OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-G-03

SUBJECT: INFIRMARY CARE

POLICY: An infirmary shall be available to provide limited medical, dental, and nursing services for patients with health care problems whose care may be managed in an in-patient setting. Infirmary services may include isolation, observation, first aid, nursing care and post-operative care. Infirmary care is not used as an alternative to hospital level; acute care services, or a licensed nursing care facility. Clinical issues are the responsibility of the Chief Medical Officer or designee and operational issues are the responsibility of the Health Services Manager or designee. Individuals may be assigned beds inside of an infirmary at the discretion of the Health Service Manager or designee for sheltered housing needs, hospice care, or suicide monitoring. Infirmary beds are located at OSP (22), EOCI (8), SRCI (16), CCCF (14) and TRCI (16).

REFERENCE: OAR 291-124-050 (3)
NCCHC Standard P-G-03

PROCEDURE:

A. Definitions of the types of care provided in the infirmary:

1. MEDICAL SURGICAL DENTAL CARE – Infirmary care which is under the supervision of the Chief Medical Officer (CMO), or designee. Examples include, but are not limited to, medically unstable patients, patients receiving chemotherapy, patients recovering from dental procedures, patients recovering from surgery, etc. Infirmary care is supervised by a designated registered nurse following a physician's written and verbal order. Patients who are in the infirmary for dental reasons are under the supervision of the dentist. Throughout the remainder of this procedure, for patients requiring infirmary services for dental care, the "designee" to the CMO is the dentist.

2. NURSING CARE – An assignment to the infirmary for the convenience of nurses providing nursing care. Examples include, but are not limited to, observation and assessment, dressing changes, diagnostic testing preps, etc. The infirmary care of these patients is supervised by a designated registered nurse. The infirmary nurse will notify the CMO/designee of a nursing admission within the first twenty-four (24) hours. Infirmary assignments for nursing care are to be re-evaluated in seventy two (72) hours by the CMO/designee and the infirmary nurse for re-classification.

B. Definitions of alternative housing options that may occur within the infirmary:

1. SHELTERED CARE – A housing assignment that may occur within the confines of an infirmary. Sheltered housing provides a protective environment but does not require 24-hour nursing care. In the community, these individuals could be at home, however, in an institution, it is more suitable for the individual to be housed in this sheltered environment. Individuals housed in the infirmary for sheltered care are not covered by this policy and procedure. Charting occurs on regular health care record forms and access to care is by verbal or written request. These individuals will be followed as a special needs patient and seen by a provider every two (2) months or as indicated.

2. HOSPICE CARE – As defined by Policy and Procedure P-G-12, "Care for the Terminally Ill."

3. SUICIDE MONITORING – a housing assignment that may occur within the confines of the infirmary in consultation with CTS and Health Services. Health Services will consult with Security prior to the inmate's arrival to ensure that the infirmary cell is as suicide-proof as possible. (See P&P P-G-05, Suicide Prevention Program.)

C. General standards for infirmary care:

1. The infirmary is staffed by nursing personnel according to the number of patients, severity of illnesses, and the composite of requirements to care for each patient.

2. Nursing care is provided according to procedures outlined in the manual entitled Clinical Nursing Skills: Nursing Process Model and other written instructions. These are available in the Health Services infirmary area.

3. Use of nursing protocols is not permitted for individuals housed within the infirmary.

4. Patients cared for in the infirmary will be within sight or sound of health care personnel at all times. Audio-visual monitoring equipment may be employed to accomplish this.

5. Documentation of infirmary care beyond assessments that address abnormal findings shall be completed on infirmary progress notes utilizing narrative or SOAP charting.

6. The Health Status is updated on admission and discharge as indicated per Policy and Procedure #P-A-08 – Communication on Special Needs Patients. The Health Status Screen on the DOC400 will also be reviewed

to determine if there are any mental health property or medication restrictions or if there has been a suicide attempt in the past three years.

7. Admissions and discharges to the infirmary are tracked on the Inmate Health Plan, Inpatient/Hospital Log.

8. Patients transferred between infirmaries will upon arrival at the new facility be assessed by the nurse and CMO or designee. Unless otherwise indicated, their type of care may remain the same as when transferred. Communication must occur between infirmaries when a transfer is initiated.

9. When an inmate is hospitalized, the infirmary nurse, or designee, is responsible for obtaining a daily progress report from the hospital and documenting in the health care record.

D. The procedure for admission is based upon the reason for infirmary care:

1. Admissions to the infirmary for medical surgical dental care:

a. Once oriented to this procedure, physicians, nurse practitioners, physician assistants and dentists have privileges to admit patients for infirmary care.

b. The practitioner (physician, nurse practitioner, physician assistant, dentist) responsible for the admission shall make an entry in the infirmary progress notes of the patient's health care record noting the reason for admission. This note is to be completed within one working day of the patient's admission.

c. The practitioner responsible for the admission shall complete the "Infirmary Admission Orders Medical Patient" form and notify the CMO/designee, as well as the infirmary nurse, of the admission to discuss the patient's plan of care.

d. The CMO/designee shall complete a physical examination and clinical chart review within one working day of admission for infirmary care. The physical examination is not necessarily a complete physical, but is at least symptom/system specific examination. The CMO/designee will complete the "Physician Infirmary Admission Note" (see attached) at this time.

e. The infirmary nurse shall complete an "Infirmary Assessment" (attached) within four (4) hours of admission. This becomes part of the permanent health care record.

f. Health Services staff shall orient each patient to the “Infirmary Guidelines” that are posted in the infirmary (attached). These guidelines are institution specific and describe housing unit regulations, which are to be followed by the patient while assigned to the infirmary.

g. The CMO/designee is responsible for the care of each patient in the infirmary for the purpose of providing medical/dental care.

2. Assignment to the infirmary for nursing care:

a. Once oriented to this procedure, registered nurses are privileged to assign patients to the infirmary when only nursing care is required. The referring RN will document on the progress note the patient’s status and the reason for the infirmary assignment. This nurse will also report patient status to the infirmary nurse.

b. The infirmary nurse completes an “Infirmary Assessment” within four (4) hours. For patients admitted for diagnostic preps, it is only necessary to complete a SOAP entry on a regular progress note.

c. The CMO/designee will be notified of the assignment within twenty-four (24) hours. Infirmary assignments for nursing care are for a maximum period of seventy-two (72) hours. Within seventy-two (72) hours, the CMO/designee and the infirmary nurse will discuss need for re-classification.

d. Health Services staff shall orient each patient to the “Infirmary Guidelines” that are posted in the infirmary (attached). These guidelines are institution specific and describe housing unit regulations, which are to be followed by the patient while assigned to the infirmary.

E. Responsibilities of certain health care providers during infirmary housing assignments:

1. Medical surgical dental care

a. CMO or designee shall complete a symptom or system specific examination and clinical chart review within one working day of admission.

1) The CMO or designee shall make rounds Monday through Friday and shall complete an infirmary progress note on each patient.

2) Changes in plans of care are to be noted in the infirmary progress notes by the CMO or designee with physician orders written as indicated.

b. Infirmary Nurse

1) The infirmary nurse is responsible for ensuring that the physician orders are processed and carried through.

2) The infirmary nurse completes a nursing assessment, and vital signs at least once a shift or as indicated by the nurse's assessment. Assessments are completed utilizing the "Assessment Form." These assessments may be more frequent if instructed by the physician or indicated by the nurse's nursing assessment. Vital signs shall be documented on a parameter flow sheet.

3) The infirmary nurse shall notify the CMO or designee of any significant changes in the patients' condition.

4) The infirmary nurse is responsible for ensuring that treatment orders, medications, etc., are administered as prescribed and documented and that activities of daily living are met.

5) At the end of each sift, the off going infirmary nurse shall give a report to the oncoming infirmary nurse.

2. Nursing Care

a. CMO or designee

1) For admissions that are nearing seventy-two (72) hours, discuss with the infirmary nurse need for re-classification and/or changes in the plan of care.

b. Infirmary Nurse

1) Vital signs shall be taken, and a nursing assessment completed utilizing the "Assessment Form", at least once a day or more often as indicated by the nurse's assessment. Vital signs shall be documented on a parameter flow sheet.

2) The infirmary nurse is responsible for ensuring that treatment orders, medications, etc., are administered and documented and that activities of daily living are met.

3) At the end of each shift, the off going infirmary nurse shall give a report to the oncoming infirmary nurse.

4) Within seventy-two (72) hours, the infirmary nurse shall discuss updating classification with CMO or designee.

F. Discharge Procedure

1. Medical surgical dental care

a. CMO or designee

1) A physician's order shall be written indicating that the patient either be discharged from the infirmary, or, discharged from medical surgical dental care.

2) At the time of discharge from the infirmary, an infirmary progress note shall be written indicating plans for continued monitoring or treatment.

b. Infirmary Nurse

1) Once the CMO or designee has written a discharge order, arrangements will be made through the institution assignment staff for an appropriate housing assignment.

2) An entry will be made on the infirmary progress note indicating:

a) patient instructions given
b) follow-up care appointments scheduled for care and treatments
c) housing assignment placement

2. Nursing Care – Infirmary Nurse

a. When the infirmary nurse determines that the patient's health status warrants return to general housing, arrangements shall be made through the institution assignment staff for an appropriate housing assignment.

b. Upon discharge, an entry shall be made on the infirmary progress note indicating:

1) patient instructions given

2) follow-up care appointments scheduled for care and treatments
3) housing assignment placement

G. Monitoring and Review

1. The Chief Medical Officer and Health Services Manager/Nurse Manager for utilization appropriateness and quality of care shall monitor infirmary admissions, discharges, and continued inpatient stays.

2. Infirmary admissions, discharges, average daily census, and average length of stay shall be tabulated on the monthly statistical report and submitted to the Health Services Administrator according to Policy and Procedure #P-A-04 – Administrative Meetings and Reports.

Effective Date: _____
Revision date: May 2007
Supersedes P&P dated: November 2006

OREGON DEPARTMENT OF CORRECTIONS HEALTH SERVICES
Physician Infirmary Admission Note

Admission: _____ Date: _____ Time: _____

Chief Complaint: _____

Subjective: _____

Past Medical History/Co-Morbidities: _____

Medications: _____

Objective: _____ BP: _____ P: _____ RR: _____ O^2Sat: _____ Temp: _____

Assessment: _____

Plan: _____

Signature: _____

Name: _____
SID#: _____
DOB: _____

OREGON DEPARTMENT OF CORRECTIONS HEALTH SERVICES
Physician Infirmary Discharge Note

Discharge:_____ Date:_____ Time:_____

Discharge Diagnosis: _____

Discharge Summary: _____

Follow-up: _____

Signature: _____

Name: _____
SID#: _____
DOB: _____

OREGON DEPARTMENT OF CORRECTIONS
HEALTH SERVICES SECTION
Infirmary Guidelines

General Instructions:

1. Upon admission to the infirmary, you are assigned to a specific bunk and you may not change bunks without permission from health services staff.

2. At no time are you allowed to enter the living area of another patient without permission from health services staff.

3. You are not allowed to leave the infirmary area without permission from health services staff.

4. Unless restricted to bed, you are expected to be out of bed for meals.

5. Horseplay, loud or obscene language, and boisterous activity are prohibited at all times.

6. You will remain on your bunk during all institution counts and after institution lights out unless there is a medical reason not to.

7. Tampering with the monitor cameras is strictly prohibited.

8. Only staff are permitted to enter the designated nurse station areas.

9. Infirmary lights will be turned on and off in accordance with institution rules. The night lights are kept on at all times.

Area Cleanliness:

1. Unless it is determined by the medical staff that you are medically incapable, you are responsible for your bunk area. This will include cleaning and may include the changing of your bed linens.

2. All trash will be placed in the receptacles provided. Do not leave trash on bedside stands and do not throw trash on the floor. You are responsible for the cleanliness of your assigned area.

3. Pictures, photographs, posters, etc., are not to be tacked, taped, or fastened in any manner, to the walls, beds or cabinets.

4. No surplus food items are to be kept after meals without permission from health services staff. You may keep one piece of fresh whole fruit at your bedside if allowed by your diet. The fruit must be consumed prior to the next regularly scheduled meal. Return all utensils, etc., to the designated area after each meal.

5. Property is limited to that which can be accommodated by your bunk area furnishings. Excess property is stored according to institution property guidelines.

Infirmary Guidelines

Television/Radio:

1. The television is not to be turned on prior to 9:00 a.m. or the beginning of the day's activities in the infirmary and will be turned off at the end of each day in accordance with institution rules.

2. The television is to be turned off during doctor rounds at those institutions that have open wards.

3. Television volume is to be kept at a level not to be heard outside the infirmary area.

4. The medical staff or infirmary security staff, not the inmates, will do adjustments or changes in television programs.

5. The use of radios within the infirmary area is according to institution policy.

Telephones:

1. All telephone calls are to be limited to 20 minutes once per hour.

2. Phone use is not permitted during count, medication lines, or provider rounds.

3. If required by the institution, you must sign up on the telephone log for your desired time of use.

Personal Hygiene:

1. Once bathing privileges have been established, you are required to bathe accordingly to the institution provisions.

2. Showers, unbraided hair, and brushing of teeth are required before all outside medical appointments, unless directed otherwise by health services nursing staff.

3. With the exception of multi-bunk dorms, when using toilet facilities, only one patient is permitted in the area at a time.

4. Soap, toothbrush, toothpaste (or baking soda), shaving soap and razors are available on an as needed basis. Razors are issued on an exchange only basis.

Clothing:

1. The wearing of gym shorts is prohibited unless authorized by the Health Services Manager, or, designee.

2. When out of bed, appropriate institution clothing or infirmary sleeping attire will be worn including a shirt and footwear.

Infirmary Guidelines

Mail and Canteen:

1. The health services secretary or officer assigned to the infirmary picks up and distributes all patient mail.

2. Mail will be delivered to you as soon as possible once it has been received from the mailroom.

3. Canteen is available weekly in accordance with institution schedules.

4. Only one week's worth of canteen items will be allowed in the bedside nightstand. Items cannot be stored in the refrigerator/freezer.

5. Medical personnel will review and refuse any canteen items that are medically contraindicated. Canteen orders are to be signed as approved by medical staff prior to being filled by canteen personnel.

Miscellaneous:

OSP Only –

a. The hours for the sun porch are the same as the hours for the yard. Patients in isolation will be allowed one hour daily on the sun porch without any other patients present. No mattresses, bedding or towels are allowed on the sun porch. There is to be no talking or waving to people on the grounds of OSP, OSPM, or outside the walls.
b. No loitering near the food preparation area and patients are not to go near the detention cells or into the side rooms at any time.
c. At the conclusion of television viewing time, all conversation among patients will cease.
d. No food from the infirmary kitchen will be served after 6pm unless medically necessary and authorized by health service staff.

EOCI Only –

a. Loitering near the north infirmary windows is prohibited.
b. Doors to infirmary cells are to be secured at all times unless otherwise authorized by health services staff.

SRCI Only –

a. No loitering near the kitchen area is permitted at any time.
b. Canteen is available for sheltered care inmates and for other patients two weeks after admission to the infirmary with provider approval.
c. HS snacks are to be eaten between the hours of 1930 and 2130 only.
d. DSU patients: overhead light will remain on at all times but can be turned down on low at 10:00 pm.
e. When out of facility patients are in the infirmary, the telephones are not to be used. You will be notified when the phones are off limits.

Infirmary Guidelines

f. When in the infirmary, clothing or full set of pajamas will be worn at all times. Footwear is required when out of bed.
g. Television viewing will be per the institution viewing guide.

TRCI Only –

a. TRCI's infirmary will operate essentially like a regular housing unit. There will be two-way line movements for dayroom/yard, TV viewing and telephone calls.
b. Inmates assigned to the infirmary for short term (less than 2 weeks) will only be allowed clothing, basic hygiene items, envelopes, address book, radio with headphones and bible.
c. Inmates on long-term status may request other personal property items such as canteen, CD players, pictures and art supplies.
d. Personal TV's are not allowed in the infirmary.

HEALTH SERVICE STAFF ENCOURAGE YOUR ADHERANCE TO THE ABOVE GUIDELINES. STAFF WILL ADDRESS ANY QUESTIONS YOU MAY HAVE.

Inmate Signature SID# Date

INITIAL INFIRMARY ADMISSION ORDERS
MEDICAL PATIENT

SUBSEQUENT ORDERS ARE TO BE WRITTEN ON PHYSICIAN'S ORDER SHEETS

Diagnosis: _____ Date: _____ Time: _____

GENERAL CARE:

_____ Intake and output
_____ Daily weights
_____ May start O^2 4 to 6 liters per minute by nasal cannula prn shortness of breath and notify provider
_____ Activity level as able
_____ Restricted activity level_____
_____ May shower or use tub bath

DIET:

_____ General diet
_____ Therapeutic diet_____

LAB/XRAY:

_____ Chemistry profile with CBC
_____ Chemistry profile
_____ CBC
_____ Urinalysis
_____ Other laboratory_____
_____
_____
_____ X-ray studies_____
_____
_____

OTHER:

_____
_____
_____

Name:_____
SID#:_____
DOB:_____

MEDICATIONS: Generic equivalent may be substituted by Pharmacy unless otherwise indicated

_____ Continue current medications
_____ Discontinue current medications and start medications listed below
_____ Tylenol 325mg tabs ii PO qid prn for headache for 7 days
_____ ASA 10gr PO qid prn for headache for 7 days
_____ Antacid 30cc's or therapeutic equivalent q four hours PO for indigestion for 7 days
_____ Milk of Magnesia 15-30 cc's PO bid prn for constipation for 7 days
_____ Other medications _____

_____
_____
_____
_____
_____
_____
_____

INTRAVENOUS THERAPY:

_____ Solution
_____ Rate
_____ Duration

OTHER:

_____
_____
_____

Provider Direct Order:_____ Date:_____ Time:_____

Admitting Nurse:_____ Date:_____ Time:_____

Reviewed by:_____ Date:_____ Time:_____
MD/DO/NP/PA/DDS/DMD

*Please copy and send to Pharmacy

Name: _____
SID#: _____
DOB: _____

Attachment 5
P&P P-G-03

Oregon Department of Corrections
PROGRESS NOTES

DATE	TIME	PROB.#	

Allergy_____

Name:_____
SID#:_____
DOB:_____

Oregon Department of Corrections

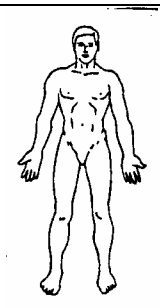
Infirmary Assessment Form

Attachment 6
P&P P-G-03

Date: **Initial Assessment Time:**

Normal Neurological
Alert, oriented to person, place, time, situation
Verbalization is appropriate for age & understandable
PERRLA
Extremity strength equal, no paresis
Swallowing /s cough or choking on liquids or solids
No sensory deficits

- ❑ WNL
- ❑ Disoriented
- ❑ Lethargic
- ❑ Stuporous
- ❑ Unresponsive
- ❑ Responds only to tactile stimuli
- Responds only to noxious stimuli



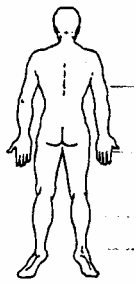
Normal Integumentary
Skin warm, dry, intact
Color pink Turgor elastic
No evidence of pressure sores, rash, or bruises
Mucous membranes moist

- ❑ WNL
- ❑ Hot
- ❑ Icteric
- ❑ Dusky
- ❑ Skin turgor poor
- ❑ Flushed
- ❑ Cool
- ❑ Pale
- ❑ Clammy
- ❑ Cyanotic
- ❑ Diaphoretic

Pressure Ulcer Scale:
Stage 1 = Reddened, intact, non-blanchable
Stage 2 = Partial thickness
Stage 3 = Full thickness/tissues
State 4 = Full thickness/muscle/bone

Normal Respiratory
Lungs clear
Breath sounds present bilaterally
Respirations 10-20/min at rest, unlabored, symmetrical
Nailbeds, mucous membranes pink

- ❑ WNL
- ❑ Decreased
- ❑ Rales
- ❑ Rhonchi
- ❑ Oxygen ___L/min
- ❑ Wheezes
- ❑ SOB
- ❑ DOE
- ❑ Cough



Normal Musculoskeletal
Full ROM all joints
No joint swelling, tenderness, deformity No muscle weakness
Gait steady

- ❑ WNL
- ❑ Weakness
- ❑ Abnormal ROM
- ❑ Deformity

Normal Cardiovascular
Heart rate regular
Apical pulse 60-100/min
Peripheral pulses palpable, equal bilaterally
Capillary refill <3"
No edema noted

- ❑ WNL
- ❑ Murmur
- ❑ Apical irregular
- ❑ Edema:
  1+ = 0-1/4"
  2+ = ¼-1/2"
  3+ = ½-1"
  4+ = >1"
- ❑ Tachycardic
- ❑ Holman's sign
- ❑ Abnormal peripheral pulse(s)

Functional Status/Activities of Daily Living (ADL's)
Independent in transfers, ambulation and activities of daily living (ADL's)
No assistive devices needed
No unusual risk for injury/fall

- ❑ WNL
- ❑ Cane
- ❑ Walker
- ❑ Wheelchair
- ❑ Assist /c ambulation
- ❑ Assist /c ADL's (describe)
- ❑ Bedrest
- ❑ Ambulate /c assistance
- ❑ Up in chair

Normal Gastrointestinal
Tolerates PO intake well
Abdomen soft, non-tender, with bowel tones (BT) active all 4 quadrants
No c/o nausea, emesis, diarrhea

- ❑ WNL
- ❑ Nausea
- ❑ Emesis
- ❑ Diarrhea
- ❑ Constipation
- ❑ Pain
- ❑ Tenderness
- ❑ Distention
- ❑ Firmness
- ❑ Abnormal BT
- ❑ NG tube
- Last BM:_____

Pain Assessment
Severity: 1 2 3 4 5 6 7 8 9 10
Location:
Exacerbating factors:

Interventions effective? YES NO PARTIALLY

Normal Genitourinary
Voiding clear, yellow urine, /s difficulty
Voiding >25cc/hr
No bladder distension noted
No abnormal discharge

- ❑ WNL
- ❑ Dysuria
- ❑ Frequency
- ❑ Urgency
- ❑ Incontinence
- ❑ Hematuria
- ❑ Discharge
- ❑ Bladder distension

Activities/Treatments

- ❑ Oral care
- ❑ Foley/pericare
- ❑ Turned Q2hr
- ❑ Dressing change:
- ❑ Assisted /c hygiene
- ❑ Skin care:
- ❑ Care plan reviewed
- ❑ Care plan updated

Psychosocial/Emotional Status
Affect neutral
Appearance, behavior, gestures, verbalization appropriate for situation

- ❑ WNL
- ❑ Anxious
- ❑ Tearful
- ❑ Angry
- ❑ Agitated
- ❑ Hostile
- ❑ Withdrawn
- ❑ Euphoric
- ❑ CTS referral done
- ❑ Visited By:

2nd Shift:

Unchanged ❑

Changed – See Progress Note. ❑

3rd Shift:

Unchanged ❑

Changed – See Progress Note ❑

Signature 1st Shift: _____

Signature 2nd Shift: _____

Signature 3rd Shift: _____

NAME:	
SID#:	
DOB:	
Allergies:	