GEORGIA DEPARTMENT OF CORRECTIONS **Standard Operating Procedures**		
Policy Name: Infirmary Care, Observation, Accommodative Living Unit		
Policy Number: 507.04.42	**Effective Date:** 02/07/2022	**Page Number:** 1 of 19
Authority: Commissioner	**Originating Division:** Health Services Division (Physical Health)	**Access Listing:** Level II: Required Offender Access

I. Introduction and Summary:

Infirmary/Observation/Accommodated Living care will be provided at selected facilities for offenders who have medical conditions which require limited Observation or require skilled nursing and/or medical care but do not require admission to Augusta State Medical Prison (ASMP), a licensed hospital and skilled nursing care facility. This procedure is applicable to all facilities that house Georgia Department of Corrections (GDC) offenders to include private and county prisons.

II. Authority:

A. GDC Standard Operating Procedures (SOPs): 507.03.04 On-Call Duties, 507.03.06 Offender Workers, 507.04.13 Continuity of Care for Ambulatory Services, 507.04.18 Discharge Planning, and 507.04.43 Medication Distribution System;

B. NCCHC 2018 Adult Standard: P-F-02; and

D. ACA Standards: 2-CO-4E-01, 5-ACI-6A-09, and 4-ALDF-4C-09.

III. Definitions:

A. **Infirmary** - An area within the facility accommodating offenders expressly set up and operated for the purpose of caring for patients who need skilled nursing care but are not in need of hospitalization and whose care cannot be managed safely in an outpatient setting or in general population.

B. **Infirmary Care** - Inpatient care provided to patients with an illness or diagnosis that requires medication and/or therapy, assistance with activities of daily living (ADL), or other nursing care on a daily basis. The care is provided under the direction of a physician, dentist, physician assistant or nurse practitioner and under the daily supervision of a registered nurse. All care provided will be in compliance with applicable state statutes and local licensing requirements. The registered nurse will make rounds once a shift. The rounds should be documented in the health record.

C. **Observation** - Offenders may be assigned to an Infirmary bed for Observation status, however their stay may not exceed a stay greater than 24 hours.

D. **Clinician** - A physician, dentist, physician assistant, or nurse practitioner.

E. **Licensed Health Care Provider -** An individual licensed in the delivery of healthcare.

F. **Procedures** - Established nursing Procedures such as providing assistance with activities of daily living, cast care, post-operative care, intravenous fluid administration, etc. See Form P-32-0001-07, Regional Infirmary Matrix.

G. **Accommodated Living Unit (ALU)** - An area within the facility accommodating offenders who can perform 100% ADLs by self or with assistance of an Offender Worker, but who need to be in close proximity to a medical unit or where the need to ambulate is limited and meals are delivered. A description of Activities of Daily Living (ADLs) would include the following: feeding, bathing, dressing, continence management, and ambulation (assistance getting into or out of bed or chair and walking).

IV. Statement of Policy and Applicable Procedures:

A. Designation of Observation/Infirmary Units and Accommodated Living Unit s:

1. The following facilities are designated as Acute Care Facilities or Regional Infirmaries that provide twenty-four (24) hour nursing care:

   a. Augusta State Medical Prison/Acute Care Facility: ASMP will have a LOP approved by GDC Office of Health Services describing all services which are provided;

   b. Lee Arrendale State Prison;

   c. Baldwin State Prison;

d. Coastal State Prison;

e. Georgia Diagnostic and Classification Prison;

f. Georgia State Prison;

g. Hays State Prison;

h. Helms Facility (Specialized Infirmary Care to include but not limited to: Post-Op Care, Proximity to Receive Chemotherapy/ Radiation Therapy, Prenatal Care for Pregnant Offenders and Dialysis for Male (only) Offenders);

i. Macon State Prison;

j. Phillips State Prison;

k. Pulaski State Prison;

l. Valdosta State Prison; and

m. Ware State Prison.

2. There are no designated Observation Units.

3. The following facilities have Accommodated Living Unit s:

a. Coastal State Prison;

b. Johnson State Prison;

c. ASMP; and

d. Pulaski State Prison.

4. Probation Detention Centers, Residential Substance Abuse Treatment facilities, Integrated Treatment Facilities (ITF) and Transitional Centers have no Observation or Infirmary capability. Utilization Management (UM) will assign offenders from these facilities to a regional Infirmary if Infirmary or Observation care is needed.

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B. Capabilities of Regional Infirmary Beds:

1. All Regional Infirmaries must be capable of managing specific types of patients with an illness or diagnosis in accordance with the Infirmary Matrix, those patients who require skilled nursing care, and those patients requiring assistance with activities of daily living.

2. Low acuity detoxification at the discretion of GDC/ contract vendor Clinical leadership;

3. Nursing Procedures and Infirmary capabilities will be standardized according to the Infirmary Matrix;

4. The Director of Nursing will provide training to the nursing staff to ensure that they are proficient and have met competency standards. This includes:

a. Intravenous therapy;

b. Nursing care Procedures;

c. Use of supplies, and

d. The operation of durable medical equipment.

5. Equipment and supplies will be standardized in all regional infirmaries in accordance with the Infirmary Matrix;

6. Intravenous fluids and pharmaceuticals will be standardized for all regional infirmaries;

7. The standards for Infirmary care and equipment are contained on Form P-32-0001-07, Regional Infirmary Matrix;

8. A physician will always be on call or available twenty-four (24) hours per day. Health care personnel will have access to a physician or a registered nurse and are on duty twenty-four (24) hours per day when patients are present; and

9. Helms Facility may house offenders that require post-op care, proximity to receive chemotherapy/radiation therapy, prenatal care for pregnant offenders and dialysis for male (only) offenders.

C. Placement of Patients in Observation Status:

1. A Licensed Health Care Provider may place a patient in medical Observation for
up to twenty-three (23) hours depending on the approved hours of nursing coverage;

2. If a Clinician is not on site at the time of admission, the nurse will notify the on-call Clinician of the patient's condition at the time of placement in Observation. The nurse will obtain a verbal order to place the patient into Observation;

3. The Clinician will provide orders as to how the patient should be medically treated or monitored, (e.g., vital signs every thirty (30) minutes, neurological examinations every two (2) hours), and the clinical criteria for notifying the

Clinician or releasing the patient back to general population. Vital signs will be obtained on placement and as clinically indicated by provider orders;

4. The nurse will document the date, time, and name of the Clinician notified in the progress notes;

5. There will be a Licensed Health Care Provider within sight or sound of the patient at all times. If it is anticipated that the patient requires continued monitoring and treatment beyond twenty-three (23) hours of nursing coverage, arrangements will be made for transfer to a regional Infirmary. Plans to transfer the patient should occur within the designated time frame;

6. Examples of conditions suitable for treatment in Observation include, but are not limited to:

    a. Asthma controlled with nebulizer therapy;

    b. Conditions not requiring continuous intravenous therapy beyond 23 hours (INT for intermittent infusion is permissible);

    c. Observation to validate stated symptoms (e.g., vomiting); and

    d. Mild influenza or gastroenteritis.

7. Patients for whom the twenty-three (23) hour time frame and/or the severity of the medical condition exceeds the criteria for placement in Observation, will be directly admitted to a regional Infirmary per UM authorization.

D. Monitoring Patients in Observation:

1. Care of patients placed in Observation will be documented in the progress note section of the health record;

2. Documentation will include the reason for placement, health assessment and plan of care while in Observation;

3. Monitoring of the patient while in Observation will be defined by the Clinician's orders, and findings from the nursing assessment; and

4. At the time of release to general population, the documentation will include an assessment of status, patient education and plan for follow-up care if needed.

E. Transfer of Patients to a Regional Infirmary:

1. When patients require transfer for admission to a regional Infirmary:

   a. The Clinician of the sending facility will contact the UM nurse to discuss the patient's medical condition and need for medical transfer;

   b. The sending facility Clinician will verbally communicate with the receiving Clinician regarding the patient's medical condition;

   c. A clinical summary document will be developed by the sending Clinician, and sent to the receiving Clinician to facilitate coordination of the transfer of care; and

   d. If transferred after hours, charge nurse will call on call provider for orders.

2. A progress note will be documented in the health record reflecting the plan for transfer to the designated regional Infirmary. An Intra-system transfer form will be completed by the sending facility. The transfer form will indicate that the movement is for Infirmary care;

3. The health record and current medications will accompany the patient to the regional Infirmary;

4. The sending Clinician will determine the most suitable method of transportation, e.g., non-emergency ambulance or a correctional van;

5. All Infirmary transfers are subject to Utilization Management policies. Utilization Management must be directly involved in arranging for the transfer. Clinician should notify the On-call UM Nurse to arrange for Infirmary transfers;

6. The Warden at the sending facility must be notified to initiate the transfer process; and

7. Patients with medical conditions requiring ambulance, rescue, or other specialized medical transportation services should be considered for hospitalization instead of Infirmary care.

F. Admission to an Infirmary of Patients Discharged from a Hospital:

1. The correctional facility Clinician will agree to accept the patient based on the information provided by the Utilization Management Office and the hospital attending Clinician who has been in charge of the patient. The UM nurse assigned to the hospitalized offender will send the "Hospital Discharge" form to the receiving Clinician; and

2. The accepting Clinician will coordinate the receipt of discharge instructions and any medications and equipment needs.

G. Admission to the Infirmary:

1. Upon arrival at the regional Infirmary:

   a. The on-call Clinician will admit the patient to the Infirmary;

b. The date, time, and Clinician notified will be documented in the progress note;

c. The nursing assessment will be completed upon admission, and Clinician orders will be obtained and documented within one hour of patient's arrival; and

d. The Clinician will complete a history and physical as soon as practical and within 24 hours of arrival.

2. If a new patient is admitted to any Infirmary on a holiday or weekend:

   a. The Clinician will be notified at the time of admission and must return to the facility to complete the admission history and physical and clinically evaluate the patient within 24 hours;

3. Patients admitted to GDC infirmaries will be admitted on the order of a Clinician and will meet the medical criteria for admission. These criteria include:

   a. Patients with acute or chronic medical conditions requiring nursing care but not requiring hospitalization; and

   b. Patients with mental health disorders requiring intense Observation, medication, or restraints.

4. Examples of conditions meeting criteria for admission to an Infirmary include, but are not limited to:

   a. Asthma refractory to initial treatment but not requiring hospitalization which can be clinically managed;

b. Uncontrolled diabetes mellitus without evidence of ketoacidosis;

c. Uncontrolled hypertension without signs or symptoms of stroke or other sequelae;

d. Conditions requiring continuous intravenous therapy or intermittent intravenous, intramuscular, or subcutaneous therapy;

e. Post-operative or post-hospital care; and

f. Wound, ostomy, or burn care requiring dressing changes, irrigation and/or wound vac.

5. Patients who have potentially life-threatening symptoms such as chest pain suggestive of myocardial infarction, head injuries with altered level of consciousness or unstable vital signs must be referred to a hospital facility providing the level of care deemed appropriate for the suspected condition.

H. The Admitting Order will include:

1. Reason for admission, initial impression;

2. Frequency of vital signs (Vital signs must be obtained upon admission or as clinically indicated at a minimum of every eight (8) hours);

3. Type of diet;

4. Activity level;

5. Diagnostic or therapeutic measures to be taken during the Infirmary stay (laboratory tests, medications, etc.);

6. Patients will be provided verbal and written orientation to Infirmary Procedures upon admission. This education will be documented in the health record;

7. Although patients may refuse medical treatment, they may not refuse placement in the Infirmary if the admitting Clinician deems it medically necessary. Admissions require a complete and separate record with a history and physical using form P-32-0001-01, Infirmary History and Physical. The history and physical will include data:

    a. Relevant to the presenting complaint;

    b. The admission note must be congruent with the admitting diagnosis; and

    c. Diagnostic, treatment and monitoring plan.

8. Patients will not be placed in the Infirmary solely for security reasons; and

9. If patients are admitted to an Infirmary an officer must be assigned to the post at all times.

I. Monitoring Patients in the Infirmary:

1. Acute Admissions:

    a. All patients admitted to the Infirmary will be within sight or sound of a Licensed Health Care Provider 24 hours a day;

    b. Nursing services will be provided under the daily supervision of a registered nurse. A registered nurse will be present in the facility twenty-four (24) hours/day. An RN will be assigned to the Infirmary eight (8) hours/day. The registered nurse will conduct rounds once a shift and document the rounds in the Infirmary medical record;

c. A registered nurse or LPN who has is competent in IV Therapy will be on duty in the Infirmary whenever there are patients on continuous intravenous (IV) therapy;

d. A Clinician will be on call for consultation regarding patients in the Infirmary will be available 24 hours per day to include off-hours, weekends, and holidays;

e. Nursing documentation will require an admission note which includes, at a minimum, chief complaint, vital signs, relevant history, relevant Observations, admission assessment and nursing plan of care. The nurse will complete form P-32-0001.04, Nursing Assessment for Infirmary Admission form;

f. Licensed Health Care Provider will make rounds a minimum of every eight hours, as clinically indicated, or per Clinician orders. Documentation of the patient's condition will be made a minimum of once every eight hours. Documentation of clinical Observations will be made using form P-32-0001-05, Infirmary Flow Sheet;

g. Patient rounds will be made by a Clinician (MD/PA/NP) daily, including weekends and holidays, and documented in the progress notes. A physician will make rounds at least every seventy-two (72) hours unless the medical condition dictates closer Observation is needed, with documentation of any pertinent findings in the health record;

h. Vital signs must be measured upon admission and at a minimum of every eight (8) hours, or as clinically ordered by the Clinician;

i. Form PI-2076, Infirmary Kardex will be initiated and updated as the Clinician orders change. The Infirmary Kardex will be shredded once the patient is discharged from the Infirmary;

j. An Infirmary Medication Administration Record (MAR) will be initiated for documenting all medications given during the Infirmary stay;

k. All lab and diagnostic results will be maintained with the Infirmary health record. ;

l. At the time of discharge, all Infirmary records will be combined with the permanent health record. Completed Consultations Reports will be filed in the Infirmary section of the health record. Pending and incomplete consults will be moved to Section 4 (consultation section) of the health record; and

m. A Nursing Care Procedure Manual and Infirmary Procedures Manual will be kept in the Infirmary and available to staff at all times.

J. Discharging Patients from the Infirmary:

1. Form P-32-0001-.02, Medical & Nursing Infirmary Discharge Summary will be utilized for documentation by a Clinician and will clearly reflect the patient's discharge diagnosis and discharge plan. The Infirmary nurse will complete the nursing portion of the Discharge Summary form upon discharge. At the time of discharge, nursing documentation will include a nursing discharge assessment, patient teaching and follow-up plan;

2. A Clinician will review, date, time, and sign all Infirmary discharges to include a written order to discharge the patient;

3. The completed Infirmary admission record will be filed in the health record behind the Infirmary Admission divider; and

4. The Clinician should update the Problem List and profile, if necessary;

K. Housing Status:

1. Offenders may be placed in Observation or Infirmary for medical housing purposes secondary to medical conditions that do not require continuous nursing care. These placements do not require an admission history and physical or an inpatient record;

2. Examples of conditions appropriate for housing in an Observation or Infirmary include but are not limited to:

    a. Mobility impairments (e.g., wheelchair patients who are medically stable, patients with healing fractures unable to live in general population, etc.); and

    b. Offenders who are being prepped for a procedure and are to have nothing by mouth after midnight.

    c. Collection of twenty-four (24) hour urine samples;

3. Offenders assigned to the Infirmary for housing purposes only, must be within sight or sound of a health care provider at all times;

4. Offenders medically housed in the Infirmary require approval from UM, physician's order and a progress note by the Clinician describing the patient's condition and reasons for housing the patient in the Infirmary/Observation;

5. The status of offenders in the Infirmary or Observation for medical housing purposes will be reviewed by a Clinician and shall be documented, at least weekly.

6. A Licensed Health Care Provider will make rounds every shift and document the status of the offender. Offenders will be transferred out of the

Infirmary/Observation housed area as soon as stable and no longer requiring being housed in these areas;

7. Offenders will be provided medical and nursing measures only as indicated by the admitting Clinician. Offenders must be admitted for all skilled nursing care.

8. Offenders housed in the Infirmary or Observation will be permitted and encouraged to participate in routine facility activities;

9. Offenders assigned to the Infirmary for housing purposes only will be required to access routine sick call per SOP 507.04.27. This does not pertain to offenders housed at ASMP; and

10. Offenders will not be housed in the Infirmary or Observation solely for security reasons.

L. Data Collection:

1. Form P-03-0005.15, Infirmary Tracking Log or form P-03-0005.16, Observation Unit Tracking Log or other approved tracking logs will be maintained and include data for every patient placed in an Infirmary or Observation unit. If the patient's status changes, the change should be noted on the appropriate log. The Infirmary Log will include the following information:

   a. Patient's name and GDC number;

   b. Date of admission/placement;

   c. Placement status (e.g., admission, Observation, housing);

   d. Admitting diagnosis;

e. Discharge diagnosis;

f. Date of discharge/release; and

g. Daily Infirmary Bed Status (DIBS) will be reported using Captiva by 10:00 A.M. five (5) days per week.

M. Readmission:

1. If a patient is readmitted to an Infirmary within three (3) days of discharge for the same condition, it is permissible to begin a new chart with an abbreviated history and physical written by the admitting Clinician in the form of a progress note which references the previous admission's complete history and physical. Beyond three (3) days of discharge, a new history and physical is required; and

2. For all re-admissions, new Clinician orders and a complete nursing assessment are required.

N. Accommodated Living Unit s (ALU) “Non-Infirmary:”

1. Criteria for Admission:

a. The patient must be able to perform 100% of ADLs by self or with the assistance of an Offender Worker;

b. The patient must have been through a bowel training program if applicable and can self-support elimination and hygiene needs;

c. The patient will be treated as a general population offender with access to all medical services and facility programming, i.e., recreation, law library, counseling services, etc.; and

d. The offender must be able to live in a housing unit that is not staffed with nursing. Medications and meals will be delivered on the unit.

2. Upon admission to an ALU, a Clinician will visually assess the patient and document the assessment in the health record:

   a. A physical assessment will be made; and

   b. The provider will determine if the patient is appropriate for admission into an Accommodated Living Unit.

3. Patients deemed not appropriate candidates for admission will be referred back through contract vendor UM for appropriate housing placement;

4. An order for placement will be written and signed by the Clinician;

5. Medical staff will ensure appropriate medical equipment is available such as:

   a. O2 concentrators;

   b. Wheelchairs,

   c. Walkers, and

   d. Trapeze bars, toilet extenders, etc.

6. Equipment must be maintained at all times in accordance with manufacture's recommendations. The Infection Control Nurse and Responsible Health Authority will round in the ALU monthly and report any negative findings for corrective action as needed;

7. Medications will be delivered on the unit by nursing staff.

8. A Clinician will make rounds once a week. Rounds will be documented on the security sign-in log.

O. Quality Improvement Activities:

1. Each quarter, the Medical Director will review a sample of health records of patients placed in the Infirmary (admitted, observed, or housed status). The sample will be 10% or ten (10) records (whichever is greater) to determine:

   a. Whether the admission to the Infirmary, Observation unit or housed status could have been prevented;

   b. Whether adequate documentation by Clinician and nurses are evident;

   c. Whether medical and nursing care was appropriate and provided in a timely manner;

   d. Whether placement of the offender in the Infirmary was consistent with approved Procedures; and

   e. The report findings will be presented at the next scheduled Continuous Quality Improvement (CQI) Committee meeting and kept in the CQI file for a minimum of three (3) years.

   NOTE: Forms associated with this SOP may be found on the GDC Intranet at Captiva/Resources/Health Services Documents/02 Physical Health/Health Record Manual/09Tracking Logs/03 Health Record Forms, and 10 GCI Forms.

V. <u>Attachments</u>: None.

VI. Record Retention of Forms Relevant to this Policy:

Regional Infirmary Matrix (P-32-0001-07) shall be used as a reference form for facilities with infirmaries and has no retention date. Upon completion, Infirmary History and Physical (P-32-0001-01), Nursing Assessment for Infirmary Admission (P-32-0001.04), Infirmary Flow Sheet (P-32-0001-05) and Medical & Nursing Infirmary Discharge Summary (P-32-0001.02) or other approved forms shall become part of the patient's permanent health record. Infirmary Tracking Log (P-03-0005.15) and Observation Unit Tracking Log (P-03-0005.16) shall be retained for three (3) years and then discarded. Infirmary Kardex (PI-2076) shall be shredded once the patient is discharged from the Infirmary.