders.

2. These written orders shall be documented directly in the resident's electronic health care record or on the Physician Orders sheet or Provider Order sheet and include the signature of the person issuing the order and the time and date the order was given. Any paper order shall be scanned into the resident's electronic health care record.

3. Verbal orders shall be recorded by the nurse on the Physician Orders sheet or Provider Order sheet and shall include the name of the person issuing the order, the person accepting the order, and the time and date the order was given. The individual who issued the order shall sign and date it on his or her next visit to the facility and then the paper order shall be scanned into the resident's electronic health care record.

Procedure G: Nursing Pathways

1. The Department's contracted health care services provider shall:
   a. develop and maintain nursing assessment and treatment pathways that complies with the regulations of the State of Maine Board of Nursing; and
   b. develop preventive medicine protocols.

2. The facility Health Services Administrator, or designee, shall assure each nurse at the facility is trained in the nursing pathways, and each nurse shall sign and date the time of this training.

3. Unless otherwise ordered by the physician, physician assistant, or nurse practitioner in a specific case, all care provided by the nursing staff shall be in accordance with approved nursing pathways. Standing orders shall not be used. *4-ACRS-4C-17*

4. Pathways involving medication shall be limited as follows:

   a. pathways may allow treatment with prescription medication without a written or verbal order in the case of an emergency life threatening situation (e.g., nitroglycerin, epinephrine);

   b. pathways may allow the use of over the counter medications without a written or verbal order; and

   c. administration of any medications, including over the counter medications, by nursing staff shall be documented in the Medication Administration Record in the resident's electronic health care record.

5. At a minimum, the nursing pathway manual shall be reviewed, revised as needed, dated and signed annually by the facility Health Services Administrator (HSA) and the Regional Medical Director.

Procedure H: Physical Therapy

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

2. Exercise areas are available to meet exercise and physical therapy requirements of individual resident treatment plans. *5-ACI-6C-15*

Procedure I: Specialty Consultations

1. All adult residents shall have access to specialty consultation services as ordered by a facility physician, physician assistant, nurse practitioner, dentist, or optometrist, and approved by the Regional Medical Director.

2. All residents shall be required to sign a one-time release (Release of Information – Off-Site Specialty Consultations, Attachment D), which shall be scanned into the resident's electronic health care record allowing information obtained from all off-site specialty consultations to be forwarded to the health care department at the facility for review by health care staff in order to make informed decisions about health care. Failure to sign the release or an attempt to revoke the release shall preclude a resident from being scheduled for off-site specialty consultations.

3. These consultations shall be provided either at the facility or in the community.

4. When there is an order for a specialty consultation, the required consultation shall be performed at the next possible opportunity if being done on-site or an appointment in the community shall be arranged in a timely manner.

5. A notation shall be made in the resident's electronic health care record that the order has been noted by the nursing staff.

6. All specialty consultations that have been requested shall be entered into the resident's electronic health care record and shall include the resident's name, the date the order was written, the date the approval of the Regional Medical Director was given, if approved, and, if approved, the date the consultation is scheduled for, and the date the consultation is completed. For any specialty consultation that requires the Department's contracted health care services provider's administrative approval, the date requested and the date the approval was given shall be documented.

7. When specialty consultations are scheduled to be done in the community, the resident may be informed that the required consultation has been scheduled but shall not be told when or where it shall take place, due to security reasons.

8. When specialty consultations are scheduled to be done in the community, designated security staff shall be notified by health care staff of the time and place so that security staff can arrange transport. Notification shall be given as soon as possible and, in a non-emergency situation, at least twenty-four (24) hours in advance. Off-site health care appointments may only be cancelled by health care staff or the facility Chief Administrative Officer, or designee, in consultation with the facility Health Services Administrator.

9. The health care staff shall provide the transport staff with a Consultation Request Form to be completed by the community provider. The completed form shall be returned by the transport staff to the health care department immediately upon return to the facility. The completed form shall be reviewed and scanned into the resident's electronic health care record by appropriate health care staff.

10. The facility physician, physician assistant, nurse practitioner, dentist, or optometrist shall review, date, and sign all specialty consultation results and/or shall make a notation of the review in the progress notes. Appropriate health care staff shall review with the resident in a timely manner any specialty consultation results.

11. Reports of results of all specialty consultations shall be scanned into the resident's electronic health care record.

Procedure J: Hospital Services

1. Each facility shall have written arrangements for the provision of medical care to adult residents in hospitals.

2. When a resident is sent to a hospital for emergency treatment, the facility nursing staff shall contact the hospital emergency department as soon as practicable to notify the hospital of the resident's pending arrival at the hospital and provide information about the emergency.

3. When a resident is hospitalized, the facility physician, physician assistant, nurse practitioner, or other health care staff shall coordinate the resident's care and treatment with the appropriate hospital staff so that only medically necessary treatment is provided.

4. If the resident refuses the treatment that has been determined medically necessary, whether the resident is nevertheless provided the treatment shall be determined in accordance with the hospital's normal practices for providing necessary medical treatment to a person in the community, including, if applicable, practices for providing involuntary treatment with a legal guardian's consent or a court order.

5. If the resident is unable to consent to or refuses medically necessary treatment (is unconscious, unable to communicate, or disoriented), whether the resident is nevertheless provided the treatment shall be determined in accordance with the hospital's normal practices for providing necessary medical treatment to a person in the community, including, if applicable, in consultation with the resident's family, legal guardian, health care power of attorney, etc.

6. Under no circumstances shall any Department employee or any person affiliated with the Department's contracted health care services provider give consent for a hospital to provide treatment to a resident who is refusing treatment or who is unable to consent to or refuses treatment, unless there is a court order to that effect.

7. In the situation of a hospitalized resident who is terminally ill and who has the capacity to make an informed decision about end of life care or who has an advance directive, end of life care shall be provided in accordance with the resident's wishes.

8. In the situation of a resident who is terminally ill and who lacks the capacity to make an informed decision about end of life care and there is no advance directive, end of life care shall be determined in accordance with the hospital's normal practices for providing end of life care to a person in the community, including, if applicable, in consultation with the resident's family, legal guardian, health care power of attorney, etc.

9. The resident or the resident's family, legal guardian, health care power of attorney, etc. shall not be permitted to give consent to treatment or end of life care that is not medically necessary.

10. If there appears to be a need for the appointment of a legal guardian or the obtaining of a court order with respect to the treatment of a hospitalized resident, the facility Chief Administrative Officer, or designee, shall contact the Deputy Commissioner, or designee.

11. The Deputy Commissioner, or designee, may, after conferring with the facility physician and any other person as appropriate, contact the Department's legal representative in the Attorney General's Office to inquire about obtaining the

appointment of an emergency guardian, obtaining a court order for involuntary treatment, or taking other appropriate action.

Procedure K: Continuity of Care

1. Facility health care staff shall: *5-ACI-6A-04*
   a. review an adult resident's health care records upon receipt from outside health care providers and from other Departmental facilities;
   b. refer the resident to community-based providers, when indicated; and
   c. assure continuity of the resident's health care from the time of admission, throughout the incarceration, and at the time of release, for all emergency and routine health care services.

2. In preparation for a resident's transfer to another facility, health care staff shall follow the procedures set out in Department Policy 18.9, Health Care Records.

3. In preparation for a resident's release from the facility, the facility Health Services Administrator, or designee, shall ensure the resident's case manager has the information needed to arrange continuity of health care, both for residents being released to the community and for residents being released to a jail, to a correctional facility in another jurisdiction, or to a psychiatric hospital.

4. The resident's case manager, in conjunction with health care staff, is responsible for developing a discharge plan to ensure continuity of health care in the community upon release by following the procedures outlined in Department Policy (AF) 27.1, Release and Reentry Planning, as applicable.

5. The health care staff shall coordinate with the case manager to provide the information needed for the case manager to schedule any necessary follow up health care appointments in the community.

6. The health care staff shall inform the case manager of medical equipment needs, medications that the resident will be provided upon release, specialist appointments that have previously been scheduled, and any other information necessary to facilitate the resident's discharge plan.

7. The health care staff shall complete a written Health Care Discharge Summary (Attachment E), at least fourteen (14) days prior to the resident's release. The summary shall be reviewed with and signed by the resident. The resident shall be given a copy and the original shall be scanned into the resident's electronic health care record.

8. In the event that there is a change in the resident's health, the discharge summary shall be updated accordingly, and the updated summary shall be reviewed with and re-signed by the resident, if necessary. The resident shall be given a copy and the original shall be scanned into the resident's electronic health care record.

9. If applicable, health care staff shall provide a resident with a supply of medication(s) at the time of release in accordance with Department Policy 18.7 (AF), Pharmaceuticals.

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

1. *5-ACI-6A-18* The Regional Medical Director, or designee, shall ensure that there is a treatment plan for adult residents with chronic conditions such as hypertension, diabetes, and other diseases that require periodic care and treatment. The plan shall include:
    a. the monitoring of medications;
    b. laboratory and other testing;
    c. the use of chronic care clinics;
    d. health records; and
    e. the frequency of specialist consultation and review.

2. *5-ACI-6A-07* All residents requiring medical supervision, including post-operative, chronic care and convalescent care, shall have a written individual treatment plan that:
    a. is developed by the appropriate health care provider for each resident requiring a treatment plan;
    b. includes directions to health care and other staff regarding their roles in the care and supervision of the resident; and
    c. enrolls the resident in the appropriate chronic care clinic to ensure continuity of care and treatment.

3. All residents enrolled in the mental health chronic care clinic shall be seen by the psychiatrist at least every ninety (90) days, or more frequently if necessary.

4. All residents enrolled in other chronic care clinics shall be seen by the physician, physician assistant, or nurse practitioner every six (6) months, or more frequently as necessary.

5. All chronic care clinic visits shall be documented on the appropriate chronic care clinic form(s) in the resident's electronic health care record.

6. The health care staff conducting the chronic care clinic shall review with the resident all decisions resulting from the clinic, including a decision to discharge the resident from the clinic.

7. If it is determined by the physician, physician assistant or nurse practitioner that the resident's condition no longer warrants follow-up in a chronic care clinic, a notation in the resident's electronic health care record shall be made explaining the reason for this decision. For a resident enrolled in the mental health chronic care clinic, such a decision must be made by the psychiatrist.

Procedure M: Residents with Disabilities
5-ACI-6C-06

1. The Chief Administrative Officer, or designee, shall consult with health care staff whenever action is initiated by any staff regarding a housing assignment, program assignment, disciplinary disposition, work assignment or transfer to another facility for an adult resident with a disability and the action might require an accommodation for the disability in accordance with Department Policy (AF) 19.2, Programs and Services.

2. Consultation shall also take place when a resident with a disability is placed in a restrictive housing unit or other housing unit on administrative status or on disciplinary segregation status, in special management housing on disciplinary restriction or protective custody status, or in the Administrative Control Unit, and the action might require an accommodation for the disability. The consultation shall take place prior to any action being implemented.

3. In an emergency, staff may take action immediately to protect safety or security. The consultation shall take place to review the appropriateness of the action as soon as possible but no later than 72 hours after the action is taken.

Procedure N: Special Housing
5-ACI-4B-28

1. When an adult resident is placed in a restrictive housing unit or other housing unit on administrative status or on disciplinary segregation status, in special management housing on disciplinary restriction or protective custody status, or in the Administrative Control Unit, and the Unit Manager, or designee, notifies the facility health care staff, the health care staff shall, as soon as possible on the day of the placement, conduct a screening and review as required by the protocols established by the Department's contracted health care services provider. The screening and review shall be documented in the resident's electronic health care record.

2. The health care staff shall review the resident's health care record to determine if there is any medical or mental health condition that might contraindicate the placement or that requires monitoring by the health care staff.

3. The mental health portion of the screening and review shall include, but not be limited to:

   a. inquiry to whether the resident:

      1) has a present suicide ideation;

      2) has a history of suicidal behavior;

      3) is presently prescribed psychotropic medication;

      4) has a current mental health complaint;

      5) is being treated for mental health problems;

      6) has a history of inpatient and outpatient psychiatric treatment;

7) has a history of treatment for substance abuse; and

b. observation of:

1) general appearance and behavior;

2) evidence of abuse and/or trauma; and

3) current symptoms of psychosis, depression, anxiety, and/or aggression.

4. The health care staff shall determine whether to make:

a. no referral to behavioral health staff;

b. referral to behavioral health staff; or

c. immediate referral to appropriate behavioral health staff for emergency treatment.

5. If the results of the screening indicate the resident is at imminent risk for serious self-injury or suicide, exhibits debilitating symptoms of a serious mental illness (SMI), or requires emergency medical care, the health care staff shall provide appropriate assessment and treatment and/or contact appropriate behavioral health or medical staff for instructions.

6. At a minimum, daily rounds in restrictive housing and special management housing units shall be made (unless medical attention is needed more frequently) by health care staff to ensure the residents access to appropriate health care, to include, but not be limited to, the following:

a. the presence of the health care staff shall be announced to the residents;

b. the health care staff shall observe each resident and inquire of each resident as to the resident's well-being; and

c. rounds in each housing unit shall be documented by health care staff in the housing log and signed by the health care staff making the rounds.

7. Health care staff shall accept sick-call slips, on a daily basis, from residents requesting non-emergency health care in any restrictive housing or special management housing unit that does not have a sick-call drop box.

Procedure O: Clinic Space, Equipment and Supplies

1. Each facility Chief Administrative Officer, or designee, shall ensure that there is sufficient and suitable space, equipment and supplies to provide on-site health care services at that facility. The equipment, space and supplies shall include:

a. examination and treatment rooms for medical care, large enough to accommodate the necessary equipment and fixtures, and to permit privacy for the resident. Basic equipment available for examination and treatment shall include, but not be limited to:

1) hand sanitization;

2) examination table(s);

3) a light capable of providing directed illumination;
4) scale(s);
5) thermometers;
6) blood pressure cuffs;
7) stethoscope;
8) ophthalmoscope; and
9) otoscope.

b. prescribed and allowed over the counter medications;

c. emergency response equipment, to include an automatic external defibrillator, and supplies for use by health care staff that health care staff inspect daily (appropriately documented);

d. adequate office space providing secure storage of health care records;

e. private interview and counseling space for medical and behavioral health care;

f. appropriate areas for laboratory, radiological, or other ancillary services when they are provided on-site;

g. waiting areas for residents that have seats and access to drinking water and toilets, if residents are to wait more than a brief period for services; and

h. basic medical supplies and equipment that are inventoried at least quarterly (appropriately documented).

2. At a minimum, inventories shall be conducted on a weekly basis of any items that pose a safety or security risk (e.g., syringes, needles, scissors, and other sharp instruments). All inventories shall be appropriately documented.

Procedure P: Elective Medical Treatment

5-ACI-6C-05

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

2. The Department's Health Services Director, or designee, shall make the final decision whether to approve any elective medical treatment.

Procedure Q: First Aid Kits, Defibrillators, and Personal Protective Equipment

5-ACI-6B-09

1. The Health Services Administrator (HSA), or designee, shall, in coordination with the Chief Administrative Officer, or designee, shall:

a. determine the locations of first aid kits, automatic external defibrillators, and personal protective equipment at the facility;

b. determine the contents of the first aid kits and ensure re-stocking as necessary;

c. develop written protocol for:

1) documented monthly inspection of the kits; and

2) the use of the first aid kits by nonmedical staff.

Procedure R: Emergency Medical Services

1. Emergency medical services shall be provided in accordance with Department Policy (AF) 18.3, Access to Health Care Services.

2. Unless the medical treatment is governed by an advance directive, in a health care emergency in which an adult resident is unable to consent to or refuse treatment (is unconscious, unable to communicate, or disoriented) and where it is necessary to provide treatment before consent can be obtained, necessary treatment shall be provided, using only the degree of physical force necessary. Any use of force shall be video recorded.

Procedure S: Medical Therapeutic Restraints, General

5-ACI-6C-13

1. Therapeutic restraints ordered for a medical reason (i.e., to protect an adult resident from accidental injury, e.g., a nonambulatory resident with dementia who would otherwise fall out of a wheelchair; to treat an adult resident whose refusal of treatment would result in an immediate and serious risk to health, e.g., a resident on a prolonged hunger strike who is refusing lifesaving nutrition or fluids or a resident with diabetes who is refusing insulin; or to prevent an adult resident from interfering with treatment in a way that would result in an immediate and serious risk to health, e.g., a resident who is tearing out stiches that were used to repair an injury to a vital organ) may be used only when less restrictive alternatives have been or are likely to prove ineffective.

2. The use of therapeutic restraints to prevent an adult resident from committing suicide or inflicting serious self-injury due to mental illness is as provided in Department Policy (AF) 18.6, Mental Health Services.

3. If a resident who has been refusing or interfering with treatment credibly agrees to cooperate with treatment, therapeutic restraints shall not be ordered. (However, non-therapeutic restraints may be used for a security reason as provided in applicable departmental policies, e.g., the resident is on disciplinary segregation status and is being escorted within the facility.)

4. Non-therapeutic (security) restraints may also be used to facilitate noninvasive measures designed to protect others from potential exposure to bodily fluids, including such measures as the involuntary application of bandages to wounds to prevent the spreading of bodily fluids.

5. The following provisions shall be adhered to any time medical therapeutic restraints are used in adult resident care:

a. therapeutic restraints shall not be used for punishment;

b. if therapeutic restraints are used, the least restrictive restraints possible shall be used and only for the period of time necessary; and

c. therapeutic restraints may not be used unless ordered by a physician, physician assistant, or nurse practitioner. The documentation shall include the order, the medical reason for the order, the justification for using restraints (to include efforts for less restrictive treatment alternatives), and the justification for the type of restraints ordered.

6. In every case in which therapeutic restraints have been ordered, except for the purpose of preventing accidental injury, health care staff shall immediately inform the facility Shift Commander, and health care staff and security staff shall jointly develop a plan for the application of the therapeutic restraints by security staff using only the degree of nondeadly force reasonably believed to be necessary. The application of the restraints shall be video recorded. In a case in which the purpose is to protect the resident from accidental injury, health care staff may apply the therapeutic restraints.

7. Only soft restraints that would be appropriate for use in hospitals shall be used for therapeutic restraints.

   a. In the case of protecting a resident from accidental injury, these consist of:

      1) bed restraint net;

      2) wheelchair seatbelt; and

      3) Posey vest.

   b. In the case of treating a resident who has been refusing or interfering with treatment, these consist of:

      1) leather, rubber, or canvas hand restraints;

      2) leather, rubber, or canvas leg restraints;

      3) leather mitts;

      4) leather, rubber, or canvas waist belt;

      5) four-point restraints made of the above materials; and

      6) five-point restraints made of the above materials.

8. Metal or plastic restraints, such as handcuffs and leg irons, shall not be used as therapeutic restraints, except in an emergency situation to prevent serious bodily injury to self or others and only if soft restraints are not readily available.

9. A resident may be restrained in a hospital or restraint bed, hospital or restraint gurney/stretcher, Stokes basket, restraint chair, or wheelchair or another chair designed for transporting or moving a resident. A resident may not be restrained in an unnatural position or face down.

10. Whenever therapeutic restraints are used, health care staff shall assess the resident as soon as possible after the application of the restraints and at least every two (2) hours thereafter if the use has not been discontinued in the meantime, and the following shall be checked:
    a. circulation, movement, and sensation in extremities (except when only a bed restraint net or wheelchair seatbelt is being used);
    b. respiratory status (except when only a bed restraint net or wheelchair seatbelt is being used);
    c. mental status (except when only a bed restraint net or wheelchair seatbelt is being used);
    d. vital signs (except when only a bed restraint net or wheelchair seatbelt is being used);
    e. that food, water, and use of the toilet has been offered as appropriate;
    f. that the resident has been offered the opportunity to have each limb removed separately from restraints for the purpose of movement every two (2) hours as appropriate (except when only a bed restraint net, wheelchair seatbelt, or Posey vest is being used); and
    g. when a wheelchair seatbelt or Posey vest is being used, that the resident and the restraint are both appropriately positioned.

11. During the resident's hours of sleep, health care staff may elect not to awaken the resident to complete the assessment.

12. The results of the assessment shall be documented in the resident's electronic health care record, including any reason for security staff not offering food, water, use of the toilet, or movement of restrained limbs (if applicable). If health care staff elect not to awaken a sleeping resident, that fact shall be documented in the resident's electronic health care record.

13. The need for continued therapeutic restraints of the resident shall be evaluated at least every four (4) hours by health care staff (except when only a bed restraint net, wheelchair seatbelt, or Posey vest is being used). The results of the evaluation shall be documented in the resident's electronic health care record. If the health care staff believes that the use of therapeutic restraints is no longer necessary, the staff shall contact the physician, physician assistant, or nurse practitioner requesting an order to discontinue the use of the restraints. The request and the response to the request shall be documented in the resident's electronic health care record.

14. During the resident's hours of sleep, health care staff may elect not to awaken the resident to complete the evaluation. If health care staff elect not to awaken a sleeping resident, that fact shall be documented in the resident's electronic health care record.

15. In any case in which therapeutic restraints are used and bodily injury or compromise to health is apparent, the resident complains of bodily injury or

compromise to health related to the use of the restraints, or the security staff otherwise believes it is appropriate, the security staff shall notify appropriate health care staff as soon as possible. The notified health care staff shall take appropriate action, up to and including contacting the physician, physician assistant, or nurse practitioner to request an order to discontinue the use of the restraints. Any action taken shall be documented in the resident's electronic health care record.

16. A new order, including the reason for the continuation, must be written for every twelve (12) hour continuation in the use of therapeutic restraints (except when only a bed restraint net, wheelchair seatbelt, or Posey vest is being used). When a bed restraint net, wheelchair seatbelt, or Posey vest is being used, a new order must be written for every weekly continuation in the use of therapeutic restraints for the first two months and for every monthly continuation thereafter.

17. A physician, physician assistant, or nurse practitioner shall personally examine the resident within twenty-four (24) hours of the initial use of therapeutic restraints, if the use has not been discontinued in the meantime.

18. Health care staff shall immediately inform the facility Shift Commander and, if applicable, the IMHU Unit Manager, when the discontinuation of therapeutic restraints has been ordered, and health care staff and security staff shall jointly develop a plan for the removal of the therapeutic restraints by security staff using only the degree of nondeadly force reasonably believed to be necessary. The removal of the restraints shall be video recorded. In a case in which the purpose was to protect the resident from accidental injury, health care staff may remove the therapeutic restraints.

19. The Health Services Administrator, or designee, and the Chief Administrative Officer, or designee, shall be notified by health care staff as soon as practicable of any order for the use of therapeutic restraints and of any order to discontinue the use of the restraints.

20. Records relating to the use of therapeutic restraints shall be maintained in the resident's electronic healthcare record as set forth in Department Policy (AF) 18.9, Health Care Records and shall, as applicable, in addition to the documentation required above, include, but not be limited to, the following:

    a. the original order for therapeutic restraints and the related documentation required above;

    b. the plan for applying the restraints, if applicable;

    c. any new order and the related documentation required above;

    d. the initial assessment by health care staff and the assessments by health care staff every two (2) hours and the evaluations by health care staff every four (4) hours, if applicable;

    e. the examination within twenty-four (24) hours by a physician, physician assistant, or nurse practitioner;

f. the order for the discontinuation of therapeutic restraints, if applicable; and

g. the plan for removing the restraints, if applicable.

21. The Chief Administrative Officer, or designee, shall arrange for a debriefing related to the use of therapeutic restraints following each incident, to include attendance by supervisory security and health care staff, with the debriefing documented and entered into CORIS as part of the documentation related to the incident, except when the restraints were ordered for the purpose of preventing accidental injury.

Procedure T: Therapeutic Restraints, Refusal of Medical Treatment

1. As set out above, therapeutic restraints may be used to provide necessary medical treatment to an adult resident who is refusing the treatment.

2. The therapeutic restraints shall be discontinued once the treatment is provided unless they are needed to prevent interference with the treatment after it is provided.

3. If the purpose of the restraints is to provide medical treatment to a resident who has a legal guardian, the following shall apply:

   a. the facility Chief Administrative Officer, or designee, shall assign a staff person to speak with the resident in an effort to persuade the resident to accept the treatment and that effort and the result of that effort shall be documented in the resident's electronic health care record;

   b. if the resident continues to refuse the treatment, an attempt shall be made to contact the resident's guardian for specific consent to provide the treatment and the attempt and the result of that attempt shall be documented;

   c. In addition to the required documentation relating to any use of therapeutic restraints, and in addition to obtaining the consent of the resident's guardian (or, if applicable as set out below, in addition to obtaining a court order), the physician, physician assistant or nurse practitioner shall specify the medical reason for the treatment, including why less restrictive or less invasive treatment alternatives with return to voluntary treatment, as soon as clinically feasible**,** are not being used; when, where and how the treatment is to be provided; and the expected duration of the treatment, to include a plan for the use of less restrictive treatment alternatives as soon as possible. The documentation shall also include the determination that the treatment is necessary to avoid an immediate and serious risk to health and the guardian's consent (or court order).

   d. Security staff shall be present during the providing of the treatment. The resident's final refusal of the treatment immediately prior to its being provided and the providing of the treatment shall be video recorded. The resident shall be monitored for adverse reactions and/or side effects.

4. If the resident's guardian cannot be contacted and it appears that contact cannot be made in a reasonable period of time, the Chief Administrative Officer, or

designee, shall contact the Department's legal representative in the Attorney General's Office to inquire about obtaining the appointment of a different guardian, obtaining a court order for involuntary treatment, or taking other appropriate action. Note: a court order may be requested for involuntary medical treatment regardless of the resident's capacity to make an informed decision regarding the treatment.

5. If the purpose of the restraints is to provide medical treatment to a resident who does not have a legal guardian, the following shall apply:
   a. the facility Chief Administrative Officer, or designee, shall assign a staff person to speak with the resident in an effort to persuade the resident to accept the treatment and that effort and the result of that effort shall be documented in the resident's electronic health care record;
   b. if the resident continues to refuse the treatment, the Chief Administrative Officer, or designee, shall contact the Department's legal representative in the Attorney General's Office to inquire about obtaining the appointment of an emergency guardian, obtaining a court order for involuntary treatment, or taking other appropriate action. Note: a court order may be requested for involuntary medical treatment regardless of the resident's capacity to make an informed decision regarding the treatment.
   c. In addition to the required documentation relating to any use of therapeutic restraints, and in addition to obtaining a court order (or the consent of an emergency guardian), the physician, physician assistant or nurse practitioner shall specify the medical reason for the treatment, including why less restrictive or less invasive treatment alternatives with return to voluntary treatment, as soon as clinically feasible**,** are not being used; when, where and how the treatment is to be provided; and the expected duration of the treatment, to include a plan for the use of less restrictive treatment alternatives as soon as possible. The documentation shall also include the determination that the treatment is necessary to avoid an immediate and serious risk to health and the court order (or emergency guardian's consent).
6. Security staff shall be present during the providing of the treatment. The resident's final refusal of the treatment immediately prior to its being provided and the providing of the treatment shall be video recorded. The resident shall be monitored for adverse reactions and/or side effects.

Procedure U: Therapeutic Restraints, Interference with Medical Treatment

1. As set out above, therapeutic restraints may be used to prevent an adult resident from interfering with medical treatment.

2. In an emergency situation, security staff may restrain a resident who is interfering with treatment to prevent an immediate and serious risk to health until a decision can be made on whether to order therapeutic restraints. If the Shift Commander determines it appropriate, the Shift Commander shall contact appropriate health care staff as soon as possible after security staff have restrained the resident to

request that a physician, physician assistant, or nurse practitioner determine whether an order for therapeutic restraints is clinically appropriate.

3. If therapeutic restraints are ordered to prevent interference with treatment, the Shift Commander shall place the resident on a constant watch.

4. While the resident is in the restraints, the resident shall be under constant direct visual observation by security staff, who shall keep a constant watch in accordance with post orders, using the security watch log

Procedure V: Medical Therapeutic Seclusion

1. Therapeutic seclusion authorized for a medical reason may be used only when the safety or health of the resident or others cannot be protected by less restrictive means. The following provisions shall be adhered to any time therapeutic seclusion is used in resident care:
   a. therapeutic seclusion may not be used for punishment;
   b. if therapeutic seclusion is used, it shall be used only for the period of time necessary;
   c. therapeutic seclusion may be ordered only by a physician, physician assistant or nurse practitioner. The documentation shall include the order, the medical reason for the order, and the justification for using seclusion; and
   d. a facility physician, physician assistant or nurse practitioner shall personally examine the resident within twenty-four (24) hours of the initial use of therapeutic seclusion if the use has not been discontinued in the meantime.

2. A therapeutic seclusion order shall be obtained by health care staff prior to the initiation of the use of therapeutic seclusion. In an emergency situation, to protect the health or safety of the resident or others, staff may isolate the resident until the order for therapeutic seclusion is obtained.

3. A therapeutic seclusion order shall be documented by the health care staff in the resident's electronic health care record.

4. Health care staff shall immediately inform the facility Shift Commander when therapeutic seclusion has been ordered.

5. The movement of the resident to therapeutic seclusion shall be done by security staff.

6. Log book entries shall include the name and title of the physician, physician's assistant or nurse practitioner authorizing seclusion, names and titles of all persons visiting the resident, records of time checks, the name of the health care staff authorizing release from seclusion and the time of release from seclusion.

7. The need for continued therapeutic seclusion of the resident shall be reevaluated at least every twenty-four (24) hours by health care staff. If the health care staff

believes that the use of therapeutic seclusion is no longer necessary, the staff shall contact the physician, physician assistant, or nurse practitioner for an order to discontinue the use of seclusion.

8. Staff having personal contact with the resident or entering the seclusion area shall follow all seclusion protocols as required by the Medical Director.

9. Health care staff shall immediately inform the facility Shift Commander when the discontinuation of therapeutic seclusion has been ordered.

10. The movement of the resident from therapeutic seclusion shall be done by security staff.

11. The Health Services Administrator, or designee, and the Chief Administrative Officer, or designee, shall be notified by health care staff as soon as possible of any order for the use of therapeutic seclusion and of any order to discontinue the use of the seclusion.

Procedure W: Checks by Health Care Staff of Security Restraints

5-ACI-3A-18

1. If health care staff is notified that an adult resident has been restrained using five-point restraints, including the use of a restraint chair, by security staff, the health care staff shall assess the resident's medical and mental health condition as soon as possible, and shall advise whether, on the basis of serious danger to self or others, the resident should be placed in the infirmary or the Intensive Mental Health Unit (IMHU) for emergency involuntary treatment with sedation (permissible only with the consent of a resident's legal guardian, if any, or pursuant to a court order) and/or other medical management, as appropriate.

2. If the resident is not transferred to the infirmary or the IMHU and the use of five-point restraints is continued, health care staff shall assess the resident at least every two (2) hours thereafter to make recommendations on medical care and adjustment or repositioning of restraints of the resident as necessary. The following shall be checked:

   a. circulation, movement, and sensation in extremities;

   b. respiratory status;

   c. mental status;

   d. vital signs;

   e. that food, water, and use of the toilet has been offered as appropriate, and

   f. that the resident has been offered the opportunity to have each limb removed separately from restraints for the purpose of movement every two (2) hours as appropriate.

3. During the resident's hours of sleep, health care staff may elect not to awaken the resident to complete the assessment.

4. The results of the assessment shall be documented in the resident's electronic health care record, including any reason for security staff not offering food, water, use of the toilet, or movement of restrained limbs. If health care staff elects not to awaken a sleeping resident, that fact shall be documented in the resident's electronic health care record.

Procedure X. Chemical Agent Decontamination

1. In a situation in which an adult resident has been exposed to a chemical agent at a facility, nursing staff, if available, shall, when it is safe to do so, provide decontamination consistent with the chemical agent manufacturer's recommendations regarding decontamination, to the extent those recommendations are not contradicted by any applicable nursing pathways.

2. If nursing staff is not available, security staff shall, when it is safe to do so, provide decontamination consistent with the chemical agent manufacturer's recommendations regarding decontamination.

3. Decontamination shall include a cleansing of the resident's eyes, face, and all exposed skin.

4. Following decontamination, staff shall observe the resident as necessary for any medical complications from the chemical agent exposure.

5. In a situation in which a resident has been exposed to a chemical agent in the community (e.g., during a transport), decontamination of the resident shall be completed by emergency medical services (EMS) personnel, if available. When EMS is not available, facility staff shall transport the resident to the nearest Department facility or to a health care facility for decontamination, if practicable. If not practicable, facility staff shall follow the manufacturer's recommendations for decontamination to the extent practicable.

6. Health care staff shall document decontamination and observation of the resident in the resident's electronic health care record and, if applicable, in an incident report as required by Department policy.

7. Other facility staff shall document the incident, including any decontamination and observation performed by that staff, as required by applicable Department policy.

Procedure Y: Medical Research

1. Disclosure of medical information for purposes of research must comply with all legal requirements, including the requirement for authorization by the Commissioner, or designee, and Department Policy 1.24, Research, Evaluation, and Performance Measurement.

2. The Department of Corrections does not permit experimental medical treatment or other experiments on its adult residents.

VIII. PROFESSIONAL STANDARDS

ACA

5-ACI-3A-18 **(MANDATORY) Four/five-point restraints are used only in extreme instances and only when other types of restraints have proven ineffective or the safety of the inmate is in jeopardy. Advance approval is secured from the facility administrator/designee before an inmate is placed in a four/five-point restraint. Subsequently, the health authority or designee must be notified to assess the inmate's medical and mental health condition, and to advise whether, on the basis of serious danger to self or others, the inmate should be in a medical/mental health unit for emergency involuntary treatment with sedation and/or other medical management, as appropriate. If the inmate is not transferred to medical/mental health unit and is restrained in a four/five-point position, the following minimum procedures are followed:**

- **Direct visual observation by staff is continuous prior to obtaining approval from the health authority or designee.**
- **Subsequent visual observation is made at least every 15 minutes.**
- **Restraint procedures are in accordance with guidelines approved by the designated health authority.**
- **All decisions and actions are documented.**

5-ACI-6A-04 **Continuity of care is required from admission to transfer or discharge from the facility, including referral to community-based providers, when indicated. Offender health care records should be reviewed by the facility's qualified health care professional upon arrival from outside health care entities including those from inside the correctional system.**

5-ACI-6A-07 **A written individual treatment plan is required for offenders requiring medical supervision, including chronic and convalescent care. This plan includes directions to health care and other personnel regarding their roles in the care and supervision of the patient and is developed by the appropriate health care practitioner for each offender requiring a treatment plan.**

5-ACI-6A-18 **(MANDATORY) There is a plan for the treatment of offenders with chronic conditions such as hypertension, diabetes, and other diseases that require periodic care and treatment. The plan must address:**

- **The monitoring of medications.**
- **Laboratory testing.**
- **The use of chronic care clinics.**
- **Health record forms.**
- **The frequency of specialist consultation and review.**

5-ACI-6A-19 **There is a defined scoped of available dental services upon admission, which includes the following:**

- **Dental Screening upon initial admission into the System by a qualified health care professional or health trained professional;**
- **Oral hygiene, oral disease education and self-care instruction that are provided by qualified health care personnel within 30 days of initial admission into the System.**
- **Dental Intake Assessment by a dentist within 30 days of initial admission into the System to assess dental pain, infection, disease, or impairment of function and establish the overall dental/oral condition. Consultation and referral to appropriate specialists are provided when medically necessary.**

5-ACI-6A-19-1 **(Effective NLT July 1, 2021) Emergent, urgent, and routine dental care is provided to each offender under the direction and supervision of a licensed**

dentist. There is a defined scope of available dental services with related timeframes. Dental examination and treatment include the following:

- **Appropriate uniform dental record using a numbered system such as the Federation Dental International System**
- **A medical history, current medications**
- **Current vital signs prior to invasive procedure**
- **Appropriate Radiographs**
- **Periodontal Screening and Recording (PSR) or a recognized periodontal health assessment**
- **Priority of Treatment**
- **Treatment Provided within acceptable designated timeframes by Priority**
- **Consultation and referral to appropriate specialists is provided when medically necessary.**

5-ACI-6A-40 **Medical or dental adaptive devices (eyeglasses, hearing aids, dentures, wheelchairs, or other prosthetic devices) are provided when medically necessary, as determined by the responsible health care practitioner being governed by institutional policy respecting treatment classification, resource availability and treatment planned timeframes.**

5-ACI-6A-41 **(MANDATORY) Withdrawal management is done only under medical supervision in accordance with local, state, and federal laws. Withdrawal management from alcohol, opiates, hypnotics, stimulants, and sedative hypnotic drugs is conducted under medical supervision when performed at the facility or is conducted in a hospital or community treatment center. Specific guidelines are followed for the treatment and observation of individuals manifesting mild or moderate symptoms of intoxication or withdrawal from alcohol and other drugs. Offenders experiencing severe, life-threatening intoxication (an overdose), or withdrawal are transferred under appropriate security conditions to a facility where specialized care is available.**

5-ACI-6B-09 **First aid kits are available in designated areas of the facility based on need and an automatic external defibrillator is available for use at the facility. The health authority approves the contents, number, location, and procedures for monthly inspection of the kits(s) and develops written procedures for the use of the kits by nonmedical staff.**

5-ACI-4B-28 **(MANDATORY) When an offender is transferred to Restrictive Housing, health care personnel will be informed immediately and will provide a screening and review as indicated by the protocols established by the health authority. The mental health portion of the screening should include at a minimum, but is not limited to:**

Inquiry into:

- **whether the offender has a present suicide ideation**
- **whether the offender has a history of suicidal behavior**
- **whether the offender is presently prescribed psychotropic medication**
- **whether the offender has a current mental health complaint**
- **whether the offender is being treated for mental health problems**
- **whether the offender has a history of inpatient and outpatient psychiatric treatment**
- **whether the offender has a history of treatment for substance abuse**

Observation of:

- **general appearance and behavior**
- **evidence of abuse and/or trauma**
- **current symptoms of psychosis, depression, anxiety, and/or aggression**

Disposition of offender:

- **no mental health referral**
- **referral to mental health care service**
- **referral to appropriate mental health care service for emergency treatment**

If the results of the inmate screening indicate the inmate is at imminent risk for serious self-harm, suicide, exhibits debilitating symptoms of a SMI, or requires emergency medical care, a health care professional shall be contacted for appropriate assessment and treatment.

Unless medical attention is needed more frequently, each offender in Restrictive Housing receives a daily visit from health care personnel to ensure that offenders have access to the health care system. The presence of health care personnel in Restrictive Housing is announced and recorded. The health authority determines the frequency of physician visits to Restrictive Housing units.

Unless mental health attention is needed more frequently, each offender in Restrictive Housing shall receive a weekly visit from mental health staff to ensure that offenders have access to the behavioral health system. The presence of a mental health staff in Restrictive Housing is announced and recorded. The mental health authority determines the frequency of mental health professionals to Restrictive Housing units.

5-ACI-6C-05 **There are guidelines that govern elective procedures for surgery for offenders.**

5-ACI-6C-06 **There is consultation between the facility and program administrator (or a designee) and the responsible health care practitioner (or designee) prior to taking action regarding chronically ill, physically disabled, geriatric, seriously mentally ill, or developmentally disabled offenders in the following areas:**

- **housing assignments**
- **program assignments**
- **disciplinary measures**
- **transfers to other facilities**

  When immediate action is required, consultation to review the appropriateness of the action occurs as soon as possible, but no later than 72 hours.

5-ACI-6C-13 **(MANDATORY) The use of restraints for medical and psychiatric purposes is defined, at a minimum by the following:**

- **conditions under which restraints may be applied**
- **types of restraints to be applied**
- **identification of qualified medical or mental health care practitioner who may authorize the use of restraints after reaching the conclusion that less intrusive measures would not be successful**
- **monitoring procedures for offenders in restraints**
- **length of time restraints are to be applied**
- **documentation of efforts for less restrictive treatment alternatives as soon as possible**
- **an after-incident review**

5-ACI-6C-15 **Exercise areas are available to meet exercise and physical therapy requirements of individual offender treatment plans.**

4-ACRS-4C-05 **First aid kits are available in designated areas of the facility. Contents and locations are approved by the health authority. An automatic external defibrillator is available for use at the facility.**

4-ACRS-4C-11 **Access to dental care is made available to each offender.**

4-ACRS-4C-17 **If treatment is provided by health-care personnel other than a physician, dentist, psychologist, optometrist, podiatrist, or other independent provider, such treatment is performed pursuant to written standing or direct orders by personnel authorized by law to give such orders.**