**DIVISION OF ADULT INSTITUTIONS FACILITY PROCEDURE**

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| **Facility:** Taycheedah Correctional Institution | | |
| **Original Effective Date:** | **Facility Procedure #:** 900.50.22 | **Page** 1 of 8 |
| **New Effective Date:** 10/09/2020 | **Supersedes Number:** NA | **Dated:** NA |
| **Chapter:** 900 Miscellaneous | | |
| **Subject:** Infirmary Care | | |
| **Required Posting or Restricted:** ☐ **Inmate** ☒ **All Staff** ☐ **Restricted** | | |
| **Warden's/Center Superintendent's Approval:** Warden Sarah Cooper | | |

## POLICY

The Division of Adult Institutions shall ensure TCI Infirmary care is appropriate and adequate to meet the healthcare needs of patients. The climate of the infirmary shall be similar to that of the clinical setting in the community. All patients housed in the infirmary unit shall mirror that of the community setting.

## REFERENCES

Standards for Health Services in Prisons – National Commission on Correctional Health Care, 2018, P-F-02 Infirmary Level Care
DAI Policy 500.30.06 – Transfer of Patient
DAI Policy 500.50.20 – Infirmary Record
DOC-3619 - Transfer of Care Referral & Report
Wis.Stat. s.302.385 Correctional Institution Health Care

## DEFINITIONS, ACRONYMS, AND FORMS

ACP – Advanced Care Provider

Acute hospital care – A level of health care provision which treats an episode of illness due to disease, trauma or surgical intervention, requiring a variety of clinical specialties, equipment and medication.

BHS – Bureau of Health Services

BOCM – Bureau of Offender Classification and Movement

DAI – Division of Adult Institutions

TCI - Taycheedah Correctional Institution

DOC – Department of Corrections

DOC-3619 –Transfer of Care Referral & Report

EMR – Electronic Medical Record

GP – General Population

HSM – Health Services Manager

HSU – Health Services Unit

HSU Medical Room(s) – An area established within the correctional facility which operates to provide health care services to two or more s for 24 hours or more. These services do not meet hospital care or Infirmary level of care.

Infirmary – Designated level of care accommodating patients who require a higher level of care beyond what a facility can reasonably and safely provide and who do not require hospitalization.

RN – Registered Nurse

## PROCEDURE

### I. General Guidelines

A. Collaboration between ACPs, or sending facility, and the infirmary HSM/designee shall occur to identify patients with health care needs who require additional care in the Infirmary setting.

B. Patients shall be within sight or sound of facility staff. Health care staff shall respond in a timely manner to meet the medical needs of patients.

C. Patients may leave the infirmary for other facility activities under ACP order.

D. Infirmary staffing shall be sufficient with appropriate health care professionals based on the number of patients, acuity of illnesses and the level of care required for each. The Assistant HSM/designee shall ensure appropriate staffing levels based on patient needs.

E. A supervising RN shall ensure that care is being provided as ordered at least daily.

F. Patients shall receive ACP and nursing assessments based on the patient's level of care needs, condition and acuity.
   1. Acute patients weekly
   2. Chronic patients monthly

G. The patient's plan of care shall be addressed by a multi-disciplinary team.

### II. Admission Guidelines for Infirmary Placement

A. The patient shall require supervision and management of a complicated or extensive plan of care.

1. There shall be a possibility that complications would arise without skilled supervision of the treatment plan, ultimately generated by an ACP and carried out by the healthcare staff.
2. The need for skilled supervision and/or management shall be routinely reviewed and re-evaluated at the Infirmary multi-disciplinary meeting.

3. The patient shall receive frequent assessment, intervention and evaluation of a complex medical and/or surgical condition.

B. The patient's condition requires observation, assessment, and monitoring of a complicated or unstable condition, or complex case.
   1. When the unstable condition requires the skills of a licensed nurse in order to assess, detect, and evaluate the need for modification of the treatment plan.
   2. When there is the possibility of complications or further acute episodes.

C. The patient shall receive complex teaching when medical condition requires extensive teaching to promote treatment plan compliance. (e.g., an unstable diabetic with limited cognitive ability)
   1. The teaching itself is the skilled service, not the activity being taught.

D. Evaluation by a licensed healthcare staff shall occur at a minimum of weekly and by an ACP at least monthly.

E. The patient shall require oversight of a medication regimen where there is a possibility of adverse reactions and/or need for frequent changes in dosage or type of medication. This may include pain management, parenteral antibiotic and/or TPN administration (e.g., management of pain in the terminally ill, intermittent or continuous antibiotic therapy for an infectious disease process).

F. The patient's pain status shall be unstable as evidenced by frequent adjustment of medications.

G. The patient must have a medication regimen where there is a possibility of adverse reactions and/or a need for multiple and/or frequent changes in dosage or type of medication.

H. The patient requires tube feedings and cannot do these independently.

I. The patient shall require wound care that is extensive, which may require frequent care (e.g., stage III-IV pressure injury, venous stasis ulcers, complex post-op wounds or fresh skin grafts/flaps, which require a specialty bed).
   1. Wound care shall be ordered by an ACP.
   2. Skilled observation and assessment of the wound is necessary, which requires weekly and as needed documentation that reflect changes in wound status to support the medical necessity for continued observation.

J. The patient requires frequent skilled Rehabilitative Services which may include Physical, Occupational, and/or Speech Therapy.
   1. The patient may have a loss of function resulting from an acute event or an exacerbation of a chronic condition.
   2. Therapy services shall relate to the restoration of lost function (e.g., gait, transfer, stair training, or bed mobility, activities of daily living skills).
   3. Continuation of physical therapy services is acceptable as long as there is evidence that the patient is making functional improvement and the services continue to require the skills of a licensed therapist.

K. The patient requires assistance or provision of activities of daily living, (e.g., feeding, bathing, dressing, or mobility) for which the GP setting is not suited or safe.

L. Management and/or prevention of further exposure to communicable or infectious diseases.

M. The patient requires specialized equipment that cannot be accommodated in the GP setting.

N. Psychiatric conditions which require medical and/or nursing intervention.

O. The patient requires end of life/palliative care.

P. When there are questions about a patient's care needs and whether the patient meets criteria for admission, the patient shall be admitted so an appropriate plan of care can be determined through ongoing assessment and evaluation.

## III. Infirmary Referrals

A. The sending facility shall
   1. Complete the DOC-3619 and forward to the Infirmary Nursing Supervisor/designee.

2. Communicate patient health needs with the Assistant Infirmary HSM/designee.
3. Document communication in the patient's health record.
4. Communicate with facility staff to coordinate transportation to the Infirmary on the agreed upon admission date and time.
5. Communicate with BOCM staff the transfer to the Infirmary, as appropriate.
6. Facilitate an RN to RN report no sooner than 24 hours prior to planned admission date.
7. Facilitate movement of the paper Health Record (if applicable), medications, and medical equipment for transfer.

B. The Assistant Infirmary HSM/designee shall
1. Review the referral with the Infirmary ACP/designee.
2. Determine referral status and complete and sign the DOC-3619.
3. Communicate with the referring facility Nursing Supervisor/designee and plan an appropriate and acceptable time frame for Infirmary admission.
4. Communicate accepted Infirmary referrals and expected admission date with the Infirmary ACPs, Infirmary Charge RN/designee and other staff as identified (Infirmary staff, Unit Sergeant, etc.).
5. Facilitate any unit needs to accommodate admission/placement.
6. Maintain data of all Infirmary referrals (e.g., numbers, determination).
7. Evaluate and assign an appropriate bed.
8. Scan the completed DOC-3619 in the patient's health record.

## IV. Admission Assessment and Documentation

A. The Infirmary ACP/designee shall:
1. Order admission to the Infirmary and complete the plan of care orders upon arrival to the Infirmary.
   a. Prescriber Orders – Infirmary Admission shall be used for standard admission orders.
   b. Palliative Care Admission Orders shall be used for Palliative Care admission orders.
   c. Complete Medication Reconciliation.
   d. If an ACP is not on site to complete the admission orders an on-call physician shall be contacted by an RN to obtain admission orders, including medications.
2. Evaluate the patient the day of arrival, or the next working day if not on-site and complete:
   a. Health record review.
   b. An admission note and an Admission History and Physical Examination.

c. Medical Classification including medical hold.
d. Medication Reconciliation.

B. The Infirmary RN shall:
1. Obtain an admission height, weight and full set of vital signs.
2. Complete a head to toe physical assessment in the IView Band Assessment View within 2 hours of arrival.
3. Complete a Mental Status/Cognition Assessment.
4. Complete a Braden Skin Assessment.
5. Complete a Morse Fall Risk Assessment.
6. Review the Health Record, orders and off-site schedule.
7. Develop an IPOC to meet the patient needs within 12 hours of admission.

## V. Ongoing Assessments, Care and IDT

A. The Infirmary ACP/designee shall assess patients at least monthly, and more often as their condition warrants.

B. All patients admitted to the Infirmary shall receive
1. A complete head to toe physical assessment by an RN in the IView Band Assessment View every shift for the first 72 hours.
2. Full set of vital signs every shift for the first 72 hours.

C. Additional assessments shall be completed with any concern, a change in condition or if a patient falls.

D. All palliative care patients shall have a focused assessment completed every shift.

E. An RN shall
1. Notify an ACP with any patient concerns, needs or changes in patient condition.
2. Ensure the plan of care is current and maintained through the use of the nursing process.
3. Utilize hand-over communication between appropriate disciplines and shifts.
4. Ensure IPOCS are
a. Maintained to include all current nursing diagnosis, orders and needs as reflected in the health record to maintain and promote optimal patient outcomes.
b. Reviewed by nursing to guide their care and treatment daily.

F. A licensed nurse shall complete Caregiver Rounding with each patient. This shall occur on both first and second shifts of each day.

G. A multidisciplinary team care conference shall be held weekly to review patient's plan of care, current status, any concerns and potential needs/changes, acuity.

H. Multidisciplinary Team Care Conference discussions shall include how often the patient requires
   1. Routine nursing assessments
   2. Multidisciplinary Team Care Conference discussion

I. Discharge decisions from the Infirmary shall be made by the multidisciplinary team and by order of an ACP.

## VI. Non-DOC Facility, After Hours and Holiday Referrals

A. The referring facility shall contact the Assistant Infirmary HSM/designee to review patient referral, potential Infirmary needs, equipment and urgency. The information provided shall include medical, surgical and psychiatric history.

B. The onsite Infirmary RN shall communicate with the on call ACP to obtain a verbal order to admit a patient to the Infirmary.

C. The onsite Infirmary RN shall ensure all steps outlined in section IV above are followed for admission.

## VII. Discharge From the Infirmary

A. Discharges from the Infirmary shall be determined and planned through Multidisciplinary Care Conferences.

B. The ACP shall have final determination of the discharge appropriateness and write a discharge from Infirmary order.

C. For continuity of care ACP to ACP report shall be provided face to face if the patient is staying at TCI or called to the ACP at the transferring facility.

D. A discharge summary and recommended plan of care shall be completed for all patients released from the infirmary by an ACP.

E. A head to toe physical assessment shall be completed and documented in the Health Record by an RN within 24 hours of planned discharge.

F. If the RN has any concerns about the assessment findings and planned discharge, the RN shall:
   1. Notify the ACP
   2. Notify the Assistant Infirmary HSM/designee.

G. An RN to RN (Infirmary RN to receiving facility RN) report shall be completed within 24 hours prior to discharge.

## VIII. Staff Responsibilities

A. Assistant Infirmary HSM/designee
   1. Ensure daily oversight of staff, Infirmary processes and environment.
   2. Ensure assessments and caregiver rounding are completed in a timely manner.
   3. Develop and lead the weekly multi-disciplinary team meetings.
   4. Ensure regular and random health record review for compliance with standards of practice.
   5. Hold monthly meetings for Infirmary staff.
   6. Participate in hand over communication between shifts.

B. ACP
   1. Initiate and discontinue Infirmary level care as the patient condition warrants.
   2. Participate in the multi-disciplinary team meetings.
   3. Assume primary oversight of patient's medical plan of care.

C. Infirmary RN
   1. Assume oversight and supervision of the LPNs and CNAs.
   2. Participate in shift to shift report ensuring important handover communication is communicated shift to shift.
   3. Keep the Assistant Infirmary HSM/designee advised of patient concerns/changes.
   4. Ensure assessments and caregiver rounding are completed in a timely manner.
   5. Ensure plan of care is up to date and reflects current needs of the patient.
   6. Communicate any change in condition of patients to the ACP.