
Division of Institutions
Policy and Procedure

I. PURPOSE

To establish and delineate the process for the facility Officer in Charge (OIC), Licensed Practical Nurses (LPNs), and Unlicensed Assistive Personnel to contact a Registered Nurse (RN) to evaluate urgent and non-life-threatening offender complaints of illness and/or injury during the absence of the facility's registered nurse and/or provider.

II. DEFINITIONS

A. Emergent

A condition that is acute and potentially threatens life/limb or function; requires immediate medical attention.

B. Face-to-Face Encounter

Occurs when the triage nurse requests custody to bring the offender to the triage facility or use the Video Conferencing Equipment to perform an assessment/evaluation.

1. Shall be at the discretion of the triage nurse, or the on-call provider.
2. Shall be limited to those facilities in close proximity to the triage facility; otherwise, the offender shall be transported for care as directed by the triage nurse at providers' direction.
3. The Triage Nurse determines the need to refer to provider at CPHC for Video Conferencing evaluation and facilitates appointment with the facility OIC and CPHC.
4. Face to face encounter shall be conducted via Video Conferencing Equipment prior to patient admission to Special Management/Restrictive Housing at facilities without nurse on site. Triage nurse shall record encounter utilizing the restrictive housing screening template.

C. Non-urgent

A condition that is minor or non-acute and does not require immediate attention or care.

D. Telephone Triage

The process of collecting information over the telephone or video conferencing equipment to determine the level of seriousness of a health problem, and to determine whether medical, dental, nursing, psychosocial, supportive, or informational interventions are needed.

E. Urgent

A condition that is acute but not severe but requires medical attention within a few hours.

III. POLICY

A. If there is an emergent situation that requires Emergency Medical Services (EMS) to be called, the OIC shall inform the designated triage nurse of the emergency after the offender is transported.

1. The OIC shall follow the established emergency procedure for their facility.

2. The triage nurse shall document the event and complete a consultation in the patient's health care record.

B. Facility OIC, Licensed Practical Nurses (LPNs) and Unlicensed Personnel shall access telephone triage when there is not a Registered Nurse or Provider on-site.

C. Designated triage facilities shall have a Registered Nurse assigned to provide triage services to include but not limited to, evaluation/assessment of urgent and nonlife-threatening emergent conditions using the applicable Nursing Protocols/Standing Orders to determine appropriate interventions and disposition.

D. Facilities without 24 hours/7-day nursing coverage shall have "night boxes" for over-the-counter (OTC) nursing protocol medications. The OIC shall be responsible for securing the night box and for retrieving and distributing medications as ordered by the triage nurse.

E. In accordance with the facility standard operating procedures (SOPs) the OIC shall notify the facility nurse of all triages and/or emergency room trips conducted when nursing staff are not on site.

F. The telephone triage nurse shall document calls received on the Telephone Triage Monthly Log as well as in Electronic Medical Record (HERO).

G. Training and Competency Assessment

1. Facility Nurse Supervisor/Manager or designee shall provide initial and as needed training on telephone triage to officers and nursing staff that utilize triage facilities.
2. New officers shall receive orientation to telephone triage, prior to being given the assignment of calling the Triage Nurse.
3. Nursing staff shall receive orientation to telephone triage within the first 90 days of employment. RNs shall not conduct telephone triage until the training and competency is completed.

H. Triage Assessment

1. Rule out life-threatening emergency first, then proceed with the assessment/evaluation.
2. If possible, a speaker phone or video conferencing equipment shall be used to discuss patient complaint with the patient and officer, LPN, or Unlicensed Personnel.
3. Speak directly with the patient as well as the officer, LPN, or Unlicensed Personnel, unless emergency protocol has been activated.
4. Interpreter Service should be used for non-English speaking patients.

IV. PROCEDURES

A. In preparation for the triage call, the OIC/designee shall interview the offender using the DC 975 OIC Triage Worksheet.

1. The DC 975 OIC Triage Worksheet shall be completed prior to calling the Triage Nurse.
2. The completed DC 975 OIC Triage Worksheet is used to inform the Triage Nurse of the offender's health concerns/complaints.

B. After identifying themselves, the Triage Nurse shall document the time call received, facility calling and name of the staff member calling in the patient's health care record by choosing DAC-DAC as the security complex and then choosing their current facility.

C. The triage nurse shall document in the patient's health care record information provided by the patient, officer, LPN or Unlicensed Personnel regarding the chief complaint or concern.

- D. The triage nurse shall instruct the patient to self-check vital signs using a monitor designed for self-use.
 - 1. The triage nurse shall guide the patient through the process.
 - 2. The triage nurse shall document in the triage note the vital signs were self-checked.
- E. The triage nurse shall consult, if needed, with the physician/physician extender/dentist on-call in the respective medical region of the facility that is calling.
- F. The triage nurse or on-call provider may determine that a face-to-face encounter with the offender is required in order to perform an assessment/evaluation to determine the appropriate interventions/disposition.
- G. If transport requires special arrangements, approval shall be made by the OIC/designee.
- H. The triage nurse shall conduct a nursing assessment/evaluation using the applicable standing orders/nursing protocols.
- I. Implementation of a standing order for over-the-counter medications does not require signature by the facility provider.
- J. The triage nurse shall document the specific standing orders/nursing protocols used, the assessment/evaluation, findings, communications, interventions and disposition in the patient's health care record.
- K. The triage nurse shall select the appropriate co-payment charge, if self-declared, emergency co-payment should be applied if not true emergency or patient is not transported for treatment.
- L. If orders outside of the Standing Orders/Nursing Protocols are needed, the triage nurse shall obtain a verbal/telephone order from the on-call provider and document in the patient's health care record.
- M. The ordering provider shall be marked as the co-signing provider for prescription medication orders and orders outside of the Standing Orders/Nursing Protocols. The facility provider shall be marked as the reviewing provider.
- N. The triage nurse shall give the patient and the OIC instructions on the nursing interventions, transcribe medication orders on a DC 175 Medication Administration Record and give directions on how to take the medication ordered.
- O. The Triage nurse shall verify with the patient and OIC if they understand the directions/instructions provided and to call the triage nurse back if needed.

- P. The triage nurse shall document in the patient's health care record information, directions/instructions provided and that the offender and officer understood.
- Q. If the patient refuses treatment, the officer shall notify the triage nurse who shall counsel the offender.
 - 1. If the patient continues to refuse, the triage nurse shall complete the Offender Refusal form.
 - 2. The triage nurse shall document on the Offender Refusal form the specific counseling/education provided to the patient and send to the calling facility for the patient to sign.
 - 3. The OIC shall submit the original signed document to the facility nurse at the calling facility to be entered into medical record.
- R. If triage results in the patient being transferred to a hospital, the triage nurse shall enter the consult order into the patient's health care record.
- S. The patient's facility medical staff shall be responsible for entering the UR the next business day.
- T. Follow-Up

The triage nurse shall schedule in the patient's health care record a follow-up triage appointment with the nurse at the calling facility for the next business day.

- U. Pending Discharges from Community Hospitals After Hours
 - 1. If Comprehensive Health Services licensed staff are not on site and the community hospital notifies the facility's OIC of an offender to be discharged, the OIC shall refer them to their designated telephone triage nurse. The triage nurse shall discuss the patient's condition with the hospital caseworker or discharging hospital nurse to determine the patient's current medical needs. On call provider shall be contacted to discuss patient condition and medical needs as indicated.
 - 2. If the patient's health care needs/acuity rating has changed, the triage nurse shall work with the OIC to determine the appropriate facility for the patient to be housed by utilizing Medical Mission spreadsheet.
 - 3. The triage nurse shall call the new unit receiving the patient and give report to the facility nurse.

4. The sending OIC will arrange transportation from the discharging hospital to the appropriate facility.
5. Accurate patient acuity rating should be completed as soon as possible upon arrival at the receiving facility and entered into the patient's health care record.
6. The triage nurse shall record the hospital report and disposition in the patient's health care record.

V. Prescription Medications

1. The officer shall not have prescriptions filled until instructed by the triage nurse.
2. The OIC shall obtain prescription medication orders through the triage nurse as recommended by the on-call provider.
3. No more than three days' worth of the prescription shall be dispensed unless specified by the triage nurse (depending on the prescription and the number of days until normal Comprehensive Health Services business hours.)
4. The OIC shall coordinate medication packaging, and appropriate MAR documents for pick up with the triage nurse for any controlled or direct observed therapy medications.
5. Triage nurse shall advise the facility OIC regarding directions for administering medication.
6. The triage nurse or designee shall prepare applicable MAR and DOT medications for custody administration. DC 175 MAR, and/or DC 175A Controlled Substance Medication Administration Record will be provided to custody by the medication preparation nurse.
7. The OIC shall ensure the facility nurse receives the signed medication administration forms on the next Comprehensive Health Services clinic business day. The facility nurse shall scan the completed medication administration forms into the patient's health care record.

W. Emergency Room Trips

The OIC shall ensure the custody officer transporting the offender to the emergency room has the name and phone number of the triage nurse. The officer shall give the information to the hospital nurse or physician to contact the triage nurse directly to discuss discharge treatment and instructions.

X. Quality Control of Night Box/Equipment

1. The Nurse Manager/designee shall be responsible for maintaining contents, quantities (par level) and monitoring monthly for expiration dates.
2. Night box shall be kept in a locked area and locked when not in use.
3. A list of medications, quantity and expiration dates shall be with the night box.

V. REFERENCES

A. 5th Edition Standards for Adult Correctional Institutions

5-ACI-6A-04, 5-ACI-6A-06, 5-ACI-6A-08, 5-ACI-6B-04, 5-ACI-6C-03, 5-ACI-6C-04

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