ICE/DRO RESIDENTIAL STANDARD

MEDICAL CARE

I. **PURPOSE AND SCOPE. Residents have access to health care maintenance services, including those related to mental health, dental care, prevention, health education, and emergency care in a timely and efficient manner.**

In many facilities, medical care for ICE/DRO residents is provided by the Public Health Service's Division of Immigration Health Services (DIHS). The term "DIHS-staffed facility" refers to a residential facility in which medical care is provided by DIHS.

II. **EXPECTED OUTCOMES.** The expected outcomes of this Standard are as follows:

1. Residents will have access to health care education and maintenance services that are determined by the health care authority to be necessary and appropriate. Services will include prevention, diagnosis, and treatment of medical, dental, and mental health conditions.
2. Newly admitted residents will be informed how to access health services, in a language they can understand.
3. Residents will be able to initiate requests for health services.
4. Residents will have access to the care determined necessary by the health care authority from a resident's admission to the residential facility until they are discharged from treatment, transferred to another facility, or removed from the United States. When indicated, care shall include referral to community-based providers.
5. A transportation system will be available that ensures timely access to health care services, determined necessary by the health care authority, that are only available outside the facility.
6. A resident who requires close, chronic or convalescent medical supervision will be treated in accordance with a plan approved by licensed physician, dentist, or mental health practitioner that includes directions to health care providers and other involved personnel.
7. Residents will have access to specified 24-hour emergency medical, dental, and mental health services.
8. Female residents will have access to pregnancy testing and specified pregnancy management services.

9. All possible steps will be taken to ensure infectious and communicable diseases, including tuberculosis, hepatitis, and HIV/AIDS, are prevented or managed.
10. New direct-care staff will receive tuberculosis tests prior to their job assignment and periodically thereafter, and will be required to obtain the hepatitis B vaccine series.
11. Biohazard waste will be managed and medical and dental equipment decontaminated in accordance with sound medical standards and in compliance with applicable local, state, and federal regulations.
12. Residents with chronic conditions (such as hypertension and diabetes) will receive chronic care and treatment that includes monitoring of medications, laboratory testing, and chronic care clinics. Other residents will be scheduled for routine medical examinations, as determined by the health authority.
13. The facility administrator, or other designated staff, will be notified in writing of any resident whose medical or mental health needs require special consideration in such matters as housing, transfer, or transportation.
14. Residents will have access to emergency and specified routine dental care, provided under direction and supervision of a licensed dentist.
15. Residents will be provided health education and wellness information.
16. Each newly admitted resident (including transfers) will immediately receive a documented medical and mental health screening. Each facility's health care provider shall conduct a health appraisal and physical examination on each adult resident within 7 days of arrival, and on each minor within 24 hours of arrival.
17. Residents with mental health conditions will be referred, as necessary, for detection, diagnosis, treatment, and stabilization to prevent psychiatric deterioration while confined.
18. Crisis intervention services will be available for residents who experience acute mental health episodes.
19. Restraints for medical or mental health purposes will be authorized only by a qualified medical or mental health provider, in accordance with the requirements specified in this Residential Standard.
20. Residents whose mental health needs exceed the capabilities of the facility will be transferred to facility with the capacity to meet their needs.
21. Prior to placement in a non-residential facility specifically designated for the care of the

severely mentally ill or developmentally disabled, a resident shall be afforded due process in compliance with applicable federal, state, and local laws.

22. Prescription and nonprescription medicines will be stored, inventoried, dispensed, and administered in accordance with sound standards, and facility needs for safety and security.

23. Health care services will be provided by a designated health authority, and clinical decisions will be the sole province of the responsible clinician.

24. Health care services will be provided by trained and qualified personnel whose duties are governed by job descriptions and who are properly licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements.

25. Residential and health care personnel will be trained, at least annually, to respond to health-related emergency situations within four minutes of notification, and to properly use first aid kits, available in designated areas.

26. Information about each resident's health status will be treated as confidential. Active health records will be maintained in accordance with accepted standards, separate from other residents' residential files, and shall be accessible only in accordance with written procedures and applicable laws.

27. The informed consent standards of the facility's jurisdiction will be observed and adequately documented at the facility.

28. Medical and mental health interviews, examinations, and procedures will be conducted in settings that respect residents' privacy, and a female resident will be provided with a female observer for health care performed by male health care providers.

29. Health record files on each resident will be well organized, available to all practitioners, and properly maintained and safeguarded.

30. When a resident is transferred to another facility, the transferring facility will ensure appropriate records are transferred in accordance with established ICE policy.

31. Where required, residents have regular access to translation services and/or are provided information in a language that they understand.

32. The standard complies with federal laws and with DHS regulations regarding residents with special needs.

III. **DIRECTIVES AFFECTED.** None

IV. **REFERENCES**

American Correctional Association 4th Edition Standards for Adult Detention Facilities: 4-ALDF-2A-15, 4C-01 through 4C-31, 4C-34 through 4C-41, 4D-01 through 4D-21, 4D-23 through 4D-28, 2A-45, 7D-25.

Residential Standard on "**Admission and Release."**

Residential Standard on "**Environmental Health and Safety**," particularly in regard to:

- Storing, inventorying, and handling needles and other sharp instruments,
- Standard ("universal") precautions to prevent contact with blood and other body fluids,
- Sanitation and cleaning to prevent and control infectious diseases, and
- Disposing of hazardous and infectious waste.

Residential Standard on "**Sexual Abuse and Assault Prevention and Intervention**."

Residential Standard on "**Suicide Prevention and Intervention**."

Residential Standard on "**Hunger Strikes**."

Residential Standard on "**Terminal Illness, Advance Directives, and Death**."

United States Public Health Service (USPHS) Division of Immigration Health Services (DIHS) Policies and Procedures Manual.

National Commission on Correctional Health Care, Standards for Health Services in Jails.

Flores v. Reno

V. **EXPECTED PRACTICES**

1. General

Every facility shall directly or contractually provide to its resident population:

- Initial medical screening
- Cost-effective primary medical and dental care as required by the health authority to maintain the health of the resident.
- Emergency care
- Specialized health care, as deemed necessary by the health authority to maintain

the health of the resident

- Mental heath care
- Hospitalization as needed within the local community

A designated health authority shall have the overall responsibility for health care services pursuant to a written agreement, contract, or job description. The health authority may be a physician, health services administrator, or health agency. When the health authority is other than a physician, final clinical judgment shall rest with a single, designated, responsible physician, referred to in this Residential Standard as the clinical director.

The health authority shall be authorized and responsible for making decisions about the deployment of health resources and the day-to-day operations of the health services program.

All facilities shall employ, at a minimum, a medical staff and support personnel large enough to perform basic exams and treatments for all residents. The essential positions needed to perform the health services mission and provide the required scope of services shall be described in a staffing plan that is reviewed at least annually by the health authority.

Health care personnel shall perform duties for which they are qualified by training, licensure, certification, job descriptions, and/or written standing, or by direct orders by personnel authorized by law to give such orders. The facility administrator, with the cooperation of the health care authority, shall negotiate and keep current arrangements with nearby medical facilities or health care providers to provide required health care not available within the facility, including securing appropriate custodial staffs to transport and remain with residents for the duration of any off-site treatment or hospital admission.

Ordinarily, clinical decisions shall be made by the responsible physician and shall not be countermanded by non-clinicians. If there is disagreement on the type or extent of treatment that is medically necessary, JFRMU shall make the determination, in consultation with the clinical director and in accordance with the policies and procedures of DIHS. The health care program and the medical facilities shall be under the direction of a health services administrator (HSA) and shall be accredited and maintain compliance with the standards of the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

2. Communicable Disease and Infection Control

a. General

Each facility shall have a written plan (or plans) that address the management of infectious and communicable diseases, including prevention, education, identification, surveillance, immunization (when applicable), treatment, follow-up, isolation (when indicated), and reporting to local, state, and federal agencies.

Plans shall include:

- Coordination with public health authorities
- Ongoing education for staff and residents
- Control, treatment, and prevention strategies
- Protection of individual confidentiality
- Media relations
- Management of tuberculosis; hepatitis A, B, and C; HIV infection; and avian influenza
- Reporting communicable diseases to local and/or state health departments in accordance with local and state regulations

In regard to the avian influenza, reference is made to the March 2006 32-page Avian Influenza Implementation Plan from DRO Director John P. Torres. The plan establishes guidelines and procedures in anticipation of an influenza pandemic in North America.

In the Quarterly Administrative Meetings described later in this Residential Standard, communicable disease and infectious control activities shall be reviewed and discussed.

In accordance with the Residential Standard on "**Environmental Health and Safety**," management of biohazard waste and decontamination of medical and dental equipment shall comply with applicable local, state, and federal regulations.

b. Additional Requirements Regarding Tuberculosis

As indicated below in the section on **Medical Screening of New Arrivals**, screening for tuberculosis is initiated at intake, and in accordance with CDC guidelines.

For all **confirmed and suspected** active tuberculosis cases, designated medical staff shall report:

- All cases to local and/or state health departments in accordance with local and state regulations, identified by the custodial agency and the resident's identifying number of that agency. (ICE residents are reported as being in ICE custody and identified by their Alien Numbers.)
- All ICE residents, as well as residents expected to transfer into ICE custody, cases to the DIHS Epidemiology Unit,:
    - By phone to (202) 732-0070, -0071, or -0100, or
    - By faxing a health department notification form to (202) 732-0095.

  Reporting shall include identifying information, Alien Number, case status, available diagnostic results, and treatment status.
- Any movement of ICE residents, including hospitalizations, facility transfers, releases, or removals/deportations shall be reported to the local and/or state health department and the DIHS Epidemiology Unit. If any confirmed or suspected active ICE resident is released or removed prior to the completion of treatment, designated medical staff shall facilitate post-custody case management and continuity of therapy by coordinating with the Epidemiology Unit and the local and/or state health department.

Designated medical staff shall collaborate with the local and/or state health department on tuberculosis and other communicable disease contact investigations.

c. Varicella (chickenpox)

Designated medical staff shall notify DIHS of any varicella cases among ICE residents, and of any ICE residents exposed to active varicella who do not have a history of prior varicella or varicella immunization.

d. Employee Health

The medical authority shall:

- Ensure that all new direct care medical staff members are tested for tuberculosis prior to their job assignments and periodically thereafter.
- Ensure that all new medical staff members have received the hepatitis B vaccine series.

The facility administrator shall:

- Ensure that all new direct care program staff are tested for tuberculosis prior to their job assignments and periodically thereafter.
- Ensure that all new direct care program staff have received the hepatitis B vaccine series. If required staff who are not medical providers, it shall be conducted through an independent health provider service.

3. Notifying Residents About Health Care Services

In accordance with the Residential Standard on "**Resident Handbook**," the facility shall provide each resident, upon admittance, a copy of the resident handbook or equivalent, in which procedures for access to health care services are explained.

In accordance with the section on **Orientation** in the Residential Standard on "**Admission and Release**," access to health care services shall be included in the orientation curriculum for newly admitted residents.

4. Facilities

a. Examination and Treatment Area

Adequate space and equipment shall be furnished in all facilities so that all residents may be provided basic health examinations and treatment in private.

The medical facility shall:

- Be located within the primary perimeter, in an area restricted from general resident access.
- Have its own perimeter to ensure restricted access.

A waiting area shall be located at the entrance to the medical facility that is under the direct supervision of custodial staffs and not medical staff. A resident toilet and drinking fountain shall be accessible from the waiting area.

b. Medical Records

Medical records shall be kept separate from residents' residential records, and stored in a securely locked area within the medical unit.

c. Medical Housing

If there is a specific area, separate from other housing areas, where residents are admitted for health observation and care under the supervision and direction of health care personnel, the following minimum standards shall be met:

1). Care

- A clearly defined scope of care services available.
- A physician on call or available 24 hours per day.
- Health care personnel have access to a physician or registered nurse and are on duty 24 hours per day when patients are present.
- All patients within sight or sound of a staff member.
- A care manual that includes nursing care procedures.
- A housing record that is a separate and distinct section of the complete medical record.
- Compliance with applicable federal and state statutes and local licensing requirements.

2). Wash Basins, Bathing Facilities, and Toilets

- Residents have access to operable washbasins with hot and cold running water at a minimum ratio of one for every 12 occupants, unless state or local building codes specify a different ratio.
- Sufficient bathing facilities are provided to allow residents to bathe daily, and at least one bathing area is configured and equipped to accommodate residents with physical impairments or who need assistance to bathe. Water is thermostatically controlled to temperatures ranging from 100° F to 120° F degrees.
- Residents have access to toilets and hand-washing facilities 24 hours per day and are able to use toilet facilities without staff assistance. Unless state or local building or health codes specify otherwise:

- Toilets are provided at a minimum ratio of one to every 12 residents in male toilet facilities and one for every 8 in female toilet facilities.
- All housing units with three or more residents have a minimum of two toilets.

5. Pharmaceutical Management

Each facility shall have written policy and procedures for the management of pharmaceuticals that include:

- A formulary of all prescription and nonprescription medicines stocked or routinely procured from outside sources.
- A method for obtaining medicines not on the formulary.
- Prescription practices, including requirements that medications are prescribed only when clinically indicated, and those prescriptions are reviewed before being renewed.
- Procurement, receipt, distribution, storage, dispensing, administration, and disposal of medications.
- Secure storage and perpetual inventory of all controlled substances (DEA Schedule II-V), syringes, and needles.

  All pharmaceuticals shall be stored in a secure area with the following features:

  - A secure perimeter
  - Access limited to authorized medical staff (never residents)
  - Solid walls from floor to ceiling and a solid ceiling
  - A solid core entrance door with a high security lock (with no other access)
  - A secure medication storage area

  The pharmacy shall also have a locking pass-through window.
- Administration and management in accordance with state and federal law.
- Supervision by properly licensed personnel.
- Administration of medications by personnel properly trained, and under the supervision of the health services administrator, or equivalent.
- Accountability for administering or distributing medications in a timely manner and according to physician orders.

6. Nonprescription Medications

Generally, all medications expected to be used by residents shall be approved by the medical department. Residents may, as needed, have access to general over the counter medications such as Tylenol, Motrin, or other nonprescription medications. Because children are routinely present in a family residential facility, care must be taken to provide lockable boxes or locations within each housing area to secure nonprescription medications that may be used by residents.

7. Medical Personnel

All health care staff shall have valid professional licenses and/or certifications. DIHS shall be consulted to determine the appropriate credentials requirements for health care providers.

Medical personnel credentialing and verification shall comply with the standards established by JCAHO.

8. Medical Screening of New Arrivals

a. Medical Screening

Immediately upon their arrival, all newly admitted residents shall receive initial medical and mental health screening by a health care provider.

Screening shall include observation and interview items related to the resident's potential suicide risk and possible mental disabilities. For further information, see the Residential Standard on "**Suicide Prevention and Intervention**."

If at any time during the screening process there is an indication of, or request for, mental health services, the health authority must be notified within 24 hours to assess whether a full mental health evaluation is indicated. See the section on **Mental Health Program** below.

To the extent practicable, medical and mental health interviews and examinations shall be conducted in settings that respect residents' privacy.

If language difficulties prevent the health care staff from sufficiently communicating with the resident complete the intake screening, the staff shall obtain interpreter assistance.

- Such assistance may be provided by another staff or by a professional service, such as a telephone interpreter service.
- Only in emergency situations may a resident be used for interpreter assistance,

and then only if the interpreter is proficient and reliable, and only with the consent of the resident being screened.

- During in-processing and prior to the resident's placement in a housing unit, the health care provider shall complete the Intake Screening form I-794 (or facility equivalent) and record all findings of the medical screening process.

b. Physical Exam

Each facility's health care provider shall conduct a physical examination on each adult resident within 7 days of arrival, and on each minor within 24 hours of arrival. Medical and mental health interviews, examinations, and procedures shall be conducted in settings that respect residents' privacy. All female residents should be provided with a female escort for medical examinations with male health care providers.

Residents diagnosed with a communicable disease shall be isolated according to local medical procedures.

c. Tuberculosis Screening

All new arrivals shall receive TB screening in accordance with guidelines of the Centers for Disease Control (CDC). A chest x-ray is the primary screening method. The PPD (mantoux method) shall be the secondary screening method.

Residents with symptoms suggestive of active TB shall be placed in a negative pressure isolation room and promptly evaluated for TB disease.

Also see the earlier section on **Communicable Diseases and Infection Control**, specifically the **Additional Requirements Regarding Tuberculosis**.

d. Substance Abuse and Dependence

All residents shall be evaluated through the initial intake screening for their use of or dependence on mood and mind-altering substances – such alcohol, opiates, hypnotics, sedatives, etc., that were not administered under a doctor's care. Any resident determined to be abusing or dependent on such substances will not be admitted to a family residential facility.

9. Mental Health Program

a. Mental Health Services Required

Each facility shall have an in-house or contractual mental health program, approved by the appropriate medical authority that provides:

- Intake screening for mental health or illness
- Referral, as needed, for detection, diagnosis, and treatment of mental conditions
- Crisis intervention and management of acute mental health episodes
- Stabilization of mentally ill residents and prevention of psychiatric deterioration while confined
- Transfer of residents whose mental health needs exceed the capability of the facility, to a facility with the capacity to meet those needs.

b. Mental Health Provider

The term “mental health provider” includes a psychiatrist, psychologist, social worker and other mental health practitioner.

c. Mental Health Screening

Newly admitted residents are to receive initial mental health screening by a health care provider as part of the overall medical intake screening. If there is indication of a thought or mood disorder, a referral shall be made to the mental health provider using form DIHS 812-1.

Screening is done prior to the resident’s placement in a housing unit.

d. Mental Health Examinations and Appraisal

Based on in-processing screening, medical documentation, or subsequent observations by residential staff or medical personnel, the health authority shall immediately refer any resident who has or may have an acute or chronic mental illness or disability to a mental health provider for a mental health examination and appraisal.

Such examinations and appraisals shall:

- Review available documentation regarding such factors as mental health treatment, psychotropic medications, drug or alcohol treatment, and sexual abuse victimization.
- Review available documentation regarding predatory behavior.
- Assess for any differential diagnoses, such as pertinent physical conditions, head traumas, or organic brain disorders.

- Assess the resident's current mental health status and condition; suicide and violence potential; and drug and alcohol abuse or addiction.
- Recommend an appropriate level of care, for example:
    - Remain in general population with appropriate treatment plan.
    - Transfer to a facility with the capacity to meet the needs of patients who cannot reside in a general population.
    - Short-term community hospitalization until a plan for the placement of the patient and remaining family members can be implemented.
- Recommend and/or implement a treatment plan, including such matters as transfer, housing, voluntary work, and other program participation.

e. Referrals and Treatment

Any resident referred for mental health treatment shall receive a comprehensive evaluation by a licensed mental health provider, as soon as possible and no later than 14 days.

The provider shall develop an overall treatment and management plan, which may include transfer to a mental health facility if the resident's mental illness or developmental disability needs exceed the treatment capability of the facility.

The medical authority shall ensure due process in compliance with applicable federal, state, and local laws prior to a transfer.

f. At Risk Residents

Residents who have been identified as posing a continuing risk to themselves or others shall be removed from a family residential facility and placed in an appropriate facility.

g. Restraints

Restraints for medical or mental health purposes may be authorized only by a qualified medical or mental health provider, after reaching the conclusion that less restrictive measures are not successful. The facility shall have written procedures that specify:

- The conditions under which restraints may be applied
- The types of restraints to be used

- How a resident in restraints is to be monitored
- The length of time restraints are to be applied
- Requirements for documentation, including efforts to use less restrictive alternatives
- After-incident review

In all facilities, the medical authority or mental health provider shall complete a Post-Restraints Observation Report.

h. Involuntary Administration of Psychotropic Medications

Involuntary administration of psychotropic medications will only occur under the care of a physician at a hospital or alternative medical facility appropriate to the needs of the resident.

The medical provider will provide emergency medical treatment to a resident who presents a risk to himself or others. The medical provider will not provide medical treatment to a resident solely for the purposes of restraint, unless a medical professional determines that they present a danger to themselves or to others.

If a resident is likely to present a safely concern to DRO or facility personnel ,the Field Office should work with their Chief Counsel Office and the U.S. Attorney's Office to obtain a court order to authorize involuntary medical treatment to facilitate the removal process.

i. Telepsychiatry

Telepsychiatry is the use of electronic communication and information technology to provide or support clinical care at a distance. For telepsychiatry consultation, informed consent from the resident is required, just as would be required for a face-to-face encounter with a mental health provider. See the section on **Informed Consent and Forced Treatment** later in this Residential Standard.

If telepsychiatry services are offered, the facility's medical authority shall have written procedures that cover such matters as authorization, resident consent, refusal of treatment (including premature termination of an interview), communication arrangements, resident privacy, medical records documentation, and follow-up.

10. Periodic Health Examinations

The clinical director or health services administrator (or their equivalents) may determine that residents not covered below in the section on **Special Needs and Close Medical Supervision** are to be scheduled for periodic routine medical examinations (annually, for example).

11. Dental Treatment

An initial dental screening exam should be performed within 14 days of the resident's arrival. The initial dental screening may be performed by a physician, physician's assistant, or nurse practitioner - if trained by a licensed dentist.

Residents shall be afforded only authorized dental treatment (in accordance with the DIHS dental benefits package):

- **Emergency dental treatment** shall be provided for:
  - Immediate relief of pain, trauma, and acute oral infection that endangers the health of the resident, and
  - Repair of prosthetic appliances when there is adequate documentation supporting the inability of the resident to maintain reasonable caloric intake.

Routine dental treatment may be provided to residents for whom dental treatment is inaccessible for prolonged periods of confinement, including amalgam and composite restorations, prophylaxis, selected root canals, extractions, x-rays, the repair and adjustment of prosthetic appliances, and other procedures required to maintain the

resident's health. Accessory dental treatment is not provided which includes: fixed prosthodontics (crowns, implants, etc), fabrication of complete and partial dentures, or orthodontic treatment.

12. Sick Call

Each facility shall have:

- Regularly scheduled “sick call” times when medical personnel are available to see residents who have requested medical services.
- A procedure that allows residents the opportunity to request health care services (including mental health services) provided by qualified medical staff in a clinical setting.

If the procedure is a written request slip, they shall be provided in English and the most common languages spoken by the resident population of that facility. If necessary, residents, especially those illiterate or non-English speaking, shall be provided assistance to complete a request slip.

Request slips shall be:

- Freely available for residents to request health care services on a daily basis
- In English and the foreign languages most widely spoken among the residents
- Be completed by the resident or a minor’s parent or guardian
- Contain the resident's name, A-number (or other facility ID number), gender, age, and reason for requesting a medical appointment
- Be dated and signed by the resident or a minor’s parent or guardian.

All facilities must have a procedure in place to ensure that request slips are received by the medical department the same day that the resident submits the request, or no later than the following morning. For an urgent situation, the housing unit staff or other staff (such as a work detail supervisor) shall call the medical department or refer the matter to a staff supervisor.

The designated health care provider shall review the request slips and determine when the resident will be seen.

Sick call shall be held 7 days a week during regular working hours, except federal holidays.

All facilities shall maintain a permanent record of all sick call requests. The health authority in DIHS-staffed facilities shall maintain sick call records within the resident’s file.

13. 24-Hour Emergency Medical Treatment

Each facility shall have a plan for the delivery of 24-hour emergency health care when immediate outside medical attention is required.

A plan shall be prepared in consultation with the facility's routine medical provider, to include:

- An on-call provider;
- A list, available to all staff, of telephone numbers for local ambulances and hospital services

14. First Aid and Medical Emergencies

In each residential facility, the designated health authority and facility administrator shall determine the contents, number, location(s), use protocols, and monthly inspections procedures of first aid kits.

An automatic external defibrillator should be available for use at the facility.

Residential staff shall be trained at least annually to respond to health-related emergencies within four minutes of notification. The training shall be provided by a responsible medical authority in cooperation with the facility administrator and shall include:

a. Recognizing of signs of potential health emergencies and the required responses.

b. Administering first aid and cardiopulmonary resuscitation (CPR).

c. Obtaining emergency medical assistance through the facility plan and its required procedures.

d. Recognizing signs and symptoms of mental illness, suicide risk, retardation, and chemical dependency.

e. The facility's established plan and procedures for providing emergency medical care including the safe and secure transfer of residents for appropriate hospital or other medical services, such as by ambulance when indicated. The plan must provide for expedited entrance to and exit from the facility.

When an employee is unsure whether emergency care is required, he or she shall immediately notify the on-duty supervisor, and if the supervisor has any doubt about whether emergency care is required, he or she shall immediately contact a health care provider to make the determination.

15. Delivery of Medication

Distribution or administration of medication shall be in accordance with specific instructions and procedures established by the health care provider. Written records of all medication given to residents shall be maintained.

Medication may not be delivered or administered by residents.

16. Health Education and Wellness Information

The health authority shall provide residents with education and wellness information on such topics as self medication dangers, personal hygiene and dental care, prevention of communicable diseases, smoking cessation, family planning, self care for chronic conditions, self examination, and the benefits of physical fitness.

17. Special Needs and Close Medical Supervision

The medical care provider for each facility shall notify the ICE facility administrator in writing when a resident has been diagnosed as having a medical or psychiatric condition requiring special attention. Such conditions may include, for example, chronic illness, mental illness, physical disability, pregnancy, special diet, medical isolation, HIV/AIDS, etc.

When a resident has been diagnosed as having a medical or psychiatric condition requiring special attention, the medical care provider shall notify the facility administrator via a Resident Special Need(s) Form I-819 or similar form.

When a resident requires close medical supervision, including chronic and convalescent care, a treatment plan that includes directions to health care and other personnel regarding care and supervision shall be developed and approved by the appropriate physician, dentist, or mental health practitioner.

Female residents shall have access to pregnancy testing. Pregnant females will have

access to pregnancy management services that include routine prenatal care, counseling and assistance, nutrition, and postpartum follow-up.

Exercise areas will be available to meet exercise and physical therapy requirements of individual's treatment plans.

18. HIV/AIDS

An HIV/AIDS diagnosis may be made only by a licensed physician, based on a medical history, current clinical evaluation of signs and symptoms, and laboratory studies.

a, Clinical Evaluation

When current symptoms are suggestive of HIV/AIDS infection, the following shall be implemented:

1). Clinical evaluation shall determine the medical need for isolation.

The health authority shall not recommend to ICE/DRO that the resident be separated from the general population, either pending a test result or after a test report, unless clinical evaluation reveals a medical need for isolation.

2). Following a clinical evaluation, if a resident manifests symptoms requiring treatment beyond the facility's capability, the provider shall recommend resident transfer to a hospital or other appropriate facility for further medical testing, final diagnosis, and acute treatment as needed, consistent with local medical procedures.

3). Any resident with active tuberculosis should also be evaluated for possible HIV/AIDS infection.

4). An HIV positive diagnosis must be reported to government bodies according to state and federal requirements. Reports of AIDS, and not HIV infection, are required by the CDC. State laws differ considerably, and the clinical director is responsible for ensuring that all applicable state requirements are met.

b. Exposure

Exposure of a resident to potentially infectious body fluids, such as needle sticks or bites, shall be reported as soon as possible to the clinical director.

Staff exposed to potentially infectious body fluids should seek medical assistance and report the incident as soon as possible to the clinical director.

c. Precautions

All residents should be assumed to be infectious for blood-borne pathogens, and standard ("universal") precautions are to be used at all times when caring for all residents. No additional special precautions are required for the care of HIV positive residents.

The **Standard Precautions** section of the Residential Standard on "**Environmental Health and Safety"** provides more detailed information.

19. Informed Consent and Forced Treatment

As a rule, medical treatment shall not be administered against a resident's will.

- Except in emergency circumstances, the facility health care provider shall obtain signed and dated consent forms from all residents, parents or guardians before administering any special medical procedures not delineated in the general consent form signed upon admission.
- Informed consent standards of the jurisdiction shall be observed, and consent forms shall either be in a language understood by the resident, or interpreter assistance shall be provided and documented on the form.

  If the resident refuses to consent to treatment, medical staff shall make reasonable efforts to convince the resident to voluntarily accept treatment.

  - Medical staff shall explain the medical risks if treatment is declined and shall document their efforts and the refusal of treatment in the resident's medical record.
  - When recommended by the medical staff, a resident who refuses examination or treatment may be removed from the facility if his or her refusal poses a risk to the general population, staff and visitors.
  - Forced medical treatment shall not be conducted at family facilities. (See section on **Special Provisions for Care of Children**).
  - In the event of a hunger strike, see the Residential Standard on "**Hunger Strikes**."

The Residential Standard on "**Terminal Illness, Advance Directives, and Death"** provides details regarding living wills and advance directives, organ donations, and "do-not-resuscitate" orders.

20. Special provisions for care of children

Medical Care of Children (infant to 11 years)

Each child upon arrival at the facility will be enrolled in a Well Baby or Well Child Clinic. The physical exam and periodic well-child checks will follow the same format each visit. These exams shall be documented on the DIHS Pediatric Physical Assessment Form. These exams will start with the initial visit, then follow at regular intervals as follows: 2 to 4 weeks of age; 2 months old; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; then annually from 3 to 10 years of age. At 11 years of age, the assessment will be documented on the adult physical exam sheet.

The format for the exams is the same at each age level but will put emphasis on the differences for each age group, and will include the following.

1. Developmental Tasks
   - Physical
   - Behavioral
   - Mental
2. Diet and Nutrition
   - Adequate
   - Appropriate for age/development
3. Immunizations
   - Up to date
   - Documentation
4. Subjective Data: includes previous medical history, any current medical problems, medications, and allergies
5. Objective Data:
   a. Vital signs: includes blood pressure, temperature, pulse, respirations, height and weight. In children up to 23 months this will also include head circumference.
   b. Physical exam, head to toe, to include dental health
6. Assessment: shall include a discussion of findings with the parent or guardian.
7. Plan: includes timing of follow up, medications and laboratory tests (if indicated), referral to next level of care (if indicated), and next exam.
8. Anticipatory guidance: instructions to parents on what to expect in their child's development and how to deal with changes in a residential setting. Includes injury prevention, nutrition, educating child.

9. Child and parent education regarding dental hygiene, use of any medications, follow-up, and sick call procedures

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Medical Care of Adolescents (12 to 18 years)

In addition to the above exam process, the adolescent exam shall include a special emphasis on preventive services in order to reduce serious morbidity and premature mortality. The five categories included in preventive services screening and counseling will include:

1. Screening for risk factors for injury, chronic illness, and need for immunizations

   Counseling about the following to reduce health risks:

   - Cardiovascular diseases
   - Smoking cessation
   - Obesity/Nutrition
   - Hypertension
   - Hyperlipidemia

2. Counseling regarding health risk behaviors:
   - Alcohol and drug use
   - Sexually Transmitted Diseases (age-appropriate)
3. Immunizations against HPV and Meningococcal meningitis
4. General health guidance and recommendation for frequency of health visits
5. Dental health.

   Anticipatory Guidance for parents of adolescents will include but not be exclusive to:

   - Appropriate parental decisions
   - Adapting parental practices to meet changing needs of the child and the family
   - Health guidance throughout child-rearing spectrum

21. Medical Records

a. Health Record File

The health authority shall maintain a complete health record file on each resident that is:

- Organized uniformly in accordance with recognized medical records standards.

- Available to all practitioners and used for all health care documentation.
- Properly maintained and safeguarded in a securely locked area within the medical unit.

b. Confidentiality and Release of Medical Records

All medical providers shall protect the privacy of resident's medical information to the extent possible, while permitting the exchange of health information required to fulfill program responsibilities and to provide for the well-being of residents. These protections apply not only to records maintained on paper, but also to electronic records.

In general, information about resident's health status is confidential, and the active medical record shall be maintained separately from other residential records and be accessible in accordance with sound medical practice and applicable laws.

The health authority shall, however, provide the facility administrator and designated staff information that is necessary:

- To preserve the health and safety of the resident, other residents, staff, or any other person.
- For such administrative and residential decisions as housing, voluntary work assignments, security, and transport.
- For such management purposes as audits and inspections.

When information is covered by the Health Information Privacy Act (HIPA), specific legal restrictions govern the release of medical information or records.

Copies of health records may be released by the facility health care provider directly to a resident or any person designated by the resident, upon receipt by the facility health care provider of a written authorization from the resident. Form I-813 may be used for this purpose.

In absence of an I-813 Form, a written request may serve as authorization for the release of health information, as long as it includes the following (and meets any other requirements of the facility health care provider):

- Address of the facility to release the information
- Name of the individual or institution to receive the information
- Resident's full name, A-number (or other facility identification number), date of birth, and nationality

- Purpose or need for the release
- Nature of the information to be released with inclusive dates of treatment
- Resident's signature and date

Following the release of health information, the written authorization shall be retained in the health record.

Facilities are required to notify JFRMU each time a resident's medical records are released.

Residents who indicate they wish to obtain copies of their medical records shall be provided with the appropriate form. The facility staff shall provide the resident with basic assistance in making the written request (if needed), and assist in transmitting the request to the facility health care provider.

If facility staff receives a request for a resident's medical records:

- The request shall be forwarded to the facility health care provider, or
- The requester (if other than the resident) shall be advised to redirect the request and be provided with the appropriate name and address.

c. Inactive Health Record Files

Inactive health record files shall be retained as permanent records in compliance with DIHS established procedures.

22.. Transfer and Release of Residents

ICE/DRO shall make appropriate notifications to the facility and medical staff when residents are to be transferred or released.

Medical/Psychiatric Alert. Medical staff shall notify the facility administrator in writing when they determine that a resident's medical or psychiatric condition requires:

- Clearance by the medical staff prior to release or transfer, or
- Medical escort during removal or transfer.

Notification of Transfers, Releases, and Removals. The facility health care provider shall be given advance notice prior to the release, transfer, or removal of a resident, so that medical staff may determine and provide for any medical needs associated with the transfer or release.

Transfer of Health Records. In advance of a resident's transfer, the resident's

medical records or copies shall be mailed to the receiving facility's medical department in a sealed envelope or other container, labeled with the resident's name and A-number and marked "MEDICAL CONFIDENTIAL." The medical records are to arrive at the receiving facility in advance of the resident's arrival.

Immunization records of a minor shall be provided to the parent or guardian upon release. Other requirements for the transfer of records are contained in the Residential Standard on "**Transfers of Residents**."

23. Terminal Illness, Fatal Injury, or Death of a Resident

Procedures to be followed in the event of a resident's terminal illness, fatal injury, or death are in the Residential Standard on "**Terminal Illness, Advance Directives, and Death**." That Residential Standard also addresses resident organ donations.

24. Medical Experimentation

Residents may not participate in medical, pharmaceutical or cosmetic experiments or research.

25. Administration of the Medical Department

Quarterly Administrative Meetings

The facility administrator and health services administrator shall meet at least quarterly and include other facility and medical staff as appropriate.

The meeting agenda shall include, at a minimum:

a. An account of the effectiveness of the facility health care program

b. Discussions of health environment factors that may need improvement

c. Review and discussion of communicable disease and infectious control activities

d. Changes effected since the previous meetings

e. Any necessary recommended corrective actions

Minutes of each meeting shall be recorded and kept on file.

Health Care Internal Review and Quality Assurance

The health authority shall implement a system of internal review and quality assurance. Elements of the system shall include:

- Participating in a multidisciplinary quality improvement committee.
- Collecting and analyzing data combined with planning, intervening, and reassessing.
- Evaluating defined data.
- On-site monitoring of health service outcomes on a regular basis through:

  a. Chart reviews by the responsible physician or his or her designee, including investigation of complaints and quality of health records.

  b. Review of prescribing practices and administration of medication practices.

  c. Systematic investigation of complaints and grievances.

  d. Monitoring of corrective action plans.

  e. Reviewing all deaths, suicide attempts, and illness outbreaks.

  f. Developing and implementing corrective action plans to address and resolve identified problems and concerns.

  g. Re-evaluating problems or concerns to determine whether the corrective measures have achieved and sustained the desired results.

  h. Incorporating findings of internal review activities into the organization's educational and training activities.

  i. Maintaining appropriate records of internal review activities.

  j. Issuing a quarterly report to the health services administrator and facility administrator of the findings of internal review activities.

  k. Ensuring records of internal review activities comply with legal requirements on confidentiality of records.

Peer Review

The health authority shall implement an external peer review program for physicians, mental health professionals, and dentists, with reviews conducted at least every two years.

26. Examinations by Independent Medical Service Providers and Experts

On occasion, medical and/or mental health examinations by a practitioner or expert not associated with ICE/DRO or the facility may provide a resident with information useful in administrative proceedings before the Executive Office for Immigration Review and

ICE/DRO.

If a resident seeks an independent medical or mental health examination, the resident or his or her legal representative shall submit to the JFRMU a written request that details the reasons for such an examination. The Chief JFRMU shall approve the examination, as long as it would not present an unreasonable security risk. If a request is denied, the JFRMU shall advise the requester in writing of the rationale.

Neither ICE/DRO nor the facility may assume any costs of the examination, which shall be at the resident's expense. The facility shall provide a location for the examination but no medical equipment or supplies, and the examination must be arranged and conducted in a manner consistent with security and good order.

Should the independent examination result in treatment recommendations that would involve increased costs or services not covered by DIHS policy, the facility's medical authority shall consult with DIHS.

Standard Approved:

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John P. Torres **Date**
Director
Office of Detention and Removal