



**DEPARTMENT OF PUBLIC SAFETY
CORRECTIONS ADMINISTRATION
POLICY AND PROCEDURES**

EFFECTIVE DATE:
April 7, 2020

POLICY NO.:
COR.10.1E.04

SUPERSEDES (Policy No. & Date):
COR.10.1E.04 & 10/20/2015

SUBJECT:

INITIAL HEALTH ASSESSMENT

Page 1 of 4

1.0 PURPOSE

The purpose of this policy is to ensure patients receive an initial health assessment.

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.04 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.
- c. HRS, § 353-13, Examination by Medical Officer.
- c. National Commission on Correctional Health Care, Standards for Jails and Prisons, (2018).

.2 Definitions

- a. Clinically Significant Findings: Any deviation from the normal that significantly impacts the health, safety, and welfare of the patient.
- b. Health Assessment: A multi-step process whereby an individual's health status is evaluated, including questioning the patient about symptoms, performing a physical examination, vital signs, diagnostic testing, immunizations as needed and taking a comprehensive medical, dental and mental health history.
- c. Physical Examination: Objective hands-on evaluation of an individual. It involves the inspection, palpation, auscultation, and percussion of a patient's body to determine the presence or absence of physical sign of disease.
- d. Treating Clinician: A nurse practitioner, physician assistant, or physician.

NOT-CONFIDENTIAL

COR P & PM	SUBJECT: INITIAL HEALTH ASSESSMENT	POLICY NO.: COR.10.1E.04
		EFFECTIVE DATE: APRIL 7, 2020
		Page 2 of 4

.3 Forms

- a. PSD 0498 Medical/Dental/Mental Health Intake Screening (attached)
- b. PSD Health Care Classification Report (HSCR) (attached)

4.0 POLICY

Health care professionals shall assess and plan for meeting the health needs of each individual patient.

5.0 PROCEDURES

- .1 An initial Health Assessment shall be implemented within the first seven (7) days for prisons and fourteen (14) days for jails. This assessment shall consist of:
 - a. A review of receiving screening results.
 - b. A complete medical, dental and mental health history completed by qualified health professionals.
 - c. A health care professional shall record vital signs including weight, height, blood pressure, pulse, respirations and temperature. Patient's weight and blood pressure are required annually and shall be recorded in the medical record.
 - d. A physical examination (as indicated by the patient's age, gender, risk factors) performed by a physician, mid-level provider or trained Registered Nurse.
 - 1. The hands-on portion of the health assessment may be performed by a registered nurse only when the RN completes appropriate training that is approved or provided by the responsible physician.
 - 2. The treating clinician shall review all physical examinations with positive findings, when completed by other trained health professionals.
 - e. Administration of immunizations, when appropriate.
 - f. An intake exam or health assessment with any of the following findings shall be referred to a provider for acute care follow-up within three (3) days of the health assessment or the provider's next clinic whichever occurs sooner.

NOT-CONFIDENTIAL

COR P & PM	SUBJECT: INITIAL HEALTH ASSESSMENT	POLICY NO.: COR.10.1E.04
		EFFECTIVE DATE: APRIL 7, 2020
		Page 3 of 4

1. Diabetic with Blood Pressure (BP) >140/80
 2. Diabetic with broken skin on legs or feet (set up day wound check)
 3. History Asthma using inhaler > 2 times per week
 4. History of Diabetes AccuCheck Blood Sugar (BS) > 140 and/or + urine ketones (place on daily AccuCheck until seen in clinic)
 5. History of hypertension BP >150/80 (place on daily BP checks until clinic visit)
 6. History of Myocardial Infraction (MI), Cardio Vascular Disease (CVD) (obtain base line Electrocardiogram (EKG))
 7. Patients with any positive findings in initial receiving screening and health assessment
- g. An intake physical examination need not be repeated on individuals re-admitted into the system within a year of being released when the receiving screening shows no change in health status.
 - h. Development of a problem list with diagnostic and therapeutic treatment plan for each problem.
 - i. Completion of form 0497 Health Status Classification Report (HSCR). Health Care staff shall not make facility placement recommendations.
 - j. Diagnostic tests for communicable diseases shall be performed unless there is documentation from the health department that the prevalence rate does not warrant it.
 1. A Purified Protein Derivative (PPD) status check or update shall be performed on all inmates.
 2. Newly identified positive PPD's over 10 mm require a chest X-ray.
 - k. Laboratory or diagnostic tests for disease such as pulse oximeter and peak flows for asthmatics and a urine dipstick shall be performed.
 - l. Performance of a vision test.
 - m. Review of form PSD 0498, Medical/Dental/Mental Health Intake Screening by a health care professional.

NOT-CONFIDENTIAL

COR P & PM	SUBJECT: INITIAL HEALTH ASSESSMENT	POLICY NO.: COR.10.1E.04
		EFFECTIVE DATE: APRIL 7, 2020
		Page 4 of 4

- n. Review of any accommodation or reasonable modification needs as a result of the presence of a disability; including, but not limited to, mobility devices, auxiliary aids, etc. All disabilities and accommodations or reasonable modifications issued by health care staff, shall be noted in the patient's file. If a patient needs an accommodation or modification outside of those covered in COR.10.1G10, Durable Medical Equipment, health care staff shall assist the inmate in completing form PSD 8773, Request for Accommodation/Modification.
- o. Scheduling of mental health and dental follow-up when necessary.
- p. A pelvic examination, or a referral for a pelvic exam, with or without a Pap smear, when clinically indicated.

APPROVAL RECOMMENDED:


 _____ April 7, 2020
 Medical Director Date

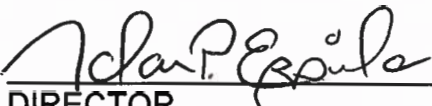
APPROVAL RECOMMENDED:


 _____ April 7, 2020
 Health Care Division Administrator Date

APPROVAL RECOMMENDED:


 _____ April 7, 2020
 Deputy Director for Corrections Date

APPROVED:


 _____ April 7, 2020
 DIRECTOR Date

NOT-CONFIDENTIAL

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

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

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

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

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