

APPENDIX 2

RJD CORRECTION FACILITY

RECEPTION PROJECT

SEPTEMBER 8, 2008

DAVID VERCOE

Work Plan

RJD Site Work Plan

	Tasks	Who	Status	Start	Finish
Week 1				9/8/08	9/12/08
1	Develop: a flow map of the actual intake process; include "work arounds" and regular practices of everyday intake. Each discipline will present their intake process.	R/C team; analyst to record and distribute on week two			
2	Review new reception plan and materials	NCPR, Team Lead, Proj Manager			
3	Address established training requirements. Training will be scheduled and provided by the project team with field staff assistance if available. Schedule training to be completed within 45 days.	NCPR, DON			
4	Present Pre survey tool of incoming population and committee agenda	Team Leader, NCPR, Analyst			
Week 2				9/15/08	9/19/08
1	Discuss flow plan and address hurdles/changes for each discipline and how to comply with policy. Include discussion of staffing issues and thoughts to development of staffing plan in week #3.	R/C team			
2	Plan coordination of jails with Records/Intake Department. Implement the established coordination plan with timetables. Plan face to face meeting with jail representatives if deemed necessary.	AW and analyst			
3	Develop a committee corrective action plan with action steps for processes and activities that are identified to be changed. Coordinate interdisciplinary services and shared support staff to establish one management tool for the committee. This plan will be reviewed each subsequent week by the committee. This begins the weekly action plan.	all stakeholders, Team lead, analyst to provide updated action plan to all members each week.			

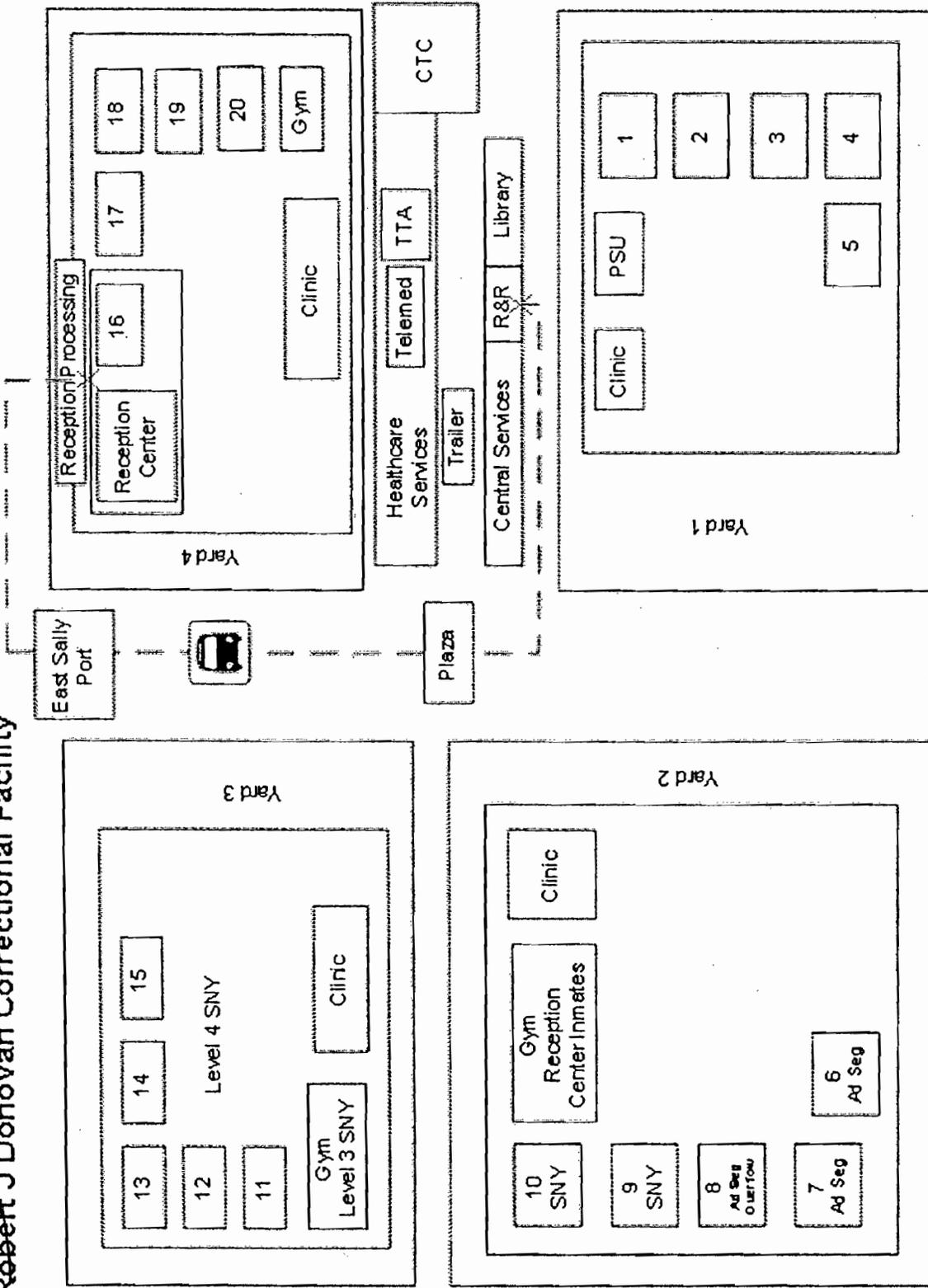
RJD Site Work Plan

4	Evaluate any remaining physical space problems, proposed work flow, transports, and significant problems or barriers to implementation.					
Week 3						9/16/08
1	Review on-going committee action plan of how the new model will function; which includes all disciplines, custody, functions and timelines.	R/C team				9/2/08
2	Evaluate the most expedient process for accessing lab data at Intake and review coordination of all information.	CMO, CHSA				
3	Identify point person(s) for directing the flow of inmates.	DON				
4	Stakeholder managers and supervisors evaluate and prepare current adequacy of staff; plan reception assignments and reallocate accordingly based upon required hours of operations in R/C. Coverage must include adequate custody, transport, nursing, dental, mental health, medical, lab and support staff. Review staff schedule changes and notification to staff to accommodate the reception needs for medical, dental and mental health staff.	Supervisors				
5	Begin PDSA trials if appropriate.					
Week 4						9/29/08
1	Review on-going committee action plan of how the new model will function; which includes all disciplines, custody and functions. Include review of staffing changes needed.	R/C Team, NCP, DON				
2	Initiate procurement for resources such as equipment, IT (e.g. faxes, computers and phones) in reception. Create a resource list, responsibilities and timelines. Develop and integrate into the on-going committee action plan to present on week 5.	all stakeholders				
3	Plan for contingencies. The committee will need to enlist the services of the Business Office for structural needs, staff hiring and procurement.					

RJD Site Work Plan

4	Schedule and track installation of necessary hardware and electrical power	AW, CHSA				
Week 5					10/6/08	10/10/08
1	Review and discuss the <i>committee action plan</i> , needs assessment and required resources and procurement for R/C.	R/C Team, NCPR, CMO, CHSA				
2	Disseminate the reception status at various staff meetings such as provider's, warden's, Access Team, and other relevant staff meetings. Disseminate notification through inmate MAC meetings, newsletters etc utilizing the established PowerPoint presentation. Discuss communication efforts.	AW, Team Leader, CHSA, NCPR, CMO				
3	Review and evaluate any additional training needs; schedule training and continue to identify any deficiencies.	NCPR, nurse educator				
4	Present coordinated plan for inmate escort with R/C committee	AW, Access to Care transport team				
Week 6						
1	Review R/C tracking tools, procedures for identification, care and follow up of high risk patients at intake. Designate Intake RN positions to begin care management.	DON, CMO, NCPR			10/13/08	10/17/08
2	Continue problem solving, review <i>committee action plan</i> .	NCPR, CHSA, Analyst				
3	Define process changes; conduct PDSA trials on any identified processes. Ensure that all staff has a clear understanding and "buy-in" of the new reception process.	Team Leader				

RICIARDI
Robert J Donovan Correctional Facility





Ad Seg 7

Ad Seg 6

Ad Seg 8
Workshop

SNY 6

Yard 2

SNY 10

Gym
Reception
Center Inmates

Clinic

Gym
Level 3
SNY

Yard 1

4

3

2

1

PSU

Clinic

Library
RAR
Central Services
Tailor
Healthcare Services
TTA
TGI

Clinic

Gym

20

Yard 4

19

18

17

16

Reception
Center
Reception Processing

East
Sally Port

Level 4 SNY

Yard 3

13

12

11

14

15

Donovan State Prison Rd

Introduction

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Project Overview

Project Data Sheet

Project Name: Reception Center Process Improvement

Project ID: Access to Care – R&R
Project Sponsor: Jamie Mangrum, CIO
Project Manager: David Vercoe
Start Date: 07/01/08
Estimated Finish Date: January, 2010
Updated by: David Vercoe (09/03/08)

Project Goal Statement:

The Reception Center process will provide comprehensive screening on the day of the arrival to prison, providing the foundation of care management by establishing identification and timely treatment of contagious diseases, acute and chronic illness, or other health problems.

Project Tradeoff Matrix

	Not Flexible	Somewhat Flexible	Most Flexible
Resources		X	
Schedule			X
Scope	X		

Deliverables

1. Plan-Do-Study-Act assessment of reception processes.
2. Monthly reporting to Senior Leadership.
3. Rollout of new processes to twelve Reception Centers.
4. Ongoing evaluation and mentoring of Reception health care teams.

Major Milestones

Milestones	Planned	Actual
Determine pilot site	August, 2008	August, 2008
Hire project staff including physicians, project managers, nurses and leaders	Summer, 2008	Summer, 2008
Naming of appropriate staff, Subject Matter Experts, etc	Summer, 2008	Summer, 2008
Pilot site completion	December, 2008	
Assessment complete – Remaining Sites	June, 2009	
Implementation Complete	January, 2010	

Dependencies/Constraints

1. Adequate staffing will be provided.
2. Funding will continue as planned.
3. Designated Staff at all Reception sites will become actively engaged in the project.
4. All key staff will remain in place throughout the entirety of the project.

Project Core Team Members

Team Members	Role
Annette Lambert	Access to Care Team Lead
Jayne Russell	Reception Team Lead
Mary Ann Simanello, RN, PhD	State-wide Nursing Consultant
Darrin Dennis, RN	Regional Nursing Cons.
Dr. Brett Williams	A2C Clinical Manager
Dr. Grace Song	Reception Clinical Mgr.
Doug Mudgett, RN	Nursing Manager
Michael McDonald	Custody Representative
David Vercoe, PMP	Project Manager
Project Subject Matter Experts	Health Care Managers Physician Champions
Site Subject Matter Experts	Associate Wardens Local Nurse Champion Local Physician Champion

Key Project Work Products

1. Key Indicator Reports

Successful Completion Criteria

1. All Reception Center inmates are individually interviewed and screened by the RN, Mid-level or Provider.
2. Initial Health Screening form is completed for each patient.
3. 100% of incoming Reception Center inmate-patients will be screened on day one by all disciplines and documented on the Reception Checklist.

Issues/Risks

1. Change management is challenging, difficult to measure and hard to sustain.
2. Space constraints at the institutions make new processes difficult to implement.
3. Adequate resources may not be sustainable.
4. Project timeframes are very aggressive.

Project Organizational Structure

- Executive Steering Committee
- Co sponsors - Mental Health & Dental
- Access to Care Implementation Team
- Reception Core Team – (Regional, State-wide support)
- Local Institution Reception Team

Access to Care Functional Structure

Affiliated Teams

Executive Steering Committee

Chief Executive Officer Medical Services
Chief Nurse Executive
Chief Physician Executive
Chief Information Officer
Director, Plata Support Services
Chief Medical Information

Access to Care Implementation Team

Chief Medical Officer, Quality and Safety
Clinical Manager
Correctional Administrator
Correctional Captain
Medical Consultant
Staff Services Manager II, Receiver Support Unit
Staff Information Systems Analyst
Project Managers
Team Lead

Reception Center / Receiving and Release Core Team

Team Lead
Project Manager
Physician Consultant
Reception Physician
Nursing Consultant
Supervising RN
AW, Healthcare
AW, Reception
Custody Rep.
Analytical Support
Clerical Support

RECEPTION IMPLEMENTATION GUIDE

September 8, 2008

Reception Scope:

All Access-to-Care projects are dependent upon a multi-disciplinary, collaborative effort. The local Reception Project Team with the aid of the Access-to-Care Team will create, continuously improve, and sustain an efficient and stream-lined Reception Process.

GOVERNANCE, ROLES AND RESPONSIBILITIES

- The organizational structure represents leaderships groups with primary responsibilities for implementing change within CDCR. All stakeholders are tasked to support and implement standardized intake reception in all designated reception prisons.
- The core team reports to the exec leadership and is the essential off-site working team that coordinates and monitors development and implementation progress of the reception program. This team will provide consultation, collaboration, and technical support to the sites in all regions. All team members will have a strong working knowledge of the reception program.
- Co-sponsors will include all respective disciplines, with significant roles in the Reception plan such as custody, medical, mental health and dental services. The co-sponsors will ensure communication and coordination in their roles and responsibilities as integral members of the on-site committee.
- The Team Leader will coordinate all central activities and provide direction to various groups and teams. This person will be accessible to all teams both upward and downward and assist with resolutions to any issues; raise problems encountered or required interventions at the sites to the Access to Care team. The Core Team will be accountable to CPR leadership to disseminate status progress and reports.
- The Project Manager will organize the team, develop charts, track activities and prepare reports. The PM will ensure that activities are completed within timelines utilizing project management tools. He will disseminate timely information and take primary responsibility for documentation and deliverables in conjunction with the SSA.

- Staff Services Analyst will work with the pilot sites and other team members to help modify, supplement and enhance the program to ensure smooth implementation and improvement strategies. This team member may jointly chair the weekly committee with the NCPD and ensure weekly deliverables. He/she will facilitate data collection and evaluation, and collaborate with other initiatives such as sick call, chronic care programs and electronic systems component.
- Physician Clinical Manager will provide clinical expertise including training and monitoring of clinical functions within reception.
- NCPD and Nursing Consultants: This support component will include monitoring activities such as coordination with care management, nursing assessments, triage and referral, and medication delivery. Team members will assist the on-site staff with development, implementation and evaluation of the reception program.
- Clerical support will consist of an OT at the regional office and designated assistance from RJD support staff.
- On-site health care organization and leadership will consist of key staff. These staff will serve in essential roles to develop and implement the Reception Center program. Assistant Warden for Health Care will provide necessary custody-health care linkage and coordination. They will work with the reception site to establish and support integration of activities for smooth service delivery. They will champion space and operational needs to meet objectives and goals. The AW for Health Care will disseminate systematic communication and reports to the Warden's Office.
- The on-site team/committee members will consist of the designated stakeholders and will meet weekly on site: They will represent
 - Administration
 - Medical
 - Nursing
 - Custody Reception Staff
 - Custody transport staff
 - Mental Health
 - Dental
 - Pharmacy
 - Lab & X Ray
 - Medical Records
 - Pharmacy
 - Clerical support
 - Others as needed

INTAKE RECEPTION PROGRAM AND GOALS

- The CDCR reception program will create a standardized intake assessment model that can be implemented and replicated at every Reception Prison in California. The model will conform to best practices and reflect efficient work flow. It is not to be designed around facilities but rather, standardizations. It will promote measurable and reliable access to care with systematic data and patient tracking.
- All incoming Reception inmate-patients will receive screening and assessments on the day of arrival to the Reception Center by medical, dental and mental health professionals. This integrated and comprehensive approach will ensure timely follow up of high risk patients and delivery of necessary medications on day one. RN's will begin the process for identification and treatment of all inmate-patients with significant health needs. The Reception model shall stratify inmates by age and medical needs. It will allow young, healthy inmates to access health care as needed, thus proposing a substantial change in reception screening and evaluation. The new process will eliminate the need for each inmate patient to be seen by a provider unless medically warranted. Providers are then able to focus care and treatment on those inmates identified as chronic or high risk patients, allowing those healthy individuals to access care as needed. This is the model developed at San Quentin. This model is a starting base to improve upon, build and redesign as the RJD team feels appropriate. We will use "lessons learned" but are not held to these practices.
- The mission statement incorporating the changes will ensure that:
100% of incoming inmates will receive an RN screening/assessment or according to defined indicators of health risk or age, inmate patients will be referred to a reception provider.
- 100% of inmate patients will receive initial lab testing, communicable disease screening, dental and mental health evaluation on day one.
- Inmates who are CDCR inter facility transfer, enrouters, or other categories of overnight will receive modified screenings as defined in existing policy.

- The implementation phase is a six month project that includes:
 - 0-2 months pre survey assessment, resolution of physical barriers, training and orientation
 - 4-6 months implementation phase and evaluation according to work plan
 - Post 6 months -Continued tracking and modification; routine reports
- In order for the program to succeed with measurable results, all stakeholders, custody and health care staff must commit to development and implementation of this new structure and organizational change. The outcome will benefit not only custody and health care but particularly inmate-patients. These collaborative efforts will increase efficiency, sharing of vital operational information and improved use of resources and space.

BENEFITS

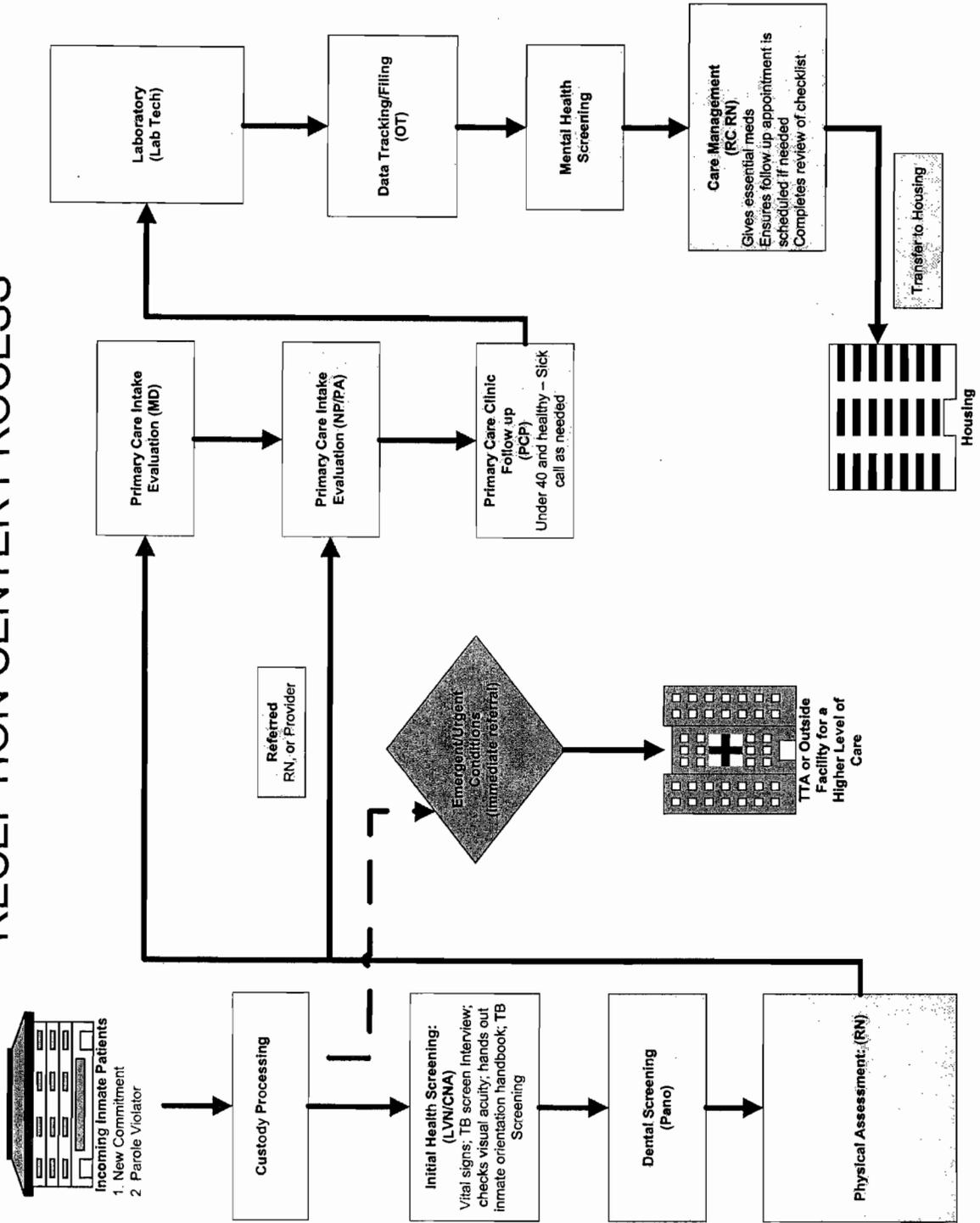
Improving intake evaluation at the front door; triaging inmate –patients to appropriate levels of care creates a positive institution-wide impact. You will experience:

- Significant decrease in the number of overall transports and movement
- Reduced trips to the TTA allowing uninterrupted evaluation of urgent medical needs as the TTA was intended; decreased hospital costs
- Improved custody/health care coordination
- Streamlined and decreased clinic volumes by eliminating the consuming priority of scheduling intake exams.
- Prompt care and treatment of high risk, chronic care patients allowing for less wait time and better clinical management by the PCP.
- Improved critical interdisciplinary collaboration
- Same day delivery of necessary medications
- Cost effective and efficient practices of allowing healthy inmates to request care as the need may arise; reduced duplication of services.

A FLOW MAPPING PROCESS

- Will be developed to provide a visual of how the process will work. (Reception Center Flow Plan sample is provided)

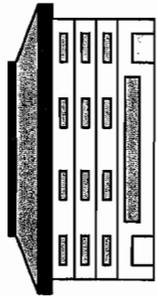
RECEPTION CENTER PROCESS



A six month project that includes:

- Month 1:
Pre-survey assessment, planning and orientation, strategies for physical barriers and project tracking, study intake process flow, development of weekly action plan
- Month 2
Staff training, inmate escort plan and process, new process trials, PDSA cycles, program evaluation plan
- Month 3
GO LIVE
Documentation and approvals
Continue new process trials
- Months 4 through 6
Tracking, Modifications, Reporting

Project Timelines



Reception Site

Months 1 and 2

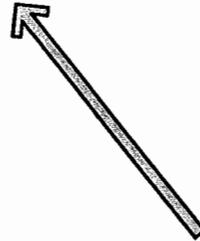
Complete baseline data survey



Test new processes where possible



Conduct Training
Procure equipment and supplies



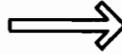
Month 3

GO LIVE
Continue PDSA trials



Months 4 - 6

Conduct on-going assessment and adjustments



Continue evaluation and data collection



Assess outcomes

TRAINING

Separate training modules will consist of:

- RN nursing assessment and comprehensive skills monitoring
- Training by dentists in oral screening
- Training for nurses to improve mental health referrals
- Care Management procedures (to be developed and coordinated with pilot in the future)
- Data collection, tracking and maintenance of logs and reports
- On-going data management and policy compliance; rapid cycle quality improvement
- Other training as identified

ON-GOING RESPONSIBILITIES

- An inadequate staffing team and/or policy requirements will impact the success of the project and the facilities' ability to comply with timelines. An example of this would be an intake population at SQ that exceeded its capacity of 90. When it exceeded 90 inmates, nurses cut corners and did not do assessments.
- The HC Manager, AW, Health Care, and Reception staff must maintain daily monitoring of incoming populations
- An SRN II must be located in the reception area for daily oversight and supervision. The nurses and other staff assigned to Reception must be vigilant and committed to this new process.
- Staff schedules, including support services such as pharmacy must conform to the shift times and needs of the program.
- Access transport teams must work concurrently with health care staff, lending dependability and support

RECEPTION FACILITY

- The Receiver's Office acknowledges competing demands for space and interim limitations until such time that statewide construction projects are completed in 2011.
- Each prospective reception facility must be assessed for physical space capability to implement the reception model. Proximity to medical, dental, mental health and lab screening services are necessary to conduct coordinated and integrated intake reception.
- We must creatively and collectively resolve immediate problems such as physical barriers, staffing, or staff that are poorly trained with low expectations. Reception assessment is a critical first step in the success of Access to Care initiatives. The Reception policies and practices must receive full dedication and support.

EQUIPMENT AND SUPPLIES

- There are some necessary items required to maintain regular communication and access to critical information.
- Reception areas require computers for Office Technicians, physicians, lab, and mental health staff.
- Copier, fax machines and telephones
- Suitable equipment and supplies for exam rooms

PROJECT TIMELINES AND PROJECT PLAN

- Work plan from 0-6 months
- Consultation Team will move to subsequent sites with on-going revisions and enhancements as needed.

POST ACTIONS REQUIRED

- Introduce care management policies and training (to be developed in future) for further collaboration of initiatives.
- Provide subsequent enhancement of the intake process regarding TB testing and communicable disease screening in accordance with future public health policy development and changes.
- Release policies must be updated and revised
- Release processes must be improved to include more timely notice of notification of release
- Provide planning and collaboration to design an electronic information system for improved access to essential information at intake and reciprocal sharing of release medical information.

REPORTING STRUCTURE AND COMMUNICATION PLAN

- Reception Committee weekly meeting and minutes; meet with team leader twice monthly
- Warden's meetings bi-weekly briefings
- Monthly Project Lead briefings –Exec. Team Sacramento
- Weekly updates and monthly metrics to sponsors

Draft..

Forms & Policies

DRAFT – RECEPTION CENTER PILOT, RJD)

STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION	Policy and Procedure #03-006 Approval Date: DRAFT Amended Date: September 2008
	Initial Health Screen and Physical Assessment - Reception Center

POLICY:

Every person newly committed or returned to the custody of the California Department of Corrections and Rehabilitation (CDCR) shall be given an initial health screen and physical assessment in the Reception Center (RC) to evaluate for contagious diseases, acute and chronic illness, or other health problems.

PURPOSE:

To identify and treat medical, dental, and mental health needs in a timely matter and provide the foundation for on-going interdisciplinary care and case management of chronic illness.

RESPONSIBILITY:

Reception Center Health Care Services (HCS) Staff: medical, nursing, dental, mental health, laboratory, and administrative support staff

Access to Care Custody Staff

HCS Administration Staff: Chief Medical Officer, Director of Nursing, Health Care Manager, Chief Dental Services, Chief Psychiatrist, Chief Psychologist, Associate Warden, Health Care Services, and Correctional Health Services Administrator

PROCEDURE:

A. General Requirements – HCS Staff Role and Responsibilities

1. HCS staff assigned to the RC shall be responsible for establishing a physical, dental, and mental health status baseline for providing primary care management to each inmate-patient.
2. All inmate-patients shall be given an initial health screen and hands-on physical assessment by a registered nurse (RN) on day one (1) of arrival to the institution.
3. All inmate-patients assessed by the RN as needing a physical examination shall be referred to the RC physician and/or midlevel provider (MLP) on day one (1) of arrival to the institution.
4. Identified health problems shall be documented by the physician or MLP on the *Problem List* CDCR#XXXX. A therapeutic plan of care shall be developed for each problem. Inmate-patients with chronic disease shall be categorized and treated utilizing the Chronic Disease Model Program guidelines.
5. Inmate-patients who present with acute medical, dental, and/or mental health conditions and assessed as needing immediate treatment, shall be escorted to the Triage and Treatment Area (TTA) for further evaluation prior to being

B. Nurse Initial Health Screen (CDCR 7277) HCS Staff Role & Responsibilities

1. HCS staff shall perform an initial health screen using *CDCR 7277*. The initial health screen includes, but is not limited to health history, medical and communicable disease, developmental and physical disability conditions, mental health, and dental information. Data obtained shall be legibly documented by all persons and include signature, date, and time of entry. *CDCR 7277-A Initial Health Screen (Supplemental) Female Inmates* shall be completed for all female inmate-patients.
2. The Certified Nurse Assistant (CNA) or LVN shall obtain vital signs (temperature, pulse, respiratory rate, and blood pressure), height, weight, and visual acuity. Visual acuity is measured using the Snellen chart.
3. The LVN shall provide each inmate-patient a copy of the *Inmate-Patient Orientation Handbook to Health Care Services*. Disposition of provision shall be documented on the *CDCR 7277*.
4. The LVN shall review inmate-patients accompanying documentation of health information from the sending institution, i.e. tuberculosis (TB) test, pending appointments/procedures for specialty services, or current medication use. The sending institution should be contacted for discrepancies or clarification as necessary.
5. The LVN shall screen all inmate-patients for signs and symptoms of TB utilizing *CDCR 7331*. A TB skin test (TST) will be administered for reported history of negative TST. A chest radiograph will be administered for positive reported history of TB.
6. The LVN shall screen all inmate-patients for identification of certain health conditions, which may put the inmate-patient at risk for being susceptible to morbidity-related coccidioidomycosis (Valley Fever). (Refer to P&P Coccidioidomycosis Identification and Reporting).
7. The LVN shall screen all inmate-patients for current use of medical and/or dental assistive devices. All assistive devices brought into the institution, shall be documented on *CDCR 7277* and *CDC 7410 Comprehensive Accommodation Chrono*.
8. The LVN shall screen all inmate-patients for current medication use and document dose, frequency, and time the last dose was taken. Medications arriving with the inmate-patient shall be obtained from custody staff.
9. Inmate-patients with a reported history of diabetes and on oral agent anti-diabetic medication or insulin shall have their blood sugar checked by the LVN and the results documented on *CDCR 7277*, prior to being screened by the RN.
10. The RN shall review all inmate-patients accompanying documentation of health information from the sending institution and contact the institution for discrepancies or clarification as necessary.

11. The RN shall screen all inmate-patients for current pain by using the numerical rating scale (See Appendix A.).
12. The RN shall screen all inmate-patients for chronic and high-risk diseases and illnesses. Persons identified as such shall be referred to the physician or MLP on the same day of arrival for Chronic Care Program (CCP) and/or high-risk evaluation.
13. The RN shall screen all inmate-patients for current medical, dental, or mental health needs; previous hospitalizations and surgery; recent alcohol and/or street drug use; suicidal ideation; and psychotropic drug use.
14. Inmate-patients receiving any routine medications such as, but not limited to, anti-infective, asthma, oral agent anti-diabetic, insulin, psychotropic, or cardiac medications as evidenced by inmate-patient report and/or documentation from sending institution, shall be referred to the physician, MLP, and/or psychiatrist. In the event that the appropriate provider is not available and/or on-site to evaluate the inmate-patient, the RN shall take a telephone order for prescription renewal not to exceed a 30-day supply.

C. Nurse Physical Assessment (CDCR Form#...)

1. Based on assessment findings, identified health risks, individual needs and age, appropriate disposition and referrals shall be scheduled by the OT for the inmate-patient prior to housing unit placement.
2. The hands-on physical assessment shall be documented on the *RN Physical Assessment form CDCR #XXXX*. The *RN Guide to Physical Assessment – 5 Minute/5 Step Head-to-Toe Assessment* shall be used for completing the hands-on physical assessment.
3. Criteria for in-mate patients requiring a **complete**, hands-on Head-to-Toe physical assessment by the RN shall include:
 - a. Inmate-patients 39 years of age and younger **without** stated complaint or acute problem
 - b. Inmate-patients without medication(s)
 - c. Inmate-patients without diagnosed chronic illness/disease
 - d. Inmate-patients not referred to the RC physician or MLP
4. Criteria for inmate-patients requiring a **focused**, hands-on physical assessment by the RN shall include:
 - a. Inmate-patients of any age with stated complaint or acute problem
 - b. Inmate-patients being referred to the RC physician or MLP based on referral criteria and/or clinical judgment
5. Following the RN assessment, all inmate-patients will be instructed on the procedure to access prison health services in their assigned housing unit through the routine "Sick Call" process and utilizing *Health Care Services Request Form CDCR 7362*.

6. Inmate-patients not requiring a primary care intake evaluation and physical examination by the physician or MLP, shall be given a nursing clearance for housing in the general population based on established criteria (criteria needs to be established and a form developed)

D. Physician/MLP Physical Examination (CDCR Form#...)

1. Utilizing CDCR Form#...Primary Care Intake Form, the RC physician and/or MLP shall complete a focused physical examination on all inmate-patients referred by the RC RN on day one (1) of arrival to the institution.
2. The physician or MLP shall complete the appropriate section(s) of the *Reception Center Medical Clearance / Restriction Information Chrono (CDCR 128-C-1)*.
3. Criteria for inmate-patients requiring a primary care intake evaluation and focused physical examination by the physician or MLP include:
 - a. Inmate-patients 40 years of age and older (may be examined by the MLP)
 - b. Inmate-patients of any age currently on prescription medication(s) (may be examined by MLP)
 - c. Inmate-patients of any age with **one (1) chronic disease** and not high risk (may be examined by the MLP)
 - d. Inmate-patients of any age with **two (2) or more chronic diseases or at least one (1) high risk condition** (must be examined by the physician)
4. Inmate-patients not examined by the physician or MLP on day one (1) of arrival shall be referred by the provider to the housing unit PCP or MLP for completion of the initial primary care intake evaluation and physical examination based on the following schedule:
 - a. Inmate-patients 40 years of age and older must be examined within 14 calendar days
 - b. Inmate-patients of any age with **one (1) chronic disease** and not high risk must be examined within 7 (seven) calendar days
 - c. Inmate-patients of any age with **two (2) or more chronic diseases or at least one (1) high risk condition** must be examined within 7 (seven) calendar days

E. Mental Health (MH) Screen

1. All inmate-patients shall receive a MH screening on the first day of arrival at an RC, but no later than within the first seven (7) calendar days, to identify mental health concerns that may indicate a need for treatment.
2. Licensed MH staff shall perform MH screening using the approved and standardized MH screening tool(s) and questionnaire(s).
3. MH screening tests to be administered include:

- i. 31 Questionnaire (MH screen)
 - ii. Quick Test (cognitive screening)
 - iii. Test of Nonverbal Intelligence (TONI-Third Edition) (cognitive screen)
4. All inmate-patients who do not pass screening criteria and with possible mental health treatment needs shall be educated for further evaluation within 18 calendar days of arrival, and prior to any placement decision.
5. Licensed MH staff shall complete the appropriate section of the *Reception Center Medical Clearance / Restriction Information Chrono (CDCR 128-C-1)*.

F. Dental Screen

1. The RC dental assistant will take a Panorex X-ray on all inmate-patients during the RC intake process.
2. The RN shall perform an oral screen on all inmate-patients during the physical assessment phase.
3. Inmate-patients who present with an acute oral or maxilla-facial condition, which is likely to remain acute, worsen, or become life threatening without immediate intervention, shall be referred to Dental Services for emergency care and immediate treatment.
4. The dentist shall complete the appropriate section of the *Reception Center Medical Clearance / Restriction Information Chrono (CDCR 128-C-1)* within day two (2) of arrival to the institution.
5. Newly committed inmate-patients shall be educated for a comprehensive dental examination within 14 calendar days of arrival.

DEFINITIONS:

Chronic Disease – any medical problem that impacts or has the potential to impact an inmate-patient's functioning and long-term prognosis that has lasted, or is expected to last for more than six months. This includes, but is not limited to, cardiovascular diseases, diabetes mellitus, chronic infectious diseases, chronic pulmonary diseases, and seizure disorders.

Focused assessment/examination – process whereby the assessment/examination is targeted towards the area(s) and/or system(s) of complaint as stated by the individual.

High Risk Condition – subset of inmate-patients with chronic diseases, whose severity of illnesses or multiplicity of diseases with poor, ongoing disease control requires management by a PCP who is board certified in Family Practice or Internal Medicine.

Initial Health Screen – initial evaluation of current medical, dental and mental health status and laboratory studies to determine an inmate-patient's suitability for a particular treatment modality. Questions regarding communicable disease, acute and chronic illness, and medication use are addressed.

Intrasystem Transfer – inmate patient transferred from one facility to another within CDCR.

Nurse Physical Assessment – process whereby the health status of an individual is evaluated by a RN using the *5 Minute / 5 Step Head-to-Toe Assessment* guide. The assessment is an objective, hands-on evaluation involving inspection, palpation, and auscultation of the inmate-patient's body to establish a baseline for prioritizing care and uncover specific findings for referral and/or follow-up.

REFERENCES:

- Bald, H. (2006). The process of conducting a physical assessment: A nursing perspective. *British Journal of Nursing*, (15)13, 710-714.
- California Code of Regulations, Title 15. Crime Prevention and Corrections. Division 3. Adult Institutions, Programs and Parole – Article 8. and Article 9.
- CDCR Division of Correctional Health Care Services. (January 2006 Revisions). *Inmate Medical Services Program Policies and Procedures, Volumes 4 & 7*.
- CDCR Division of Correctional Health Care Services. (September 2006, 92 of 133). *Mental Health Services Delivery System Program Guide*.
- CDCR Division of Correctional Health Care Services, Dental Services. (March 2006).
- National Commission on Correctional Health Care. (2008). *Standards for Health Services in Prisons*.
- Poncar, P. J. (1995). Who has time for a head-to-toe assessment? *Nursing95*, (25)3, 59.
- United States Preventive Services Task Force (USPSTF) "A" and "B".

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STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION	Policy and Procedure # Approval Date: DRAFT Amended Date: September 2008
	Intake Laboratory Studies Reception Center

POLICY:

Every person newly committed or returned to the custody of the California Department of Corrections and Rehabilitation (CDCR) shall be screened in the Reception Center (RC) for intake laboratory studies. Additional laboratory studies, as clinically determined by the physician or mid-level practitioner (MLP), may be included.

PURPOSE:

To ensure timely diagnosis and treatment of infections and medical conditions that may be identified in order to reduce the incidence of morbidity and mortality.

RESPONSIBILITY:

Reception Center Health Care Services Staff: medical, nursing, dental, mental health, laboratory, and administrative support staff.

Health Care Services Administration Staff: Chief Medical Officer, Director of Nursing, Health Care Manager, Chief Dental Services, Chief Psychiatrist, Chief Psychologist, and Correctional Health Services Administrator.

PROCEDURE:

A. General Requirements – Health Care Services (HCS) Staff Role and Responsibilities

1. HCS staff assigned to the RC shall be responsible for ensuring intake laboratory studies, and any additional laboratory and diagnostics studies ordered, are completed and reviewed prior to housing the inmate-patient among the institutional population (see Appendix A.).
2. The physician, MLP, or RN shall review, if available, previous laboratory studies, diagnostics, and preventive services on 'returned to custody inmates' and parole violators prior to ordering new tests during the RC process.
3. Previous preventive services determined by the physician and/or MLP to be within normal range and recommended timeframe for age and gender need not be repeated during the RC process unless clinically indicated and judged necessary by the provider.
4. All laboratory tests shall be performed **after** the RN, physician, or MLP completes their respective initial health screen, physical assessment, or primary care intake examination. Inmate-patients not referred to the physician or MLP shall have laboratory tests performed **after** the nursing initial health screen and physical assessment is complete.

5. The RN shall offer Human Immunodeficiency Virus (HIV) testing to all inmate-patients and Hepatitis C testing for IV drug users.
6. The inmate-patient, prior to blood-draw, shall sign CDC 7290 'Inmate Consent for Serology for HIV and Hepatitis B Antigen/Antibodies'. The inmate-patient shall be informed that test results will be reported to the California Department of Public Health (CDPH).
7. HCS staff shall conduct interviews regarding laboratory studies/diagnostics in a manner that ensures the privacy of health information, subject to safety and security concerns of the institution.

B. Intake Laboratory Studies (New Commits and Returned to Custody)

1. Intake laboratory testing shall include, but may not be limited to the following:
 - Venereal Disease Research Laboratory (VDRL) Rapid Plasma Reagin (RPR) blood test for syphilis (all men and women)
 - Gonorrhea and chlamydia urine screen (all men and women < 30 years of age)
 - Urine pregnancy test (women ≤ 50 years of age)
 - PPD implantation and/or chest radiograph for TB (see P&P #03-006, Initial Health Screen and Physical Assessment – Reception Center).
 - Other laboratory studies, as clinically determined by the physician or MLP, may be included following the primary care intake and physical examination.
2. All inmate-patients identified as positive for infectious or communicable disease, shall be reported to and followed by the institution Public Health Nurse.

REFERENCES:

- American Public Health Association (APHA) Task Force on Correctional Health Care Standards. (2003). *Standards for Health Services in Correctional Institutions*.
- CDCR Division of Correctional Health Care Services. (2006). *Inmate Medical Services Program Policies and Procedures, Volume 4 – Chapter 2*.
- National Commission on Correctional Health Care. (2008). *Standards for Health Services in Prisons*.
- Recommendations of the U.S. Preventive Services Task Force (USPSTF). *The Guide to Clinical Preventive Services, 2007*.

DEFINITION:

Intake Laboratory Studies (male): those studies that screen for tuberculosis, syphilis infection, gonorrhea, and chlamydial infection. Additional laboratory studies, as clinically determined by the physician or MLP, may be included.

Intake Laboratory Studies (female): those studies that screen for pregnancy, tuberculosis, syphilis infection, gonorrhea, and chlamydial infection. Additional laboratory studies, as clinically determined by the physician or MLP, may be included.

PROBLEM LIST

NAME/CDCR #: _____

DOB: _____ ALLERGIES: _____

Instructions: A primary care provider (PCP) shall complete this form for any medical problem lasting more than six (6) months that is thought to be a potential chronic disease process. Also include any on-going treatment (i.e. ESRD/dialysis) or major surgery (i.e. CABG). A psychiatrist shall complete this form for any DSMIV-Axis 1 diagnosis. The provider will enter: **Date Problem Identified; Problem Dx; Name and Signature; Date Resolved; and Initials** when problem is resolved. This form is to remain at the top of the Physician Order section. *(To be brought forward at each visit).*

DATE IDENTIFIED	PROBLEM DX.	SIGNATURE	DATE RESOLVED	INITIALS

INSTITUTION: _____

Appendix A**TTA Referral Guidelines**

Vital Signs	
SAO ₂	< 95%
Temperature	> 38, < 35
Respiration	> 20, < 12
B/P Systolic	> 180, < 90
B/P Diastolic	> 110, < 60
Pulse	> 110, < 50
Pain	7 or >
EENT	
Eyes	Foreign body; photophobia; pain; change in vision; severe tearing; periorbital swelling
Ears	Foreign body; bloody discharge; trauma; hearing loss; auricular or post-auricular swelling; severe pain
Nose	Severe epistaxis; facial swelling
Throat	Acute anaphylaxis; wheezing; dyspnea; unable to swallow; foreign body; drooling
Gastro-Intestinal (GI)	
Upper GI	Acute symptoms of dehydration; hematemesis, vomiting
Upper GI	> 60 years old with abdominal pain, nausea and vomiting
Rectum	Hematochezia; severe pain; mass; bleeding
Other	Severe pain causing difficulty walking; hernia; jaundice
Genito-Urinary	
	Nausea; vomiting; abdominal or flank pain
Musculo-Skeletal	
Upper & Lower Extremities	Unable to use limbs; swelling; laceration; potentially requires splinting, casting, crutches
Back Pain	Acute trauma or fall; non-ambulatory; neurologic symptoms; history of Ca; GU symptoms
Neuro-Psychiatric	
Psychiatric	Suicidal and homicidal ideation with or without plan; erratic behavior; active hallucinations
Headache	"Worst headache in life"; symptoms of stroke / TIA
Neurological	Acute neurological changes; dizziness; altered mental status
Integumentary	
Nails	Subungual hematoma; erythema; swelling
Skin	Laceration; burns
Systemic	Fever or systemic symptoms of infection; systemic complaints
Dental	
Face	Obvious facial swelling
Jaw	Obvious or undiagnosed radiographic fractures of the jaw or facial bones
Mouth	Bleeding from mouth
Pain	Severe and debilitating pain
Cardiovascular	
Chest	Chest pain; arrhythmia
Respiratory	
Cough	Hemoptysis; respiratory distress; wheezing
URI	Needs nebulized medication or oxygen
Metabolic	
Blood Sugar	350 and greater; 50 and less

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RC/R&R INMATE-PATIENT HEALTH SCREEN CHECKLIST
--

Inmate Name/CDCR #: _____
 Arrival Date/Time: _____

Attention Staff: Check and initial appropriate section; if not completed, indicate reason in **Comments** section.

HEALTH SCREEN	Complete	Incomplete	Staff Initials	Comments
CDCR 7277 NURSE INITIAL HEALTH SCREEN (Face-to-Face Interview)				
Vital Signs, VA, Ht., Wt. (CNA)				
Questions 1-4 (LVN)				
Questions 5-17 (RN)				
CDCR XXXX RN PHYSICAL ASSESSMENT (Hands-On, Head-to-Toe Physical Assessment)				
Refer to TTA				
Refer to MD				
Refer to NP/PA				
Nursing Clearance for GP				
CDCR XXXX PRIMARY CARE INTAKE FORM				
Physical Examination MD/NP/PA (If applicable)				
MENTAL HEALTH				
Mental Health Screen				
LABORATORY STUDIES				
Blood draw, urine sample, etc.				
DENTAL				
Dental Screen				
PHARMACY (If applicable)				
Medications ordered				
Physician Order sent to pharmacy				
Medications delivered to RC				
Medications delivered to patient				

HEALTH EDUCATION MATERIALS

Appendix B

Inmate/Patient Name: _____ CDCR No. _____

Educational Material	English (Check if given)	Spanish (Check if given)	Educational Material	English (Check if given)	Spanish (Check if given)
Chronic Diseases			Health Promotion		
Allergies			Anger Management		
Asthma			Brushing Your Teeth		
Breast Cancer			Caring for your Breast		
Cancer			Denture Care		
COPD			Foot Care		
Diabetes			Foreign Objects In The Rectum		
Heart Disease			Forgetfulness		
Hypertension			Headaches		
Prostate Disease			Health Records		
Seizures			Personal Hygiene		
Skin Cancer			Poisonous Bites & Stings		
Testicular Cancer			Proper Inhaler for Asthmatics		
Infectious Diseases			Sleep Guidelines		
AIDS/HIV			Skin Care		
Common Cold			Use Your Medications Wisely		
Hepatitis			Common Sense Care Sheets		
Hepatitis C			Abrasions		
Hepatitis C: Side Effects			Allergies		
Hepatitis C: Coinfection			Anxiety		
Hepatitis C: Testing Positive			Cold		
Human Lice			Constipation		
Genital Warts			Earache		
Influenza			Earwax		
MRSA - Staphylococcus			Fungal		
Tuberculosis			Hemorrhoids		
Smoking / Tobacco			Indigestion		
Human Respiratory System			Rash		
Living as an Ex-Smoker			Strains, Sprains and Contusions		
Smokeless Tobacco					
Stop Smoking					
Surviving the Smoke Free Zone					

Staff Printed Name/Title: _____ Signature: _____ Date/Time: _____

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(Insert on page 4 of the *Inmate/Patient Orientation Handbook to Health Care Services*; cross out *Reception Center Screening and Evaluations* section).

Reception Center Health Screen and Physical Assessment

When you arrive at the Reception Center (RC), you will be given a health screen and physical assessment to evaluate for contagious diseases, acute and chronic illness, or other health problems. The health care staff will ask questions about your health history concerning medical, dental, public health, and mental health conditions. Nursing staff will check blood pressure, heart, and respiratory rate; and measure your height and weight. Vision is checked, and if you have a history of diabetes, a finger stick is done to measure your blood sugar.

You will be evaluated for signs and symptoms of active tuberculosis (TB), and may be required to have a Tuberculin Skin Test (TST). The TST is placed on the forearm and checked 48-72 hours after placement. Nursing staff will explain what will be done next.

Nursing staff will ask questions about medical conditions such as HIV, hepatitis, diabetes, seizures, high blood pressure, or asthma. You will also be asked about past hospitalizations for medical or mental health reasons. A registered nurse (RN) will do a brief, hands-on Head-to-Toe physical assessment to examine for conditions that may require medical attention. Your mouth will be checked for bleeding, possible broken jaw, or any signs of infection that require immediate treatment. If you are experiencing any health problem that requires immediate attention, you will be escorted to the Triage and Treatment Area (TTA) for further evaluation and treatment.

A physician, nurse practitioner, or physician assistant will examine you on day of arrival if you are:

- 40 years of age or older
- Any age and currently on prescription medication(s), and
- Any age with a chronic illness.

Mental health staff will ask questions about thoughts or plans of hurting yourself or others, and if you are currently taking medications for any mental disorder. If you are taking prescription medications and documentation from the sending facility is available, the RN and physician will review the medications and renew the order. You will receive your medications before you leave the RC, but no later than eight (8) hours after arrival to the institution.

Laboratory staff will draw blood to test for syphilis. All men and women under 30 years of age will be asked to provide a urine sample to test for gonorrhea and chlamydia. HIV and Hepatitis C testing will be offered and done with your consent. Depending on your condition, the physician may order other tests to be done. The RN will explain these tests to you as necessary.

If you are under 40 years of age, not taking any medications, have no chronic illnesses, and are in good health, you will use the 'sick call' process when you need health services. You will be assigned a primary care provider (PCP) within your housing unit clinic. Nursing staff will provide Health Education materials to you as needed.

RN PHYSICAL ASSESSMENT (DRAFT – NOT FOR COPY/DISTRIBUTION; Sept. 2008)

INMATE NAME:
CDC NUMBER:
DATE OF BIRTH:

NSF/WNL = NO SIGNIFICANT FINDING(S) and Area of Assessment is WITHIN NORMAL LIMITS

ASSESSMENT AREA (Use back page as guide)	CIRCLE ALL SIGNIFICANT FINDING(S) or NSF/WNL if none
General Survey / Appearance	Confused; uncooperative; agitated; withdrawn; unable to respond to questions appropriately; unable to maintain eye contact; unable to follow commands; unsteady gait; slurred speech; deformities; NSF/WNL
Skin / Hair	<p>Skin turgor - poor, tight, shiny, fragile; NSF/WNL</p> <p>Skin temperature/moisture: hot, cool, clammy, diaphoretic; NSF/WNL</p> <p>Skin sensation: numbness, tingling, absent; NSF/WNL</p> <p>Skin color: pale, flushed, cyanotic, mottled, jaundice, ashen; NSF/WNL</p> <p>Skin integrity: laceration, lesion, rash, bruising; NSF/WNL</p> <p>Hair: uneven distribution; NSF/WNL</p>
Head / Ears / Eyes Nose/ Throat	<p>Head: asymmetrical; alopecia; seborrheic dermatitis; NSF/WNL</p> <p>Ears: auricles asymmetrical; skin – scales, redness, inflammation; drainage; tympanic membrane perforation; impaired; HOH (R) (L); NSF/WNL</p> <p>Eyes: impaired; blurred vision; double vision; inflammation; drainage; redness; jaundice; pupils PERLA (not equal in size, shape, reaction to light, accommodation); NSF/WNL</p> <p>Nose: congestion; sinus problems; flaring; deviated septum; drainage; nosebleeds – frequency, NSF</p> <p>Throat: pain; hoarseness; lumps; NSF/WNL</p>
Oral (Mouth/Tongue/Dental)	<p>Mouth: mucous membranes - dry, cracked, pallor; lesions; lips cyanotic; bleeding gums; uncontrolled bleeding; visible trauma; swelling to jaw; NSF/WNL</p> <p>Tongue: thrush, sores; NSF/WNL</p> <p>Dental: loose teeth; missing teeth; unable to chew; poor hygiene; NSF/WNL</p>
Neck	Swollen glands; stiffness; dysphagia; NSF/WNL
Hands / Nails	<p>Nail beds: pale, dusky, cyanotic, clubbed</p> <p>Skin: pale, cool, numbness, tingling</p> <p>Radial pulse: weak (R) (L)</p> <p>Capillary refill: delayed _____ seconds</p> <p>Hand/grip strength: unequal (R) (L); weak (R) (L)</p> <p>NSF/WNL</p>
Thorax / Lung	<p>Chest: asymmetrical: barrel; funnel; use of accessory muscles; shallow breathing; NSF/WNL</p> <p>Lungs: SOB on exertion; crackles; wheezes; gurgles; diminished air movement; chronic cough; productive cough; sleep apnea; NSF/WNL</p>
Abdomen	Firm; hard; distended; tender; recent nausea/vomiting; anorexic; NSF/WNL
Upper & Lower Extremities	<p>Upper: limited ROM (R) (L); joint swelling (R) (L); contractures (R) (L); NSF/WNL</p> <p>Lower: limited ROM (R) (L); joint swelling (R) (L); contractures (R) (L); NSF/WNL</p> <p>Leg/foot strength: unequal (R) (L); NSF/WNL</p>
Feet	<p>Skin: pale, cool, numbness, tingling</p> <p>Pedal pulse: weak (R) (L)</p> <p>NSF/WNL</p> <p>Capillary refill: delayed _____ seconds</p> <p>Edema: location _____ 1+, 2+, 3+, 4+</p>

ASSESSMENT/PLAN

DISPOSITION

REFERRED TO	Mark if Yes	LABORATORY	Mark if Yes	OTHER	
TTA (Immediate)		VDRL/RPR		HIV Testing Offered Pt's Response:	<input type="checkbox"/> Accepted (Refer to PHN) <input type="checkbox"/> Refused
Primary Care Intake Evaluation (MD)		Gonorrhea/Chlamydia (< 30 years of age)		HCV Testing Offered Pt's Response:	<input type="checkbox"/> Accepted (Refer to PHN) <input type="checkbox"/> Refused
Primary Care Intake Evaluation (NP/PA)		Urine Pregnancy (Women ≤ 50 years of age)			
Other					

RN Printed Name: _____ Signature: _____ Date: _____ Time: _____

RN GUIDE TO PHYSICAL ASSESSMENT

5 Minute/5 Step Head to Toe Assessment

Step 1 – Observe as much about the patient’s condition when you meet.

- o Ambulatory, wheel chair, or transfer assist.
- o Ambulatory with or without assist, gait steady or unsteady.
- o Conversation – reveals level of consciousness, orientation, and appropriate responses.

Step 2 – Examine head and neck.

- o Does patient maintain eye contact? What is eye condition (red, watery, lids swollen, size of pupils)?
- o Facial expression and skin condition.
- o Oral cavity – observe teeth, tongue, mucous membranes, lips. Can patient open mouth without difficulty?
- o Neck – check cervical lymph nodes, stiffness, and ability to swallow.

Step 3 – Examine upper extremities.

- o Palpate brachial and radial pulses bilaterally noting rate and character (thready, weak, strong, bounding), and capillary refill.
- o Assess skin for temperature, condition/texture, integrity and edema.
- o Hand grasp for level of strength and sensation.

Step 4 – Examine anterior and posterior chest and abdomen.

- o Chest – inspect and palpate for presence of pain and abnormalities.
- o Auscultate heart and breath sounds.
- o Abdomen – inspect for symmetry, listen for bowel sounds, palpate.

Step 5 – Examine lower extremities.

- o Palpate pedal pulses bilaterally noting rate and character (thready, weak, strong, bounding) and capillary refill.
- o Assess skin for temperature, condition/texture, integrity, edema and note condition of bony prominences.
- o Determine strength and sensation by asking patient to bend leg and push foot against your hand.

Assessment Area	NORMAL FINDINGS
General Survey / Appearance	Behavior cooperative, follows commands, attentive. Facial expression free of distress; maintains eye contact. Body appears symmetric, movements smooth, easily controlled. Posture is erect; gait rhythmic, coordinated. Speech clear, moderately paced. Thought process intact; affect appropriate. Vital Signs WNL: - Oral temp: 96.0-99.9° F; Pulse: 60-100 beats/min; Respiratory rate: 12-20 breaths/min; Systolic BP: < 130mmHg; Diastolic BP: < 85mm Hg
Skin / Hair / Nails	SKIN: evenly colored skin tones; intact, smooth and even, without lesions. Warm and dry, pinches evenly-returns immediately to normal position. No lesions, rashes, needle marks. HAIR: distribution normal and even for age and gender, texture smooth and firm. Scalp smooth, dry, without scales. Male facial hair coarse, thick, even distribution. NAILS: pink tone; texture is hard, smooth and firm; nail plate slightly convex and firmly attached to nail bed. Capillary refill ≤ 2 seconds.
Head / Neck / Nose / Mouth / Throat	HEAD: symmetric, round, erect, midline; able to hold still and upright; hard and smooth, without lesions. Face symmetric, no abnormal movements. NECK: symmetric with head centered, movement smooth and controlled. Trachea midline. Thyroid gland moves freely when swallowing. Lymph nodes non-palpable, non-tender. NOSE: frontal and maxillary sinuses free of pain. MOUTH: opens and closes fully; lips smooth, moist, pink; no lesions or swelling. No missing teeth or appliances. Gums pink, moist and firm; no lesions or masses. Tongue pink, moist. THROAT: pink without exudates or lesions.
Eyes	Open evenly and equally displaced from the midline of the face. Eyelids without redness, swelling, or lesions. Eyeballs symmetric, freely mobile. Tear ducts free of discharge. Eyelashes free of granulation. Conjunctiva pink, clear. Sclera white. Cornea smooth, transparent. PERLA. Visual acuity 20/20 with or without corrective lenses.
Ears	Auricles symmetric. Skin smooth, without lesions or discharge; free of scales, redness and inflammation. Auditory canal pink and smooth, without nodules and free of discharge. Tympanic membrane intact; pearly, gray, shiny, and translucent; no bulging or retraction. Hearing ability intact.
Thorax / Lung	Symmetric; shoulders and scapulae are at equal horizontal positions-ratio of AP to transverse diameter is 1:2. Spinal column straight. Diaphragmatic excursion equal bilaterally. No use of accessory muscles; breaths easily sitting up. Skin free of lesions and masses. Normal breath sounds auscultated – bronchial, bronchovesicular, and vesicular. Sternum midline, straight. No retractions or bulging of intercostal spaces. No pain or tenderness over lung area.
Upper Extremities	Symmetric, no redness, swelling or deformity. Skin color uniform with rest of body - warm, smooth with minimal moisture. Muscles fully developed; strength equal bilaterally. Radial, brachial, ulnar pulses easily palpated and equal in strength. Full ROM in shoulders, arms, elbows, wrists, hands and fingers. Joints-non-tender, w/out nodules.
Abdomen	Skin smooth, unbroken with fine venous network - free of lesions, nodules, and rashes. Abdomen flat, round, concave, and symmetric. Smooth, even movement during breathing. Peristaltic movement not evident. Hyperactive bowel sounds (gurgles) may be present. Non-tender and soft, no palpable masses. No bulges or swelling. No rebound tenderness or pain.
Lower Extremities	Symmetric; gait steady. Skin color uniform, cool to warm; no varicosities or deformities. Hips stable, non-tender. No bulge of fluid on knees. Patella rests firm over femur; no pain or clicking noted. No pain, heat, swelling or nodules noted in ankles and feet. Femoral, popliteal, pedal and posterior tibial pulses easily palpated and equal. Full ROM in hips, knees, ankles and feet. Symmetric muscle tone.

**MEDICATION GUIDELINES
RECEPTION CENTER/RECEIVING & RELEASE (RC/R&R)**

With supporting documentation from the sending facility, the following medication guidelines should be used when an inmate-patient presents to the institution RC/R&R:

- All medications require a written order by a provider. When a provider is not physically available in the RC/R&R, a telephone order may be obtained.
- Medications may be renewed for no more than a 30-day supply.
- Anti-infectives may be renewed for up to the previously ordered stop date.
- Medications ordered in the RC/R&R, must be provided to the inmate-patient prior to housing unit (HU) placement.
- Medications not considered to be routine and/or essential shall NOT be renewed in the RC/R&R. These medications will be re-evaluated by the Yard Clinic PCP after HU placement.
- Inhalers and nitroglycerin tablets shall be allowed to remain with the inmate-patient [Keep-on-Person (KOP)].
- Chronic diseases and illnesses in which routine medications should be considered essential include, but may not be limited to:
 - Cardiovascular i.e. hypertension, angina
 - Diabetes
 - HIV
 - Tuberculosis
 - Infectious diseases currently under treatment
 - Pulmonary i.e. COPD, asthma
 - Seizure disorders
 - Psychiatric disorders
 - PPI therapy (dyspepsia, PUD)
 - Chronic pain management

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RECEPTION CENTER INMATE-PATIENT DAILY INTAKE LOG SHEET

DIRECTIONS: The log sheet is a data collection tool used to track parts of the RC Intake process and to provide information for the monthly Outcome Monitoring Report. The sheet must be filled out completely. Please **WRITE LEGIBLY** and use an ink pen to fill out the form.

RN Printed Name/Signature: Print full name and sign.

Date: Enter the current date, including the year.

Inmate Name: Print inmate's last name, first name, and middle initial (if available).

CDCR No.: Enter inmate's CDCR number.

Arrival Time: Enter the arrival time of the bus in military time.

Date of Birth: Enter the 2-digit month, 2-digit day, and 2-digit year. For example: 01/15/67.

Referral: Enter a check mark (✓) on the referral made. Use P&P #03-006, *Initial Health Screen and Physical Assessment – Reception Center* and the *TTA Referral Guidelines* as a reference for making a referral. The OT will schedule referrals made for the RN Care Manager, if needed. Enter the 2-digit month, 2-digit day, and 2-digit year. For example: 01/15/67.

Medications: Enter a check mark (✓) in the appropriate columns. The date medications are **received** by the inmate-patient is documented in the 3rd column. *Note: If meds are not received on day of arrival, a chart audit may be necessary to determine the date meds were received.*

Chrono 128-C-1: Enter a check mark (✓) if all appropriate areas of the Chrono are complete.

Comments: Enter any comments that may explain missing or incomplete data.

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Reception Center (RC) Intake Indicators

Indicator No.	Demographic Data (collect with every audit) Indicator
1	Name of CDCR receiving institution
2	CDCR No.
3	Date of inmate birth
4	Date of arrival to institution
5	Time of arrival to institution (military time)
6	Total number of inmates arriving in RC each day (Number will vary depending on the day and will be the denominator for calculating percent)
Reception Center (RC) Intake Indicators	
7	Inmate arrives with health information from sending institution
8	Inmate arrives with prescribed medication(s)
9	CDCR 7277 complete
10	RN 'focused' physical assessment done (hands-on based on stated problem or complaint)
11	RN Head-to-Toe physical assessment done
12	Referred to RC provider (MD or MLP)
13	Physical examination done by RC provider
14	Referred to TTA from the RC
15	Referred to RN Care Manager
16	Medications ordered in RC
17	Medications received in RC prior to HU placement
18	Prescribed medications received within eight (8) hours of arrival time to the institution
19	Intake labs drawn
20	Dental screen / panorex done
21	Mental Health intake screen done
22	Chrono 128-C-1 complete

*Directions for use and calculation procedure will be developed when Intake Indicators are confirmed.

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