	DEPARTMENT OF PUBLIC SAFETY	EFFECTIVE DATE: April 7, 2020	POLICY NO.: COR.10.1E.03
	CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	SUPERSEDES (Policy No. & Date): COR.10.1E.03 & 12/10/2014	
	SUBJECT: TRANSFER SCREENING	Page 1 of 9	

1.0 PURPOSE

The purpose of this policy is to establish guidelines that ensure the continuity of health services and the elimination of unnecessary repetitive tests on transfer of a patient from one facility to another both within and outside of the Department of Public Safety system.

2.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel. To the extent any individual facility's policy conflicts with the statewide policy, COR.10.1E.03 shall control.

3.0 REFERENCES, DEFINITIONS AND FORMS

.1 References

- a. Hawaii Revised Statutes (HRS), § 26-14.6, Department of Public Safety.
- b. HRS, § 353C-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correctional Health Care, Standards For Health Services in Jails and Prisons, (2018).
- c. Department of Public Safety (PSD), Policies and Procedures (P & P), COR.10.1E.02, Receiving Screening for Medical/Mental and Dental Health.
- d. PSD, P & P, COR.10.1E.04, Initial Health Assessment

.2 Forms

- a. PSD 0401, Interfacility Transfer / Discharge Summary (attached).
- b. PSD 0486, The Transfer of Medical/Dental Records (attached).
- c. PSD 0497, Health Status Classification Report (HSCR) (attached).
- d. PSD 0498, Medical/Dental/Mental Health Intake Screening (attached).

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4.0 POLICY

- .1 Facility clinical sections shall be notified and consulted on decisions made on the transfer of patients.
- .2 Continuity of medical, dental and mental health care shall be maintained when patients are transferred from one facility to another and shall ensure that the patient is placed in the appropriate housing unit.
- .3 When transferred from an intake facility, patients who did not have an initial health assessment in accordance with COR.10.1E.04 Initial Health Assessment, shall receive one at the receiving facility in a timely manner.
- .4 Documentation, in the health record, shall be maintained to allow for continuity of health care services and medication administration.
- .5 Facility health care intake staff shall review each incoming patient's medical record or summary within twelve (12) hours of arrival to ensure continuity of care.
- .6 Except for new convictions, health care staff at the transferring facility shall be notified of a patient scheduled for transfer to another facility within the system at least forty-eight (48) hours prior to transfer.
- .7 The patient's medical and dental records shall accompany the patient when transferred to facilities within the Department system using form PSD 0486, The Transfer of Medical/Dental Records.
- .8 Health Care staff shall not make a determination as to which facility a patient may or may not be transferred to.
- .9 Form PSD 0497, Health Status Classification Report shall reflect any medical, dental or mental health restrictions.

For example, patient may lift only up to ten (10) lbs., patient not able to tolerate a high altitude, patient needs to be in a facility with twenty-four (24) hour nursing coverage, patient cannot be housed in general population, patient can only be housed in a facility within close proximity to a hospital.

Sufficient information shall be conveyed so that the patient can be transferred to the appropriate facility.

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- .10 Form PSD 0497, HSCR will be completed using the following determination codes:
 - a. **C** - cleared;
 - b. **R** - cleared with restrictions;
 - c. **H** - hold (60 days or less);
 - d. **D** - denied transfer or work.

- .11 Patients with a medical, dental or mental health condition, or other concerns that may affect their successful adaptation to another facility's environment, are to be evaluated by a physician or psychiatrist prior to completing the form PSD 0497 HSCR.

- .12 Patient transfers placed on hold for medical reasons may include those patients undergoing current medical, dental, and mental health treatment that cannot be provided at the receiving facility such as pending surgery. A hold may also be due to an acute short-term condition that temporarily limits their ability to be transferred

- .13 Patient holds shall not exceed sixty (60) days. After sixty (60) days, the patient should be denied, cleared, or cleared with restrictions by a physician.

- .14 Medical record reviews indicating any serious health concerns shall result in the patient receiving a documented physical and/or mental health assessment in the health care unit on the day of arrival, if possible. If not possible on the day of arrival, then no later than within twenty-four (24) hours upon arrival.

- .15 In facilities without weekend and holiday medical, dental and/or mental health coverage, patients shall receive a documented physical and/or mental health assessment by health care staff on the next working day.

- .16 No prescribed medication, treatment or medical diet shall be discontinued by the receiving facility, until it has been reviewed and discontinued by the facility provider.

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5.0 PROCEDURES

.1 For Inter-Department Transfers

a. Transferring Facility

1. Nursing staff shall review the transferring patient's Electronic Medical Record (EMR).
2. Nursing staff shall assess all transferring patients in the following areas:
 - a) Ability to tolerate a high altitude (contraindicated for some asthmatics, Chronic Obstructive Pulmonary Disease (COPD), and cardiac patients);
 - b) Ability to tolerate a cold damp climate;
 - c) Ability to ambulate over rough uneven terrain with or without a Medical Aid (are assistance devices needed for safe ambulation, steady gait);
 - d) Ability to lift over twenty (20) pounds of weight;
 - e) Ability to perform moderate to heavy labor;
 - f) Ability to perform repetitive movement such as bending, stooping and prolonged standing;
 - g) Stability of any medical condition to safely allow the patient to reside forty-five (45) or more minutes from the nearest medical facility;
 - h) Presence of a serious disabling mental illness that does not permit the patient to reside in the general population;
 - i) Current medical, dental, or mental health treatments that cannot be provided at the receiving facility;
 - j) Pending movements to community medical specialist.

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3. The nursing staff shall complete or update a PSD 0497 HSCR will be completed using the following determination codes:
 - a) **C** - cleared;
 - b) **R** - cleared with restrictions;
 - c) **H** - hold (60 days or less);
 - d) **D** - denied transfer or work.
 4. Nursing staff shall review all pending referrals and assess the availability of impending services at potential receiving facility locations. Any concerns that a patient may not be able to receive impending services shall be considered and noted on the PSD 0497 HSCR.
 5. The nursing staff shall ensure that the patient has a current negative tuberculosis (TB) test.
 6. If the patient is medically cleared to transfer, nursing staff shall prepare the patient's medical and dental records.
 7. The Classification Office staff shall notify health care staff at the receiving facility, of a patient scheduled for transfer, at least forty-eight (48) hours prior to transfer.
 8. If the patient is approved for transfer, nursing staff shall send the medical and dental records packet with the patient upon transfer.
 9. The Clinical Section Administrator (CSA) and Mental Health Section Administer (MHSA) or designee shall notify the receiving facility's medical, dental or mental health staff by telephone or other means of communication of a patient's need of ongoing care or acute problems that require prompt medical or mental health attention on arrival.
- b. Receiving Facility
1. Upon receiving a patient, nursing staff shall review the Electronic Medical Record (EMR) and medical packet.

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2. If the patient has not had an Initial Health Assessment in accordance with COR.10.1E.04, nursing staff shall complete one.
3. Nursing staff shall continue all services to ensure continuity of care.
4. Nursing staff shall update and issue Medical Needs Memos as needed.

.2 Procedures for Outside Transfers

Health care staff shall screen patients for transfer eligibility on an ongoing basis and/or as needed.

a. Transferring Facility

1. Health care staff shall screen patients for transfer eligibility on an ongoing basis and/or as needed. Screening shall include;
 - a) Review electronic medical record.
 - b) Tuberculosis (TB) test.
 - c) Completed form PSD 0497, HSCR.
2. Upon approval for transfer health care staff shall;
 - a) Print the medical summary from the electronic medical record, or complete form PSD 0401, Interfacility Transfer / Discharge Summary.
 - b) Fax to the receiving facility prior to the patient's transfer.
 - c) Scan dental records into the electronic medical record, then copy the medical record onto a CD or other media and send it to the outside facility upon patient transfer.
3. For transfers to FDC, health care staff shall complete required FDC forms and fax to FDC health care unit.
4. The Clinical Section Administrator (CSA) and Mental Health Section Administer (MHSA) or designee shall notify the receiving facility's medical, dental or mental health staff by telephone or other means of

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communication of a patient's need of ongoing care or acute problems that require prompt medical or mental health attention on arrival. The information obtained shall be sufficient to make informed choices regarding inmate medical care.

b. Receiving Facility

1. Immediately upon the arrival of a patient's transfer into a facility, the health care staff shall perform a review of the patient's medical summary information and/or electronic health record. Patients with more urgent medical, dental or mental health needs as indicated on the summary and/or electronic health record shall receive screening and treatment priority. All other transferred patients will have a complete documented medical record review conducted within twelve (12) hours of the patient's arrival using the Transfer Chart Review template.
2. The nurse shall document the chart review and any needed services in the medical record and make the appropriate referrals. MH staff shall document the MH review in the patient's record. The nurse and mental health staff shall develop an immediate plan of care for any serious medical, dental or mental health conditions, or continuity of care needs.
3. The nursing staff shall implement physician orders, generate any medical memos for restrictions, accommodations, reasonable modifications, auxiliary aids or services, or special diets; schedule chronic care clinics; arrange or coordinate pending medical appointments; arrange for any necessary mental health services.
4. All arriving patients will be seen in the health care clinic within seven (7) days of their transfer. During this visit the patient will receive and have documented in their electronic medical record the following verbal or written instructions regarding the facility health care procedures and services including but not limited to:
 - a) Access to the facility's health care services;
 - b) Medication administration information including self-administration requirements and nurse administration times and procedures;

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- c) Medical co-payment process;
- d) Access to over the counter medications;
- e) Requesting health record information;
- f) The medical grievance process;
- g) A review of current medications;
- h) A review of chronic conditions and the placement of the patient on a chronic care clinic schedule;
- i) A review and the offering of applicable preventive screening such as immunizations, mammogram, PPD, PAP, FOB;
- j) Review of the problem list;
- k) Distribute to the patient medical educational materials as appropriate;
- l) How to request accommodation/modification per form PSD 8772 Notice of Rights for Inmates with Disabilities.

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APPROVAL RECOMMENDED:



Medical Director April 7, 2020
Date

APPROVAL RECOMMENDED:



Health Care Division Administrator April 7, 2020
Date

APPROVAL RECOMMENDED:



Deputy Director for Corrections April 7, 2020
Date

APPROVED:



DIRECTOR April 7, 2020
Date

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STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY
HEALTH CARE DIVISION

INTERFACILITY TRANSFER / DISCHARGE SUMMARY

NAME _____

DISCHARGED TO _____

SID _____ DOB _____

DISCHARGED FROM _____

ALLERGIES/PRECAUTIONS/ALERTS

TRANSFER DATE _____

ACUTE ILLNESS

PPD Planted _____ READ ON _____ MM Results _____

CXR DATE _____ RESULTS _____

IMMUNIZATIONS Received Pending

Hepatitis 1 _____

 2 _____

 3 _____

CHRONIC CARE

(Including date of last visit(s) and mental health dx)

Influenza _____

Pneumovax _____

Other _____

CURRENT MEDICATIONS

(Include date/time of last dose if pertinent)

DATE LAST PAP, CHLAMYDIA / GC _____

DATE LAST MAMMOGRAM _____

DATE OF LAST PE _____ DUE ON _____

SPECIAL DIET

CURRENT TREATMENTS

SPECIAL NEEDS: Diabetes, Current Hep. C or TB treatment, mental health concerns, Labs, requirements during transportation, auxiliary aids or services, reasonable modifications for disability, needs required after release, etc:

SIGNATURE AND TITLE OF PERSON PREPARING THIS FORM

DATE

I ACKNOWLEDGE RECEIPT OF THIS DISCHARGE SUMMARY

DATE

THE TRANSFER OF MEDICAL/DENTAL RECORDS

TRANSFERRED TO: _____ FROM: _____ MEDICATION INCLUDED: YES NO
NUMBER OF MEDICAL RECORDS: _____ NUMBER OF DENTAL RECORDS: _____
ENCLOSED ARE THE MEDICAL/DENTAL RECORDS FOR THE FOLLOWING INMATES:

PREPARED BY: _____ DATE: _____ SEALED: YES NO
Sending Facility Health Care Staff

RECEIVED BY: _____ DATE: _____ SEALED: YES NO
Sending Facility Intake/Release

RECEIVED BY: _____ DATE: _____ SEALED: YES NO
Transport

RECEIVED BY: _____ DATE: _____ SEALED: YES NO
Receiving Facility Intake

RECEIVED BY: _____ DATE: _____ SEALED: YES NO
Receiving Facility Health Care Staff

All parties retain copy for thirty (30) days. Receiving party to initiate incident report if seal is broken.

- Original: Retained by sending facility's Custodian of Medical Records.
- Green: Retained by sending facility's Intake.
- Yellow: Retained by transporting ACO.
- Pink: Retained by receiving facility's Intake.
- Gold Rod: Retained by receiving facility's Custodian of Medical Records.

HEALTH STATUS CLASSIFICATION REPORT

NAME: _____ SID: _____ DOB: _____ FACILITY: _____

PURPOSE: Initial Health Evaluation Change in Health Status (check as many as apply.)
Hold for Health Care Evaluation/Treatment.

1. WORKLINE CLEARANCE:

CLEARED CLEARED W/RESTRICTIONS

HOLD DENIED

2. WORKLINE CLEARED WITH RESTRICTIONS:

(Check all that apply)

- 1. No Heavy Lifting ___ lbs
2. No Bending
3. No Prolonged Standing
4. Current Medications Require Indoor Work (sun sensitivity)
5. No Climbing
6. Other _____

ON HEALTH CARE HOLD UNTIL:

- 1. Medical ___/___/___ month/day/year
2. Dental ___/___/___ month/day/year
3. Mental Health ___/___/___ month/day/year

3. TRANSFER CLEARANCE:

CLEARED CLEARED W/RESTRICTIONS

HOLD DENIED

4. TRANSFER CLEARED WITH RESTRICTIONS: (Check all that apply)

A. Housing

- 1. Single Cell
2. Lower Bunk
3. No Stairs
4. Mental Health Special Housing
5. Disability Accessible
6. Other _____

C. Special Needs / Equipment

- 1. Communication Need: Blind/Vision Deaf/Hearing
2. Mobility: Crutches Cane/Walker Wheelchair
3. Assistance with ADLs/Medical Aid
4. Shoes at all Times
5. Mobility Medical Aid
6. Other _____

B. Facility Restrictions

- 1. No High Altitudes
2. 24 hour Nursing Availability
3. Ambulance Within 30 Minutes
4. Other _____

D. Recreational Activities

- 1. Activity limited to walking & stretching
2. No basketball/handball or competitive sports
3. No vigorous sports activity or heavy weight lifting
4. Other _____

1. Is there evidence or a diagnosis of a serious persistent mental health condition? NO YES

2. If yes, and possible, refer to Mental Health for clearance. Date of Referral _____.

[Place patient on a Mental Health hold. The MH team shall clear, place on hold, deny or identify any mental health restrictions applicable for to the patient and sign off on this form.]

Comments: _____

Signature Health Care Staff /Title Date Signature of Mental Health Staff /Title Date

MEDICAL/DENTAL/MENTAL HEALTH INTAKE SCREENING

ADMISSION DATE: _____ FACILITY: _____ PRIOR ADM TO THIS FACILITY Y N

NAME: _____

SID: _____ DOB: _____ SEX: _____

YES **NO**

Does the arresting or transporting officer or other custodial agency report indications that the inmate is a medical or mental health or suicide risk?

MEDICAL OBSERVATIONS:

- Are there observable signs of physical injuries? (Cuts, bruises, swollen or deformed areas)
- The inmate does not know what day it is and/or where he is. (If yes, ask about recent head injury.)
- Is there any sign of altered consciousness? (Not alert, non responsive to verbal commands, slow, slurred or incoherent speech, excessive sleepiness.)
- Are there any signs of limitations in movement? (Limping can't move a limb or joint, obvious physical deformities or complaints of pain on movement.)
- Are there any signs of body parasites? (Lice, crabs, scabies, etc.)
- Are there observable signs of illness? (Blue lips, shortness of breath, hyperventilation, hacking cough, flushed skin, rashes, orange/yellow skin or eyes, excessive sweating)
- Are there observable signs of intoxication or does the inmate appear to be under the influence of drugs? (Smells like alcohol, staggers, shaky, anxious, slurred speech.)
- Are needle marks, "needle tracks", or a fresh tattoo visible?

QUESTIONS: (Ask inmate the Questions. Inmate may not self administer. No need to expand on yes answers health care staff will obtain history based on a yes check mark)

- Do you have any allergies?
- Have you suffered a head injury within the last 48 hours?
- Have you ever had an infectious or communicable disease (e.g. Hepatitis C, TB)
- Do you currently have any symptoms of illness? (e.g., chronic cough, coughing up blood, tiredness, weight loss or gain of two or more pounds per week, loss of appetite, fever, night sweats, shortness of breath or fast breathing or any pain.) (Note all that apply)
- Are you under a doctor's care?
- Are you currently taking any medications?
- Do you have any medical conditions that limit your movement?
- Do you have any diet restrictions?
- Have you had an organ removed or an organ transplant?
- Do you use any prosthetic device(s) to aid any physical limitations? (Including eyeglasses, dentures, contact lens, hearing aid artificial eye(s), artificial limb(s).)
- Do you have any dental problems? (Toothaches, mouth sores or infections.)
- Have you ever been the victim of physical, psychological or sexual violence?
- Have you ever been enrolled in special education classes while in school?
- Have you recently been discharged from the Hawaii State Hospital?
- Have you ever suffered alcohol or drug withdrawal symptoms?
- Do you currently use any drugs or alcohol? (If so, what and when did you last use?)

FEMALES:

- Are you pregnant?
- Do you have any current gynecological problems?

PPD DATE: _____ DATE READ: _____ RESULTS: _____ X-ray Results: _____

Nsg. Disposition: Same Day Sched. Appt. with Whom/Date: _____ MH Refer.
 MH Emer. Contacted: _____ Date/Time: _____ Gen. Pop Other: _____
(Name)

REVIEWED BY RN STAFF: _____ Date/Time _____

VERBALIZED, OBSERVABLE OR OTHER DOCUMENTED SIGNS OF MH/SUICIDE RISK?:

YES **NO**

Any 3 positives to questions/observations #1 - #7 requires an SRE.

- 1. Strong feelings of remorse or shame?
- 2. Passive/withdrawn?
- 3. Is the nature of the crime high profile (media or celebrity status in community, etc.)?
- 4. Have you recently experienced a significant loss? (Relationship, death in family, job, etc.)?
- 5. Do you currently feel like you have to talk or move more slowly than you usually do?
- 6. Have there currently been a few weeks when you felt like you were useless or sinful?
- 7. Has a family member or close friend ever attempted or committed suicide?

Any one positive to questions/observations #8 - #13 (gray shade) requires an SRE.

- 8. Verbalizing hopelessness or extreme fear
- 9. Evidence of self-mutilation
- 10. If in jail or prison before was inmate ever placed on suicide or safety watch? (from OT alert)
- 11. In the past have you ever tried to hurt or kill yourself?
 When _____ Why _____ How _____ ?
 When _____ Why _____ How _____ ?
 When _____ Why _____ How _____ ?
- 12. Are you thinking about hurting or killing yourself now?
- 13. Question 1 page 1 (Arresting or Transporting Officer indicated Suicide Risk)

A positive response on any items #17 - #28 requires referral to the Mental Health Section.

- 14. Loud/obnoxious behavior?
- 15. Uncooperative behavior?
- 16. Aggressive behavior/ Restless/over reacting?
- 17. Bizarre behavior, confused or incoherent?
- 18. Have you ever received mental health treatment in a correctional facility?
- 19. Are you receiving counseling from a mental health professional or treatment center?
- 20. Have you ever been hospitalized for an emotional or mental health condition?
- 21. Are you currently taking any medication for an emotional or mental health disorder?
- 22. Have you or your friends noticed that you are currently much more active than usual?
- 23. Do you hear things or see things others cannot see or hear?
- 24. Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head? or other people know your thoughts and can read your mind?
- 25. Have you ever or are you currently thinking about harming another person?

The following questions are to be completed following a database search by the Intake Service Center.

- 26. Is the inmate a client of the Adult Mental Health Division? (ISC to check Data Base)
- 27. Has the inmate ever been on Conditional Release? (ISC to check CJIS or OT)
- 28. Has the inmate ever presented for a 704-404 Fitness Examination? (ISC to check CJIS or OT)

COMMENTS: _____

Inmate's Name _____ **Signature** _____ **Date** _____

ISC Disposition: Nurse Called: _____ Date/Time: _____ Med. Refer. MH Refer
 (Name)
 MH Emer. Called: _____ Date/Time: _____ Gen. Pop Other _____
 (Name)

INTERVIEWER/TITLE _____ **Date/Time** _____

MH Disposition: Same Day Appt. Sched with Whom/Date: _____
 MH Module Gen Pop Other _____

REVIEWED BY MH STAFF _____ **Date/Time** _____