

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 001
Title: VOLUNTARY AND VOLUNTARY TOTAL FASTING AND RE-FEEDING	Page 1 of 12 Effective Date: 15 Oct 03 Revised: 11 August 05 1830
SCOPE: Detention Hospital/Delta Clinic	

- I. Encl:** (1) Refusal to Accept Food or Water/Fluids as Medical Treatment Form
(2) Voluntary and Voluntary Total Fasting Medical Evaluation Sheet
(3) Voluntary and Voluntary Total Fasting Medical Flow Sheet
(4) Clinical Protocol for Re-Feeding

II. BACKGROUND

Refusals of food and water can be expected in any detained population as individuals may use fasting as a form of protest or to demand attention from authorities. Thirst strikes, although rare, can be more rapidly damaging given the local climate. The reasons for food refusal can be varied as can the level of fasting (not necessarily total). Religious fasting, which may be seen in Muslim detainees during Ramadan, should not be considered a hunger strike. While hunger striking has traditionally been used to describe a spectrum of situations involving fasting, for the purposes of this standard operating procedure (SOP), the term will be used as defined below.

III. POLICY

A. Joint Task Force (JTF)-GTMO policy is to avert death from hunger strikes and from failure to drink as well as to monitor the health status of detainees who are fasting voluntarily. Every attempt will be made to allow detainees to remain autonomous up to the point where failure to eat or drink might threaten their life or health. The Detention Hospital (DH) is responsible for providing health care monitoring and medical assistance as clinically indicated for detainees who are voluntarily fasting or on a hunger strike. The Officer in Charge (OIC) of the DH will ensure that the appropriate standards of care for the medical and administrative management of fasting detainees are adhered to. The DH OIC will do everything within his/her means to monitor and protect the health and welfare of hunger striking detainees including involuntary intravenous hydration and/or enteral tube feeding if necessary. DH medical personnel will make every effort to obtain consent from a voluntary faster for treatment.

B. In the event a detainee refrains from eating to the point where involuntary feeding is required, no direct action will be taken without the knowledge and written approval of

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the JTF-GTMO Commander. If the JTF-GTMO Commander, as the approval authority, makes the decision to authorize involuntary re-feeding of a detainee, he will immediately inform the Commander, USSOUTHCOM, of his decision. In turn, the Commander, USSOUTHCOM, will notify appropriate Joint Staff and Department of Defense offices of the need to initiate involuntary re-feeding of a detainee.

C. Definitions.

Voluntary Fasting (VF). A voluntary fast occurs when a detainee communicates his intent to JTF-GTMO personnel to undergo a period of fasting for a specific purpose, has had no solid food intake for a period of 72 hours (9 consecutive meals), but is taking adequate liquids/fluids by mouth.

Voluntary Total Fasting (VTF). A voluntary total fast occurs when a detainee communicates his intent to JTF-GTMO personnel to undergo a period of fasting for a specific purpose and has not taken any solids or liquids for a period of more than 48 hours.

Hunger Striker. A hunger striker is a detainee who communicates his intent to JTF-GTMO personnel to undergo a period of voluntary or total voluntary fasting as a form of protest or to demand attention from authorities. The designation of a detainee as a hunger striker is based on intent, purpose, and behavior and will be determined by the JTF-GTMO Surgeon in conjunction with input from the DH medical staff, the Commander, Joint Detention Group (JDG), and the Commander, Joint Intelligence Group (JIG). Certain situations may exist where the detainee is on a VF or VTF, but is not a hunger striker (ex. religious fast, severe depression with suicidal intent manifested by not eating or drinking).

Meal. The combined or individual consumption of fluids and/or solid food required to maintain daily metabolic requirements. These requirements vary by individual. For the purpose of this instruction, three 8 fluid ounce bottles of Ensure constitute one meal.

IV. PROCEDURES

A. Effective management of individuals or groups who refuse to eat or drink requires a close partnership between the DH medical staff and the Joint Detention Group (JDG) security force.

B. Security forces under the JDG will monitor each detainee's daily intake of meals and water.

C. The JDG will notify the DH medical staff of each detainee who meets the definition of VF or VTF as outlined above, and maintain a current missed meals list on that detainee. This list will be communicated via e-mail, phone or memorandum to the Director of Clinical Services and Support (DCSS) and the Senior Nurse Executive (SNE) each day. Included in this list will be a running total of consecutive missed meals by each

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detainee who is on a VF or VTF. In addition, the JDG can include detainees of concern who have not met the criteria for a VF or VTF, but who may not be taking in adequate nutrition or fluids.

D. Once notified, DH medical personnel will evaluate each detainee. Part of this evaluation will be to determine the intent and purpose of the VF or VTF. The JTF-GTMO Surgeon, in conjunction with input from the DH medical staff, the Commander, JDG, and the Commander, JIG, will determine whether the actions of a detainee meet the criteria for a hunger strike as outlined above. A list of those detainees on hunger strike will be forwarded by the DCSS to JDG/S3 and to the SNE and this information will be included in the daily SITREP.

E. If during the course of a hunger strike, involuntary re-feeding is required, the JTF-GTMO Surgeon will make specific recommendations to the JTF-GTMO Commander as to the timing and requirement for such involuntary re-feeding. The JTF-GTMO Commander will decide, in writing, whether to order the involuntary re-feeding of a detainee. If the JTF-GTMO Commander, as the approval authority, makes the decision to authorize involuntary re-feeding of a detainee, he will immediately inform the Commander, USSOUTHCOM, of his decision. In turn, the Commander, USSOUTHCOM, will notify appropriate Joint Staff and Department of Defense offices of the need to initiate involuntary re-feeding of a detainee.

F. Enclosure (1), *Refusal to Accept Food or Water/Fluids As Medical Treatment*, will be verbally translated at the initial assessment, alerting detainees of the dangers of failure to eat or drink. The DH medical staff shall make every effort to convince the detainee to accept treatment. Medical risks faced by the detainee if treatment is not accepted shall also be explained. A note will also be put in the out-patient chart.

V. MEDICAL EVALUATION AND MANAGEMENT

A. The DH medical staff will monitor the health of any detainee who is on a VF or VTF. Upon notification, DH medical personnel will do the following:

1. A complete medical record review
2. An intake (food/fluids) history
3. General physical examination to include: Vital signs (HR, BP, RR, T), weight and body mass index (BMI).
4. Consultation with Behavioral Healthcare Service (BHS) for an assessment of the mental and psychological status.
5. Document the evaluation on enclosure (2), the *Voluntary and Voluntary Total Fasting Medical Evaluation Sheet*.
6. A BHS provider will document the psychological evaluation on a Standard Form 600.
7. Once the detainee is being evaluated on a periodic basis, all evaluations will be recorded on the *Voluntary and Voluntary Total Fasting Medical Flow Sheet* (enclosure

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3). This form will be maintained with the detainee's Medication Administration Record (MAR).

B. Detainees on a VF or VTF will be prioritized in the following manner:

1. **Priority One.**

(b)(2)

2. **Priority Two.**

(b)(2)

3. **Priority Three.**

(b)(2)

C. If a DH medical officer has reason to believe that the continuation of the fasting state could endanger a detainee's health or life, the detainee will be admitted to the DH. Clinical protocols for refeeding can be found in enclosure (4). When, as a result of inadequate intake or abnormal output, a DH medical officer determines that a detainee's life or health might be threatened if treatment is not initiated immediately, the DH medical officer shall give consideration to forced medical treatment of the detainee. When, after reasonable efforts, or in an emergency preventing such efforts, a medical necessity for immediate treatment of a life or health threatening situation exists, the DH medical officer may request that treatment be administered without the consent of the detainee. Once again, no direct action will be taken to involuntarily feed a detainee without the written approval of the JTF-GTMO Commander as set out above. DH medical staff shall document their treatment efforts.

D.

(b)(2)

E. (b)(2)

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(b)(2) and the monitoring continued. An entry will be made in the health record to this effect.

F. Only the JTF-GTMO Surgeon will remove a detainee from the Hunger Striker list. The DCSS or his/her designated representative will notify JDG/S3 personnel via phone call, SIPR net, or in writing upon discontinuation of the hunger strike. No detainee will be removed from the monitoring phase until a DH medical officer has evaluated him and has determined that he is no longer on a VF, VTF, or hunger strike.

Refusal to Accept Food or Water/Fluids As Medical Treatment

Detainee Number _____ Age _____ Date _____

The above detainee has refused to accept food or water/fluids as medically indicated by the Camp Delta Medical Officer of the Day.

It has been explained to the detainee the grave risks involved with not following the medical advice directing him to eat life-sustaining food and to drink water/fluids. As a direct result of his refusal to eat and/or drink, he understands that they may experience: hunger, nausea, tiredness, feeling ill, headaches, swelling of their extremities, muscle wasting, abdominal pain, chest pain, irregular heart rhythms, altered level of consciousness, organ failure and coma. He understands that his refusal to eat life-sustaining food or drink water/fluids and to follow the medical advice may cause irreparable harm to himself or lead to his death.

He understands that this is not a complete list of the risks involved with the refusal to follow medical advice and that he may experience other severe complications.

He understands the alternatives available to him including oral food and fluid, oral rehydration solutions (Gatorade), oral nutritional supplements (Ensure), intravenous hydration, and intravenous nutrition (total parenteral nutrition and peripheral parenteral nutrition).

He fully understands the prognosis if he does not accept food as directed above.

Translator Signature

Witness Signature

Medical Provider Signature

Enclosure (1)

Voluntary and Voluntary Total Fasting Medical Evaluation Sheet

Detainee Number _____ Date of Evaluation _____

Date of Onset _____

CC: Hunger striker: Food Fluids Both

HPI:

H/O depression?	Y	N	MEDS:
H/O Suicidal ideation?	Y	N	
Mood problems?	Y	N	
Anxiety problems?	Y	N	ALLERGIES: NKDA or _____

PMH:

Reason for Strike? _____

Physical Assessment:

Inprocessing BMI: _____

Current Weight: _____ Current BMI: _____

Heart Rate _____ BP _____ RR _____ T _____ LOC: Yes No

Other Pertinent Physical Exam Findings:

Assessment:

Plan:

1. Explained risks of inadequate intake of food and/or water to detainee. Risks include, but are not limited to: headache, fatigue, malaise, nausea, abdominal discomfort, muscle wasting, heart problems/cardiac dysrhythmias, and death.
2. Detainee given informational handout and expressed understanding after all his questions were answered.
3. Continue follow-up as per Voluntary and Voluntary Total Fasting and Re-feeding SOP.
4. Other:

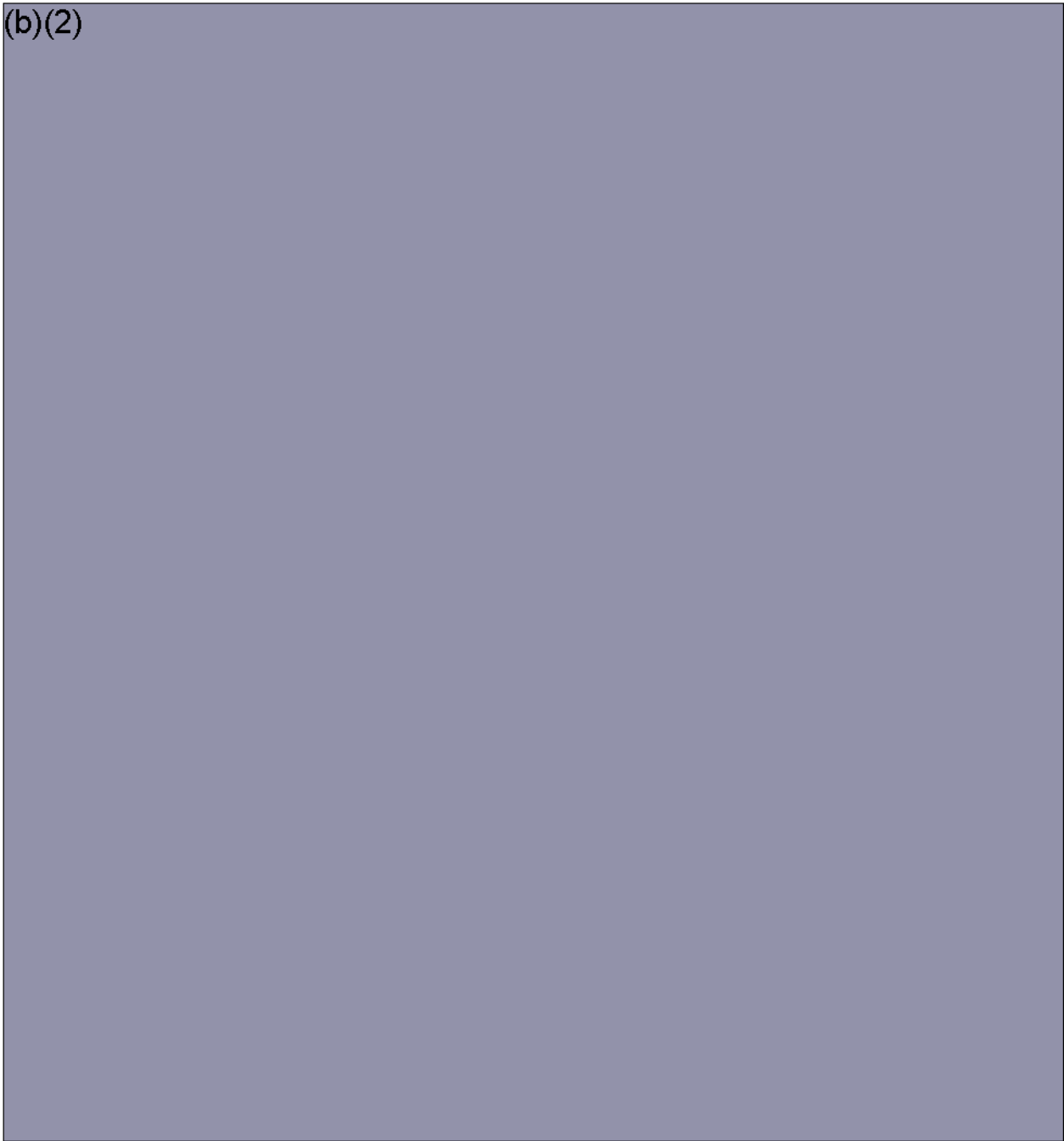
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Provider: _____

Enclosure (2)

Clinical Protocol for Re-Feeding

(b)(2)

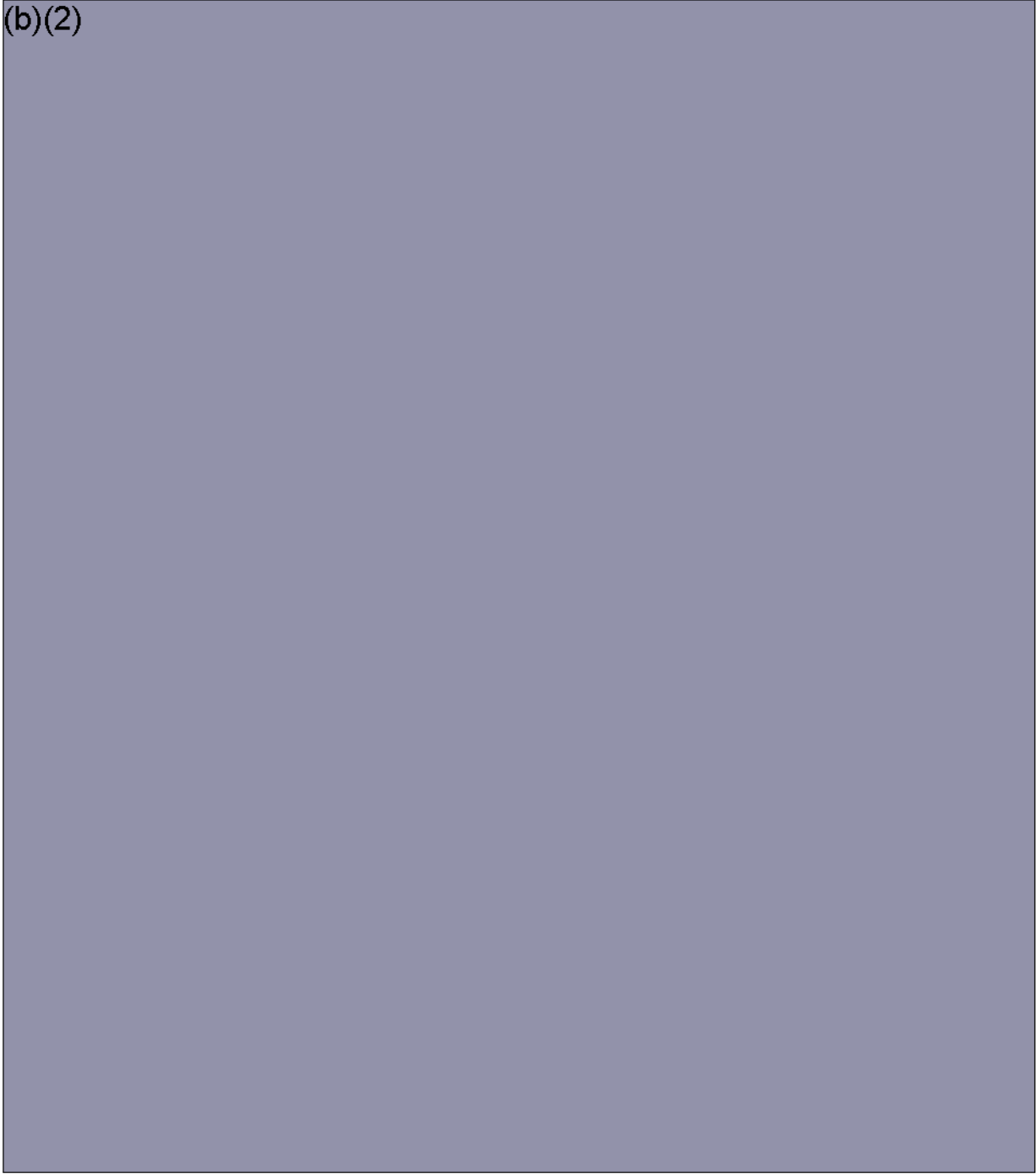


Enclosure (4)

VOLUNTARY AND VOLUNTARY TOTAL FASTING AND RE-FEEDING

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(b)(2)

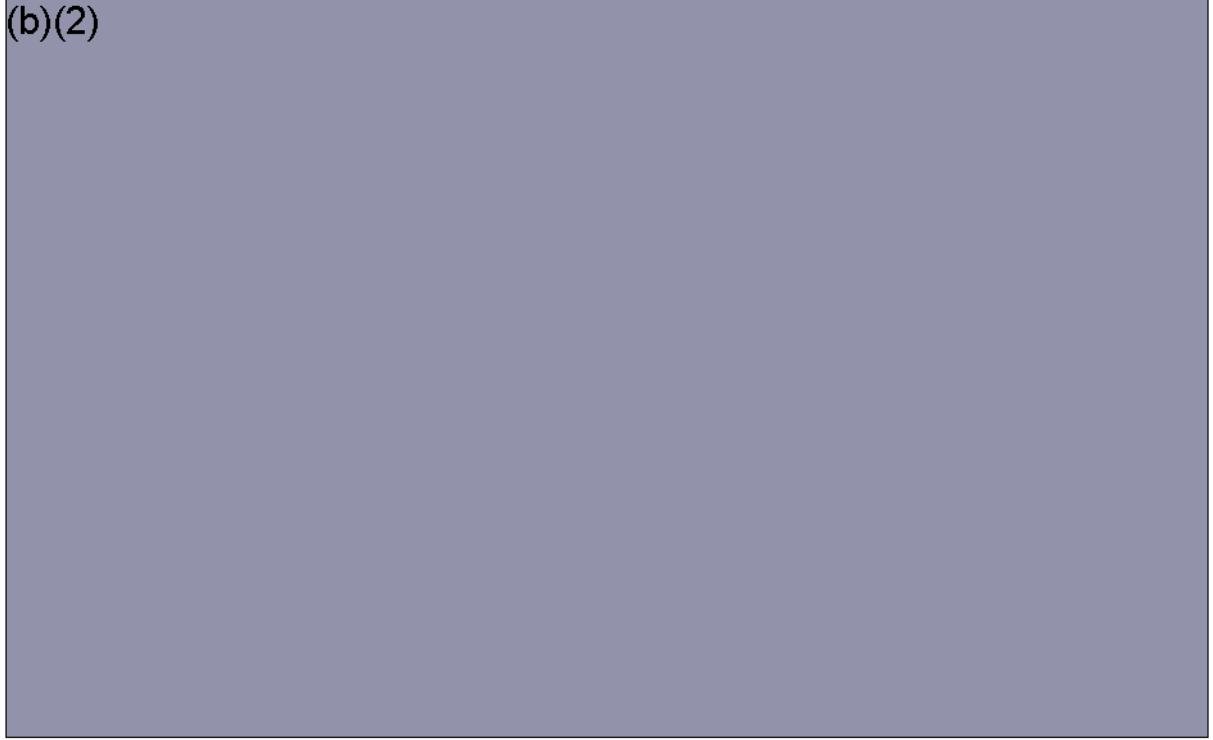


Enclosure (4)

VOLUNTARY AND VOLUNTARY TOTAL FASTING AND RE-FEEDING

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(b)(2)



Enclosure (4)

VOLUNTARY AND VOLUNTARY TOTAL FASTING AND RE-FEEDING
SOP: 001

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 002
Title: ACTIVE TUBERCULOSIS MANAGEMENT	Page 1 of 4 Effective Date: 21 Mar 03
SCOPE: Detention Hospital	

I. ENCL:

- (1) Tuberculosis Screening Process Flowchart
- (2) DS-3024, U.S. Department of State CHEST X-RAY AND CLASSIFICATION WORKSHEET

II. BACKGROUND:

Timely identification and treatment of active tuberculosis cases is required for adequate Force Health Protection of the Joint Task Force personnel in close contact with the detainee population and as a public health measure to prevent spread of disease among detainees in the detention center environment. All detainees will be screened for clinical and radiological evidence of active tuberculosis. The screening algorithm for active tuberculosis is portrayed in enclosure (1). The policy thus stated in this SOP has been coordinated through consultation with the Centers for Disease Control (CDC), United States Public Health Service.

III. POLICY:

This is a revision of the Active Tuberculosis Management SOP dated 8 MAR 02 and supercedes that document. Exceptions to this policy must be based on compelling clinical evidence and will be discussed with the Commanding Officer FH 20 or Officer in Charge FH 20 Detachment and the Task Force Surgeon prior to implementation.

IV. PROCEDURES:

- ❑ The following sections deal with the description, definitions and elaboration of the Tuberculosis Screening Process flowchart. Screening for active tuberculosis disease upon arrival of the detainee at Naval Base Guantanamo Bay, NBGTMO, is one of the first steps in tuberculosis control.
- ❑ All detainees should arrive to NBGTMO wearing a surgical mask. Many of these detainees have come from areas with a high incidence of tuberculosis. The surgical mask is a measure to lessen the potential transmission of disease should the detainee be infectious. The surgical mask will be worn until the risk of active tuberculosis has been ruled out or the detainee is placed in appropriate isolation

for completion of evaluation.

- The initial evaluation of the detainee will consist of a chest x-ray (CXR) and medical screening for symptoms that may suggest tuberculosis disease. Some of these symptoms include hemoptysis, cough lasting 2 weeks or more, fever, night sweats, and weight loss. Detainees with symptoms or historical findings that are highly suggestive of tuberculosis disease will be isolated and undergo further evaluation for tuberculosis disease.
- The CXR is the other essential element of screening for active tuberculosis. Detainees will be screened with a PA CXR – additional views may be required if clinically indicated. CXR findings will be categorized as normal, high or low suspicion by the in-processing medical officer. High suspicion CXR findings would include an infiltrate/consolidation, cavitary lesion, pleural effusion, and/or hilar/mediastinal adenopathy. Radiology will then review the films at a later date and classify the chest x-ray findings using the U.S. Department of State Chest X-ray and Classification Worksheet (DS-3024) [enclosure (2)]. Further evaluation and treatment will be based on this classification as well as the clinical history and TST results.
- Detainees with CXR findings classified as high suspicion will proceed to isolation and further evaluation for tuberculosis disease. Detainees with CXR findings classified as low suspicion will be further evaluated for symptoms. Those detainees with CXR findings of low suspicion and symptoms suggestive of active tuberculosis will proceed to isolation and further evaluation for tuberculosis disease. Those detainees with CXR findings of low suspicion without symptoms will be referred to the Latent Tuberculosis Infection (LTBI) Management flowchart. Detainees with CXR findings classified as normal will be referred to the LTBI Management flowchart.
- Clinical evaluation of detainees determined to have symptoms, historical findings, or CXR findings suggestive of tuberculosis disease will include collection of three samples for acid fast bacilli (AFB) Smears and cultures for *Mycobacterium tuberculosis*. AFB smears should be concentrated specimens which can only be done at outside laboratories (i.e. NMC Portsmouth). AFB smears done at NHGTMO are reliable only if positive. Concentrated AFB smears are collected in the same way as all other AFB smears. Sensitivity testing will be completed on all positive cultures to help detect potential resistance to common drug therapies. The Tuberculin Skin Test, TST (also known as PPD), will be used as an adjunct during the evaluation for tuberculosis disease.
- Isolation of detainees is an operationally difficult task. While there are no perfect solutions to the isolation of detainees suspicious for tuberculosis there are prudent steps that can be taken to minimize any potential spread of tuberculosis from these detainees. Detainees with high suspicion for tuberculosis will be admitted to the isolation ward for further evaluation and treatment. Standard respiratory

isolation precautions will be enforced. This would include the use of standard respiratory protection when collecting sputum from the isolated detainees. All detainees should remain in isolation until three negative concentrated AFB smears on different days have been documented.

- Detainees with symptoms and/or chest radiograph findings highly suggestive of tuberculosis disease should be considered for immediate treatment prior to getting results of AFB smears. After obtaining baseline laboratory measurements, patients with highly suspicious or known tuberculosis should be started on a four drug regimen containing isoniazid (INH), rifampin, pyrazinamide, and either ethambutol or streptomycin, unless there are contraindications to any of these drugs. Detainees with symptoms that suggest the empiric diagnosis of tuberculosis disease should be maintained on four drug therapy until there is clinical and/or culture evidence to suggest a change in therapy. Negative AFB smears or resolution of symptoms does not rule out active disease and, thus, four drug therapy should be continued at least until culture results are negative. Continued empiric treatment for tuberculosis should be considered in cases where symptoms or CXR findings improve with tuberculosis treatment despite negative culture results. Care must be taken to avoid referral of detainees with tuberculosis disease for treatment of LTBI.
- Detainees with positive AFB smears and/or cultures will be treated for tuberculosis disease with four drug therapy as outlined above and will be maintained in isolation until three concentrated AFB smears are negative. Tuberculosis suspects started on four drug therapy with three negative concentrated AFB smears and clinical improvement will return to the general population while awaiting culture results. Detainees with negative AFB smears and cultures judged medically not to have active tuberculosis disease will be referred to the LTBI Management flowchart. For tuberculosis suspects who have not started on treatment, there should be three negative AFB smears and another non-tuberculosis diagnosis to explain positive items found on screening examinations.
- Cultures should be repeated periodically and evaluated for appropriateness of therapeutic regimen. After completion of treatment for tuberculosis disease the detainee will be followed with annual questionnaires [enclosure (2)].
- A spreadsheet of PPD results will be maintained at Camp Delta Clinic. AFB results and CXR findings will be documented in the detainee's medical record.

SOP Issued: 6/28/02

(b)(6)

Commanding Officer, Fleet Hospital 20

Copy to: Commanding Officer, US Naval Hospital, Guantanamo Bay
Joint Task Force Surgeon's Office

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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Officer In Charge	Date
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_____	_____
Director for Administration	Date
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Senior Enlisted Advisor	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 005
Title: EMERGENCY AND ROUTINE CT SCANS FOR DETAINEES	Page 1 of 3 Effective Date: 26 Jun 03 Reviewed: Mar 04
SCOPE: Detention Hospital	

I. BACKGROUND:

Detainees may develop medical conditions warranting evaluation with a CT scan.

II. POLICY:

When the detainee's physician deems a CT scan necessary,

[REDACTED]

(b)(2)

III. PROCEDURE:

A. Routine CT Scans:

1. Routine CT scans will be scheduled ordered through CHCS. The Provider will notify the Transportation Coordinator through Outlook or via memo that a CT is ordered.

[REDACTED]

(b)(2)

He will notify the Detention Hospital or Delta Medical Clinic the day prior to the exam, if possible.

[REDACTED]

(b)(2)

2. On the day of the examination, the detainee will be taken to the CT scanner.

[REDACTED]

(b)(2)

3. Upon arrival, the area around the CT scanner will be secured.

[REDACTED]

(b)(2)

findings and notify the ordering provider.

(b)(2)

B. Emergency CT Scans:

1. When a physician determines the need for a CT scan for a detainee, he will notify the independent duty corpsman (IDC)/primary care provider (PCP) on duty at the camp and contact the radiology CT technician. The designated duty personnel will then notify JDOG.

(b)(2)

2. When the radiology technician is ready for the examination he will notify JDOG

(b)(2)

Appropriate laboratory studies (ie BUN/Cr) will be drawn and to be run at the NAVHOSPGTMO lab urgently. If after hours, the duty lab technician will be paged to run the lab.

3. Appropriate infectious precautions will be taken by personnel.

(b)(2)

4. Upon arrival, the area around the CT scanner will be secured.

(b)(2)

5. Should the detainee require surgery or

(b)(2)

6. In the event of a cardiopulmonary arrest or "code," the Emergency Department will be notified immediately. The Emergency Department physician will be called to the CT scanner and will begin ACLS interventions.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
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Officer In Charge	Date
IMPLEMENTED BY:	
<u>(b)(6)</u>	<u>5 SEP 05</u>
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 007
Title: OVERVIEW OF DETAINEE CARE	Page 1 of 4 Effective Date: 15 Oct 03 Reviewed Mar 2004
SCOPE: Detention Hospital	

Ref: (a) OPNAVINST 3461.6

Background: This section provides an overview of medical screening and treatment for incoming detainees. Health Services Support for detainees is provided at several levels. A physical examination (see In-Processing Medical Evaluation: SOP 001) will be performed upon detainee arrival. Daily sick call will be available to detainees and regular medical clinic follow-ups will be scheduled for chronic or ongoing medical conditions. An infirmary (Detention Hospital) exists within the prison compound and will provide care similar to an inpatient hospital ward. (b)(2)

Responsibility: The JTF Surgeon is ultimately responsible for all medical care provided to detainees domiciled in Guantanamo Bay. By direction, the Detention Hospital Commanding Officer (OIC) and Senior Medical Officer will orchestrate all care for the detainees at Delta Clinic and the Detention Hospital.

Policy: Treatment and care provided will be humane and will follow the guidelines provided by the articles of the Geneva Convention. Specifically, each detainee will be provided needed supplies to ensure hygienic conditions and healthfulness along with an adequate daily food ration. General medical care will be available within the compound and specialty care provided as needed either at the Medical Clinic or Detention Hospital.

Procedures:

In-processing

- A. Upon arrival, each detainee will be medically and administratively processed. The specific process and medical care provided is provided in the SOP 001 entitled, "In-Processing Medical Evaluation."
- B. The first Td shot will be given during in-processing; each detainee will be offered two additional Td vaccinations to assure adequate immunity against tetanus and diphtheria.
- C. Each detainee will receive an influenza vaccination since influenza is present year-round in Cuba.

- D. Each detainee will be evaluated for hepatitis immunity upon arrival. Blood test results will take about 3-4 weeks. Those testing non-immune to hepatitis A and/or hepatitis B will be given vaccination for protection against these infections.
- E. Each detainee will be screened for human immunodeficiency virus (HIV). Those that are seronegative and are not immunocompromised for other medical reasons will receive a single dose of measles-mumps-rubella (MMR).
- F. Please refer to SOP 041: *Vaccinations* for further details regarding the immunization program.

I. Sick Call

- A. A daily sick call will be offered to all detainees. The times at which this occurs will vary. Twenty-four hour medical coverage will be provided from within the compound.
- B. A hospital corpsman with the assistance of the security personnel will make daily rounds for medical evaluation and medication distribution. In addition a list of all prisoners wishing to see the medical officer or designee will be requested from the detention blocks.
- C. All requests will be triaged appropriately by the medical staff.
- D. Follow-up and sick call visits will then be performed under the guidance of the medical officer, physician assistant, and/or independent duty corpsmen in a timely manner.
- E. After sick call has been completed, evaluations at night will be limited on a case-by-case basis depending on the severity of the complaint.

II. Medical Care

- A. An Internal Medicine and/or Family Practice physician will provide primary care capabilities.
- B. The following consultative services are also typically available on a weekly basis: Dental, Dietary, General Surgery, Infectious Diseases, Orthopedics, Optometry, Physical Therapy, and Psychiatry. Other consultants will be made available on an as needed basis via visiting military specialists.
- C. Ancillary services includes:
 - 1. General diagnostic tools needed for patient evaluation shall be at the disposal of the on duty provider/supervising physician.
 - 2. Radiography: Portable radiographs will be available on-site in the delta medical clinic and hospital. A stationary x-ray unit is also available in the detention hospital. Contrast studies, ultrasound, and CT require transport to the hospital.
 - 3. Laboratory studies will be collected on site and transported for processing at the Naval Hospital GTMO laboratory. Capability will mirror those labs currently performed at NAVHOSP. Other more complex laboratories will be sent to NH Portsmouth.

III. Maintenance of an Infirmary

- A. An on-site infirmary will be available to all detainees. Its function will be to provide a level of care, which cannot be maintained within the individual's prison cell. (b)(1)
(b)(2)
- B. It will be staffed according to need. Its operation will be the responsibility of an appointed nurse corps division officer and senior medical officer who will in turn report to the camp medical OIC. Medical and surgical consultation will be conducted within the infirmary when possible.

IV. Emergency Medical Services

- A. In the event that a detainee requires emergency medical services, such services will be provided. Initial response capability will occur from within the compound by personnel standing watch.
- B. (b)(2)

V. Monthly Medical Programs:

- A. Every detainee will undergo weight checks on a monthly basis. Those with a BMI of less than 18 may have more frequent monitoring of their weight. (See *Detainee Weight Management and Nutrition Program*: SOP 014).

VI. Annual Medical Programs:

- A. Each year detainees who previously had a positive ppd will be screened with a chest radiograph and those ppd negative will undergo annual ppd screening. (See *Latent Tuberculosis Management* SOP 031).
- B. Each year all detainees will receive the influenza vaccination during the months of October-December. Efforts should be made to immunize prior to Ramadan. (See *Vaccinations*: SOP 041)

VI. Reporting of Medical Care:

- A. A daily log of all patient visits will be maintained. If a prisoner requires follow-up care, this will be clearly communicated to the responsible custodial personnel and documented in the medical record.
- B. Each morning, daily medical SITREPS will be tabulated under the direction of the Officer In Charge. Brief summaries of hospitalized detainees as well as upcoming surgeries, clinic visits, and hunger strike will be included.

Detention Hospital
Guantanamo Bay, Cuba

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Officer In Charge	Date
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Director for Administration	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 009
Title: MORTUARY AFFAIRS AND ADVANCE DIRECTIVES	Page 1 of 4 Effective Date: 26 Jun 03 <u>Reviewed: 04 NOV 04</u>
SCOPE: Detention Hospital	

- Ref:**
- (a) Geneva Convention on Prisoners of War
 - (b) JTF GTMO Standard Operating Procedures for Mortuary Affairs
 - (c) NAVMEDCOMINST 5360.1

I. BACKGROUND:

As a consequence of disease, battle injury, and non-battle injury it is assumed that some loss of life may occur among detainees.

II. POLICY: JTF GTMO conducts mortuary affairs services in support of detainee operations. Mortuary services include the supervision and execution of matters pertaining to:

- A. Search, recovery, identification, and evacuation of deceased U. S. Military, civilians, and detainees.
- B. Recovery and disposition, including collection, receipt, recording, and storage of personal effects of deceased personnel.
- C. The maintenance of pertinent records and reports in connection with graves registration services. A graves registration program will only be implemented at the direction of USSOUTHCOM.

III. PROCEDURE:

- A. Normal mortuary services (current/concurrent death program) will remain in effect as long as the operational and logistical situation permits. Mortuary affairs will not be performed per reference (a), but “consistent with” the Geneva Convention.
- B. JTF GTMO Mortuary Affairs Officer (J4) serves as coordinating activity for all aspects of mortuary affairs at GTMO and coordinates directly with USSOUTHCOM Joint Mortuary Affairs Office (JMAO).
- C. Limited mortuary services are available at Naval Hospital Guantanamo Bay.

D. All U. S. remains will be handled per reference (b) and (c).

E. Detainee remains.

1. If a detainee dies while in the Detention Hospital or Delta Medical Clinic the JDOG watch officer, Detention Hospital Officer in Charge, Duty Medical Officer and Senior Medical Officer will be notified immediately.

2. Detainee remains will be cared for per reference (a) and as amplified by the following procedures:

(a) To the extent possible, detainee remains will be cared for in a matter consistent with their religious tradition.

(b) JTF GTMO JOC Watch Officer will notify USSOUTHCOM CAC and provide detainee personal data.

(c) JTF Surgeon will conduct post death medical evaluation.

(d) JTF GTMO JMAO, in coordination with USSOUTHCOM CAC, will request a Pathologist from the Armed Forces Institute of Pathology (AFIP). The AFIP/Armed Forces Medical Examiner (AFME) takes the request for action and a Pathology team will be ready to fly within 4 hours of notification.

(e) An autopsy will be conducted in every case to document the cause of death for all detainees.

(f) JTF GTMO JMAO will send a copy of detainee death certificate to USSOUTHCOM CAC (surgeon).

(g) The Department of State will contact the embassy of the decedent's home of record and advise them of the death and for a determination of the detainee remains disposition as well as disposition of detainee personal effects.

(h) (b)(2)



(i) (b)(2)



(j) Detainee personal effects will be handled in the same manner as those of U.S. decedents.

(1)(b)(2)

F. Advanced Directives.

1. Detainees have the right to self-determination and the opportunity to request advance directives or living wills.
2. Given the inherent difficulty in next of kin notification, no health care surrogates will be chosen. The JTF Commander will act as the health care surrogate for all detainees under advisement of the JTF Surgeon and JTF GTMO Staff Judge Advocate.
3. To the degree possible, cultural sensitivity will be maintained in executing these requests. For detainees wishing to execute an advance directive/living will, form NHGTMO 6320/24 will be completed and placed in the record. The medical officer will ensure the detainee understands this process and its implications prior to accepting the directive.

G. Do Not Resuscitate.

1. Detainees have the right to end-of-life medical care. They also have the right to refuse resuscitation in the event of cardiopulmonary arrest. Detainees requesting such orders will discuss them with a medical officer.
2. Only the medical officer can write a DNR order; it must be reviewed and approved by the Detention Hospital CO, the JTF Surgeon and Staff Judge Advocate. Documentation within the medical record must be clear and include the following at a minimum:
 - Diagnosis and prognosis
 - Description of the detainee's mental state
 - Express wishes of the detainee and evidence of informed consent
 - Reference to an advanced directive/living will if one exists

H. Suicide.

1. The medical staff is trained to recognize signs of suicidal thinking and behavior. Detainees will be screened during in-processing and if identified as "at risk" referred for psychiatric evaluation.
2. Duty medical staff and security personnel will be informed of any detainees on a "suicide watch" and follow the instructions of the consulting psychiatrist. The JTF Surgeon via the Detention Hospital CO will be apprised of any such determinations.

STANDARD OPERATING PROCEDURES

Detention Hospital

Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge

Date

IMPLEMENTED BY:

Director for Administration

Date

Senior Enlisted Advisor

Date

ANNUAL REVIEW LOG:

By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

<p>DETAINEE HOSPITAL GUANTANAMO BAY, CUBA</p> <p>Title: MEDICATION DISPENSING POLICY</p>	<p>SOP NO: 010</p> <p>Page 1 of 7 Effective Date: 22 Oct 04</p>
<p>SCOPE: Detention Hospital and Delta Clinic</p>	

I. REFERENCES:

- A. *NAVMED P-117 Manual of the Medical Department, Chapter 21 Pharmacy Operation and Drug Control*
- B. *BUMED Instruction 6710.70 Guidelines for Controlled Substances Inventory*
- C. *NAVHOSPGTMOINST. 6710.13A*

II. ENCLOSURES:

- A. Medication Administration Understanding
- B. Medication Administration Competence Assessment
- C. Medication Administration Record (MAR)
- D. Controlled Substance Inventory Board (CSIB) Inventories Sheet
- E. Not in Stock (NIS) Communication Log

III. PURPOSE:

To provide guidelines for the procedures to be followed in dispensing medications to the detainees located within Camp Delta: Delta Clinic, Detention Hospital, and Delta Bloc. The Detainee Acute Care Unit (DACU), located at the US Naval Hospital GTMO is included in these guidelines.

IV. BACKGROUND:

The pharmacy technician (NEC 8482) provides pharmacy support by dispensing medications pursuant to valid prescriptions written by credentialed providers. The Pharmacist, Naval Hospital GTMO, provides clinical oversight of the pharmacy technicians assigned to the Detention Hospital command.

V. RESPONSIBILITY:

- A. The Director for Clinical Support Services (DCSS) has overall responsibility for pharmaceuticals and reports directly to the Senior Medical Officer (SMO) via the Officer in Charge (OIC). The Leading Petty Officer (LPO) for the Pharmacy is responsible for the proper organization, efficient inventory management, and proper dispensing and issuance of all

pharmaceuticals. Operational procedures shall be in compliance with all provisions of Chapter 21 of the Manual of the Medical Department.

B. Security of Pharmaceuticals: The Detention Hospital pharmacy technician will ensure the proper security of the pharmaceuticals transported to Camp Delta. The pharmacy LPO will ensure that adequate medication stock is kept available at the Camp Delta medical facilities. A satellite pharmacy will be run from the Detention Hospital, which will provide most stock medication to the Camp Delta Clinic, the Detention Hospital, and Delta Block. At the camp, all pre-dispensed medications will be kept in a designated drug cabinet. All controlled substances will be kept in (b)(2) and the (b)(2) will maintain the narcotics log and locker key. A small stock of frequently used immunizations will be stored in the Detention Hospital Pharmacy reefer. Larger quantities of immunizations will be stored at the Naval Hospital GTMO Pharmacy and transferred to the Delta Clinic on an as needed basis.

VI. DISPENSING OF MEDICATIONS:

A. The Camp Delta medication formulary will be determined by the Senior Medical Officer. The formulary will be reviewed on an annual basis.

B. The medical providers will enter all prescriptions into CHCS. A CHCS terminal and label printer will be available for the pharmacy technician to use in the dispensing of prescriptions. The pharmacy technician will fill all prescriptions and will apply CHCS generated prescription label and auxiliary warning labels to the bottles as appropriate. Medications ordered beyond a one-time use and dispensed by the Hospital Corpsmen will be dispensed from the Detention Hospital pharmacy.

C. Medications that are labeled as PRN may be given to detainees by the corpsman or nurse working on the blocks. If the PRN medication has been given for three consecutive shifts the Corpsman/RN will make a note to the doctor stating the medication and the reason it is being administered. In the Detention Hospital, the inpatients must have a written order from the Senior Medical Officer or admitting physician for the PRN medications to be administered.

D. The controlled substances are kept in (b)(2) and dispensed to the custody of the nursing staff. The oncoming and off going RNs will be in charge of counting the narcotics and securing them in the locker at change of shift. The Narcotic Log (NAVMED #6710/4) will be signed by both nurses to validate the narcotic count is correct. All other dispensed medications will be kept in a designated area within the Clinic/Detention Hospital and will be stored according to type of medication and detainee identification number (ISN#).

E. Corpsmen may pass medications on the blocks after they have completed the five-day Corpsman Medication Orientation to Camp Delta and have had direct observation by the Team Leader. The corpsmen will also sign the MEDICATION ADMINISTRATION UNDERSTANDING form (Enclosure 1) and complete, with a skilled preceptor, the MEDICATION ADMINISTRATION COMPETENCE ASSESSMENT (Enclosure 2).

VII. WASTING OF NARCOTIC MEDICATIONS:

A. When a narcotic medication is returned for any reason, it will not be returned to the (b)(2) . The medication will be annotated as wasted on the back of the Narcotic and Controlled Drug Account Record (NAVMED 6710/1) for that particular medication. The amount given, amount wasted, wasted initials, and witness initials will be filled in. Two nurses or a nurse and a corpsman are authorized to annotate the waste of the narcotic.

VIII. DOCUMENTATION OF MEDICATION ADMINISTRATION

A. When the nurse takes Doctor's Orders (SF 508) off the chart, the nurse will initial off to the side of each order as it is taken off and transcribed to the Medication Administration Record (MAR) (Enclosure 3). There are three different MARs in use, one for the Delta Clinic/Delta Block, one for the Hospital and the Special Duty (Camp 5/Echo). After all of the orders are transcribed appropriately, the nurse will sign, date and time when he or she completed the transcription of the orders.

B. The MAR must contain the ISN number of the detainee on the bottom left side; block number must be on the bottom. The signature of the person transcribing MAR and a nurse will be on the top; medications must list name, amount, route, and frequency; and all persons writing on MAR must legibly sign and initial the initial code box at the bottom of page. The codes that are accepted on the MAR are: **NIC = (Not in Cell)**, **F = (Fasting)**, *** = (Not in Stock)**, **** = (Refused)**, and ***** = (Not Given, must specify or note the reason not given)**. Each medication will have a red line drawn between each order to differentiate the individual medications. All allergies must be listed in the top left hand corner in red ink. When a medication is discontinued or completed it will be yellow highlighted.

C. When verifying the day's charts, the RN will compare the MAR with CHCS and will annotate: "Chart verified with MAR, CHCS (and, when appropriate, profile)" and then sign, date and time on the Doctor's Order sheet.

D. When medications are discontinued by a medical provider, an RN or HM will ensure all discontinued medications are pulled from the detainee's drawer at the time the order is transcribed. The discontinued medication(s) will be placed in the bin in the Medication Room labeled Discontinued Medications for the Pharmacy Technician to remove.

E. Each evening, in the absence of a pharmacy technician, the RN and an HM will go through all the detainee medication drawers with the MARs to assure the correct medications are in the proper drawers and no drugs are past their expiration date.

F. When medications are given to a detainee, the RN or the HM will annotate by signing initials off on the MAR to indicate medications were given.

G. Whenever a narcotic or controlled substance is given, annotation will be made in the nurses notes stating the reason why the narcotic was given, including the detainee's perceived

pain level as noted on a scale of (1-10), and, 30 minutes or so later, the detainee's reaction to the medication (e.g. less pain, sleeping, etc) as to its effectiveness.

H. Whenever possible, no detainee will have more than one MAR at any given time. When more than one MAR is necessary because of the space required by medications already discontinued, a new MAR is to be transcribed to reduce the number of MAR pages necessary.

I. When more than one MAR is necessary, each page will be numbered – “one of two, two of two . . . , and so forth.

J. When MARs are transcribed, either at the end of the month, or at points during the month, a nurse shall verify and initial the new MAR to indicate it accurately reflects the current provider's orders for the detainee.

K. At change of shift, the off going RN will review the MAR's to ensure all medications have been passed for that shift and to ask questions generated by the MAR documentation before oncoming RN arrives.

IX. CONTROLLED SUBSTANCE INVENTORY

A. A controlled substance inventory will be conducted quarterly in the Detention Hospital, the Detention Hospital Main Operating Room (MOR), the Delta Clinic, and the Delta Block. This inventory will be conducted by the appointed members of the Controlled Substance Inventory Board (CSIB) during the months of January, April, July, and October.

B. A report of the inventory will be generated and reported to the OIC via the Director of Nursing Services (DNS). The report will include reviews of the NAVMED 6710/4 Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs; SF 508 Doctor's Orders; and ten selected MAR's. If any discrepancies are noted, the DEA 106 Report of Theft of Controlled Substance will be available to document unaccounted for narcotics.

C. In each Narcotic Log Book, a record will be kept of the CSIB (Enclosure 4).

X. DETAINEE ACUTE CARE UNIT (DACU) MEDICATION GUIDELINES:

Detainee Acute Care Unit medication administration is covered by the NAVHOSPGTMOINST 6710.13A. The NAVHOSPGTMOINST IS in accordance with MANMED, Chapter 21 and BUMEDINST 6710.70. NAVHOSPGTMO conducts the controlled substance inventory of the narcotics located in the DACU.

XI. REORDERING OF MEDICATIONS:

A. If a medicine is to be continued by a provider, it should be reordered prior to the administration of the last dose in the container. The medication should be reordered when there are three doses remaining. The **Not in Stock (NIS) Communication Log** (Enclosure (5)) sheet will be readily accessible at each medication station for the pharmacist to review on day shift.

On this sheet, nursing staff will list the ISN # of the detainee and the medication that needs to be refilled. Ward stock medications will also be reordered by placing what is needed on this form.

B. When a medication is reordered, the RN or HM will write on the label of the medication container that the medication has been reordered, include the date to prevent duplicating orders.

C. Not in stock medications may occur due to the medication not being located in the Detention Hospital Pharmacy. When the medication is on island it will be available (in stock) by the next day. If the medication is not in stock, available on the island, it may take up to five weeks to receive the medication. If a medication is not in stock for up to 24 hours, the RN and the SMO need to be notified.

XII. REFUSAL OF MEDICATIONS BY DETAINEES:

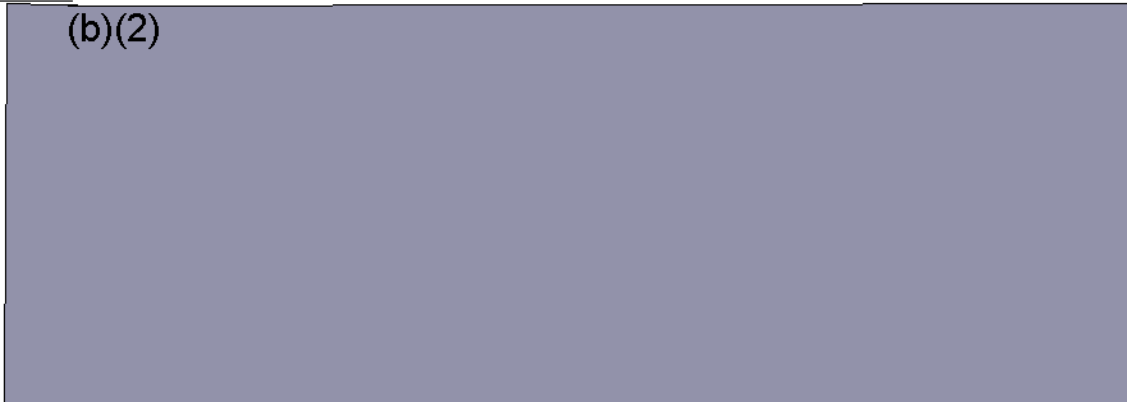
A. A **refusal** is when the medication is offered twice at different times during the same medication pass and the corpsman has obtain a response from the detainee, i.e. wave off, verbal gesture, etc.

B. Any medication refusals in the hospital and on the block need to be brought to the attention of the Military Police (MP) on duty. They are required to log this information in to Detainee Information Management System (DIMS) for tracking purposes. On the MAR, the medication must be marked as refused by placing an asterisk (*) in the given box along with the RN/corpsman's initials. On the blocks, an MP **MUST** be with you as you pass meds and/or conducting sick call, taking note of any refusals. The corpsman will notify the Clinic Nurse if not accompanied by the block MP prior to conducting your duty.

C. Certain types of medication refusals must be brought to the Medical Officer's (MO) attention **immediately** after the medication pass. List I contains important medications that need to be addressed as soon as possible with the Medical staff. List II consists of all other medications that do not severely impact the health of the detainee immediately but still need to be reported to MO.

LIST I:

(b)(2)



LIST II:

a. (b)(2)

D. If the detainee refuses medication from List I, the corpsman, at the end of that medication pass, will annotate a note in the detainee's medical record on the SF 600 stating which medication was refused and hand it **DIRECTLY** to the MO.

E. If the detainee refuses meds from List II more than three times in one week, the corpsman will annotate a note in the detainee's medical record on the SF 600 and place it in the "MO to Sign" bin. The corpsman shall inform the detainee if he continues to refuse the medication, the MO will be notified and the decision to continue or discontinue the medication will be made.

STANDING OPERATING PROCEDURES

Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge Date

IMPLEMENTED BY:

Director for Administration Date

Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By: (b)(6) Date: 15 Oct 05
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____

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Title: _____
SOP NO: _____ Date: _____

MEDICATION ADMINISTRATION UNDERSTANDING

I _____ have completed supervised medication administration with my preceptor _____.

I understand:

- The seven rights to medication administration are:
 - 1) The right person
 - 2) The right dose
 - 3) The right time
 - 4) The right route
 - 5) The right drug
 - 6) The right person administering the medication
 - 7) The right documentation

- I am NEVER to administer medications without taking the MEDICATION ADMINISTRATION RECORD (MAR) to the cellblock with me to identify the detainee, the drug, the dose, the time and the route at the time of administration.

- I am to chart the medication given or the refusal of medications at the time medications are offered to the detainee.

- I will identify the detainee every time I administer a medication by verifying reviewing the Detainee Operations Center (DOC) Roster located in the in front of the MAR and by checking the identification band (ID) at the front of each cell. The second identification is to verify the detainee with the detainee's picture, which is located above the detainee's cell. I will not rely on asking a detainee his ISN number as a method of identification.

- Simply noting 'not in stock' (NIS) as a reason for not administering a detainee's medication because I could not find the medication is inappropriate. When a medication is missing, I know to follow up with the nurse or the Pharmacy Tech, as soon as I return to the clinic. If narcotics or any controlled medications are refused by the detainee, I am to give the narcotic or controlled medication back to the nurse for proper disposal.

- I shall visualize the detainee has actually swallowed his oral medications before leaving the cell area.

- I am not to leave powders, medication bottles, pills, lotions, or any other medical material in a detainee's cell for use at other times unless I have specific permission from the RN/MD/DOC via a memo on file at the DOC.

I have read the above statements. I feel competent to administer medications to the detainee population in Camp Delta after completing this orientation.

Student's Signature

Date

**MEDICATION ADMINISTRATION COMPETENCE ASSESSMENT
Camp Delta Medical Clinic, Guantanamo Bay, Cuba**

Competency Statement: Demonstrates a thorough understanding of the medication administration procedures and policies at Detention Hospital; to include, Delta Clinic, Delta Block and the Detainee Acute Care Unit (DACU). A nurse of the Camp Delta Clinic will verify individual competence via the individual’s verbalization and the direct observation of performance.

The trainee will be able to:	Instructor (discuss)		Trainee (perform)	
	Initial	Date	Initial	Date
Instructor: Initial in the column to indicate the trainee’s performance.				
Correctly pull all meds for medication pass.				
Correctly transcribes meds on the MAR, including PRN’s.				
Correctly documents on the MAR when medications are given, refused, discontinued or not in stock (NIS).				
Demonstrates the correct steps to take when a new medication is ordered but not received.				
Understands the process for giving medications on the standing orders list.				
Understands the process for placing medications in containers other than those they were dispensed in.				
Verbalizes the 7 RIGHTS of medication administration with each detainee/medication.				
Demonstrates proper procedure for discontinuing a medication. (Yellow highlight all discontinued medications).				
Correctly instructs the detainee on the purpose of the medication.				
Knows (or correctly looks up) the corresponding generic or brand name of the medications on their medication rounds.				
Correctly demonstrates the correct administration of IM, SQ, and Intradermal medication administration.				
Utilizes resources available and appropriately seeks answers when faced with an unfamiliar medication.				

Rank/Name _____ has successfully completed all objectives required for verification of competency in Medication Administration.

Signature of Nurse/Team Leader	Date	Date

STANDARD OPERATING PROCEDURES
JTF-GTMO Detention Hospital
Guantanamo Bay, Cuba

APPROVED BY:	
_____	_____
Officer In Charge (OIC)	Date
REVIEWED BY:	
_____	_____
Senior Medical Officer (SMO)	Date
_____	_____
Director for Clinical Support Services (DCSS)	Date
_____	_____
Senior Nurse Executive (SNE)	Date
_____	_____
Director for Administration (DFA)	Date
_____	_____
Senior Enlisted Advisor (SEA)	Date
ANNUAL REVIEW LOG:	
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Title: _____	_____
SOP NO: _____	Date: _____

JTF-GTMO MEDICATION ADMINISTRATION RECORD

ALLERGIES _____ TRANSCRIBED _____ VERIFIED _____ MONTH/ YEAR _____

MEDICATION LEGEND: * = REFUSED ** = NOT IN STOCK *** = NOT GIVEN

START DATE	STOP DATE	SCHEDULED MEDICATION	TIME										

SICKCALL VISITS
PSYCH PRESENT

SICKCALL LEEND: S = SICKNESS I = INJURY X=NO SICKCALL R=REFUSED * = NO COMPLAINTS
 PSYCH LEGEND: C=SEEN (NOTE IN CHART) X=NO PSYCH SICKCALL R =REFUSED *=NO PSYCH COMPLAINTS

INITIALS / PRINTED NAMES

BLOCK#

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MEDICATION ADMINISTRATION RECORD (BACK) S:N 0105-LF-216-5581

SINGLE ORDERS – PRE-OPERATIVE

MEDICATION DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDE R DATE	MEDICATION-DOSAGE ROUTE OF ADMINISTRATION FREQUENCY	DOSES GIVEN-											
		DATE	TIME	DOSE	INIT.	DATE	TIME	DOSE	INIT.	DATE	TIME	DOSE	INIT.

CONTROLLED SUBSTANCE INVENTORY BOARD (CSIB) INVENTORIES

CSIB INVENTORY DATE	MEMBER CONDUCTING INVENTORY

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 011
Title: OUT-PROCESSING PROCEDURES	Page 1 of 5 Effective Date: 21 Mar 03 Revised Date: 26 July 05
SCOPE: Detention Hospital	

I. BACKGROUND: Detainees may be transferred to other facilities or repatriated to their originating countries.

II. POLICY:

1. Evaluation and thorough documentation of a detainee's health status and health care while under the control of JTF GTMO is a crucial component of the repatriation or transfer process.
2. All detainees leaving JTF GTMO's custody will undergo a complete physical exam as outlined below to ensure acceptable health and to ensure that contagious infectious diseases have been adequately treated.
3. The Senior Medical Officer is responsible for coordinating the evaluation and documentation associated with repatriation or transfer. All other staff are to provide support as requested. Procedures and directives from higher headquarters should be anticipated and be strictly followed.

III. PROCEDURES:

1. A credentialed provider will complete a Narrative Medical Summary. All deformities and scars will be scrupulously detailed in the report. The detainee will be weighed and a BMI will be calculated and recorded. A full set of vital signs will be documented.
2. The Senior Medical Officer will expeditiously review all records to determine completeness and identify any uncompleted and necessary medical treatments and advise the Officer in Charge of any such issues.
3. A determination must be made as to the ability of the detainee to travel or any special considerations for travel that must be met must be identified. The Senior Medical Officer or Officer in Charge will communicate any uncompleted and necessary treatments, the suitability of the detainee to be released, recommendations for further treatment, and any special medical considerations that must be met to the Joint Task Force Surgeon for planning purposes and coordination at higher levels.

4. The detainee's current medication administration record (MAR) will be "closed out" and placed in the medical record. A 90-day supply of the appropriate medications per the recommendation of the out-processing physician will be obtained and distributed to the detainee prior to their leaving custody.
5. No routine laboratory or radiographic studies will be done. These studies will only be done if clinically indicated at the time of the out-processing exam.
6. The original records will be closed out, sealed and retained in permanent files at the Medical Planners Office (JMG). No other copies will be distributed from the Detention Hospital or Delta Medical Clinic.
7. A discharge narrative summary will be written and will include a detailed narrative summary of the detainee's condition upon arrival in JTF custody, all hospitalizations and significant treatments, and a list of medical problems, current medications, both the in-processing and out-processing weights, PPD history, list of vaccinations, a complete physical examination, and approval for air travel. Copies of this document will be made and filed as noted above with the medical record. The term "Fit for Flight" must be included at the end of the narrative.
8. Videotaping or photographing of detainees will be decided on a case-by-case basis or as directed by higher authority. In all such cases, notify the Joint Task Force Surgeon.
9. A 90-day supply of appropriate medications will be prepared to accompany the detainee on his journey and will be turned over to the escorting authorities upon out-processing from JTF GTMO custody.
10. A scopolamine patch will be placed on each detainee 4 hours before the flight.

REVIEWED AND APPROVED BY:

Officer In Charge

Date

IMPLEMENTED BY:

Director for Administration

Date

Senior Enlisted Advisor

Date

ANNUAL REVIEW LOG:

By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 012
Title: CAMP 4 MEDICATION DISPENSING POLICY	Page 1 of 3 Effective Date:
SCOPE: Detention Hospital	

I. BACKGROUND:

1. The pharmacy representative on the Camp Delta Medical Team provides pharmacy support to the team by dispensing medications pursuant to valid prescriptions written by designated providers and issuing medications needed for the direct administration to patients.

II. RESPONSIBILITY:

1. The designated pharmacy representative at the camp is responsible for the proper organization, efficient inventory management, and proper dispensing and issuance of all pharmaceuticals. Operational procedures shall be in compliance with all provisions of Chapter 21 of the Manual of the Medical Department.

2. Security of Pharmaceuticals: The Detention Hospital pharmacist will ensure the proper security of the pharmaceuticals transported to Camp Delta Clinic. The pharmacy representative will ensure that adequate medication stock is kept available at the camp.

3. All pre-dispensed medications will be kept in a lockable drug cabinet and all dispensed medications will be kept in separate designated lockers. The pharmacy representative and the medical staff administering the dispensed medications to the patients will hold custody of the keys to the locker. The narcotics log and locker key will be maintained by (b)(2) All immunizations stored at the camp will be kept in a lockable refrigerator within the Camp Delta Clinic.

III. POLICY:

1. The Senior Medical Officer (SMO) shall determine which medications are to be stocked at the Camp Delta Clinic.

2. The designated camp medical providers will enter all prescriptions into CHCS. A CHCS terminal and label printer will be available for the pharmacy technician to use in the dispensing of prescriptions. The pharmacy technician will fill all prescriptions following the provider's entry and will apply CHCS generated prescription

label and auxiliary warning labels to the bottles as appropriate. It is preferred that medications ordered beyond a one-time use will be dispensed from the Detention Hospital pharmacy with the first dose dispensed from the Camp Delta Clinic pharmacy locker.

3. The prescriptions are dispensed to the custody of the nursing staff who will be in charge of administering the medications to the patient. All dispensed medications will be kept in designated lockers within the camp clinic and will be stored in alphabetical order.

IV. PROCEDURE:

1. Dispensing of medications to detainees.

a. The assigned hospital corpsman shall review NAVMED 6550/8 Medication Administration Record (MAR) and compare detainee ISN number and location against current alpha roster. If necessary make appropriate changes in individual MAR folders and move medications to appropriate place in medicinal locker.

b. Gather appropriate medicinals from Camp Delta Clinic and report to security personnel at Camp 4. Notify security personnel which detainees require meds. (b)(2)

c. The hospital corpsman with (b)(2) will dispense all medications from the bean port at each compound. Camp 4 security will be responsible for bringing the appropriate detainees to the bean port. The hospital corpsman will verify the following prior to dispensing any medications.

- 1). Have orders and MAR been verified by nursing staff?
- 2). Are you authorized to give this medication?
- 3). Is it the correct patient? Verify against ISN wrist band.
- 4). Is it the correct medication?
- 5). Is it the correct dose?
- 6). Is it the correct route of administration?
- 7). Is it the correct time to give the medication?

d. Document the administration of all medications and or refusals on the MAR and notify nursing staff of any concerns.

e. Transcribe any changes to medications on MAR. The nursing staff will verify accuracy on a regular basis.

f. In the event of inclement weather an ambulance will be brought onto the compound for shelter.

STANDING OPERATING PROCEDURES

Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
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Director for Administration	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 013
Title: PATIENT ADMINISTRATION DEPARTMENT	Page 1 of 4 Effective Date: 11 Jun 03 Reviewed: 04 Nov 04 (Recommend deleting SOP)
SCOPE: Detention Hospital	

I. REFERENCES:

- a) Manual The of the Medical Department (P-17) Chapter 16, Health Records.
- b) Policy Memorandum 8-02 from SouthCom

II. PURPOSE:

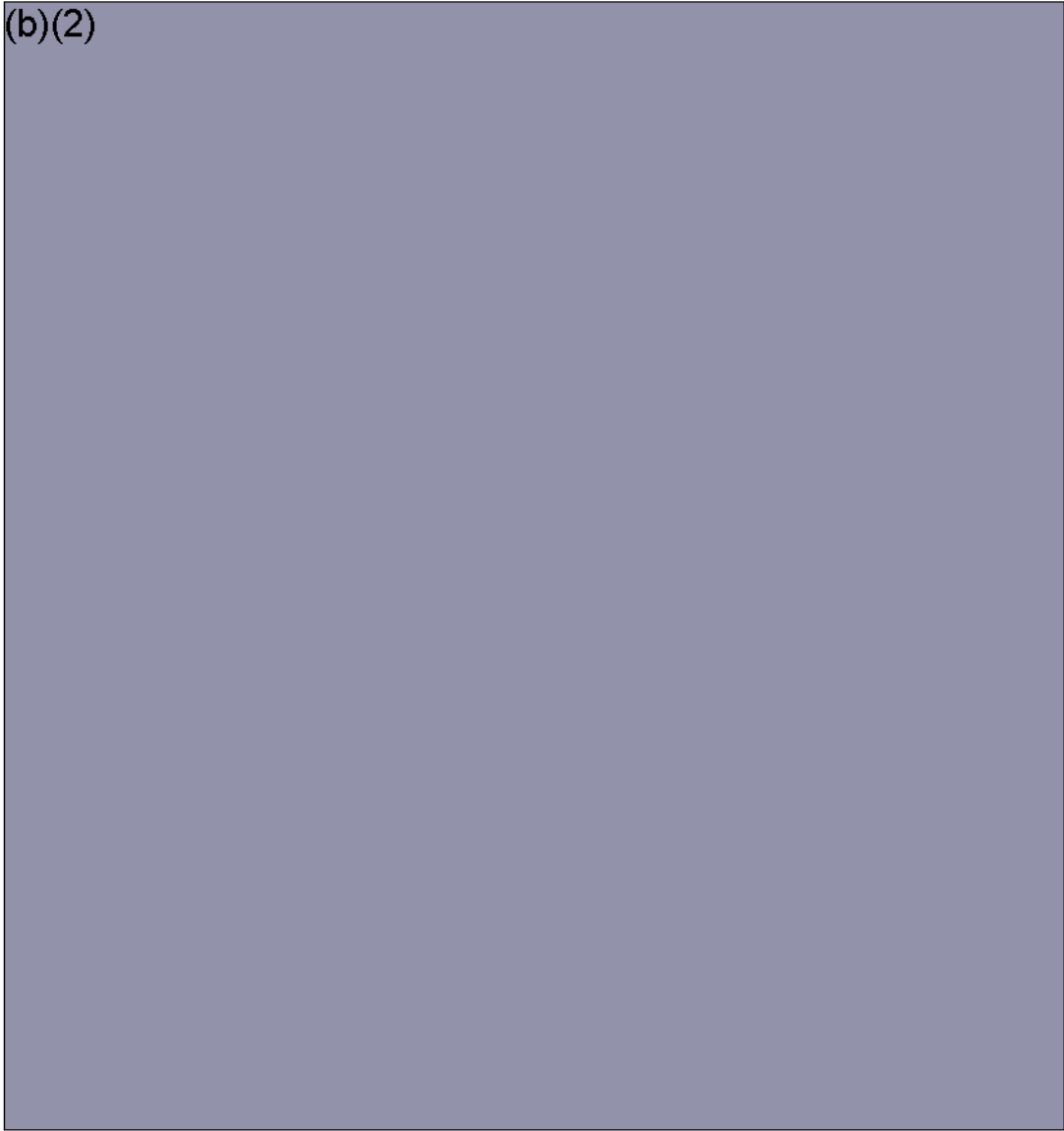
To establish standard operating procedures for the Patient Administration Department at the Detention Hospital.

III. RESPONSIBILITIES:

- 1. The Patient Administration department is responsible for the admission, disposition, and tracking of Detainees arriving at the Detention Hospital for inpatient care. Patient Admin is also responsible for the creation, maintenance and final disposition of Detainee Inpatient Records.
- 2. Patient Admin will maintain custody of the Detention Hospital staff member's Health and Dental Records. Patient Admin will be responsible for the accountability and maintenance of these records.
- 3. Admissions and Dispositions: When a Detainee arrives at the Detention Hospital, an entry will be made in the Admissions and Dispositions Log Book noting the date of arrival, patient name (last 4 digits of the detainee ISN number), admission number, diagnosis, and admitting physician. The admission numbers are sequential and will be utilized when entering the admission in CHCS.
- 4. Admit the Patient in CHCS via the ADT menu:

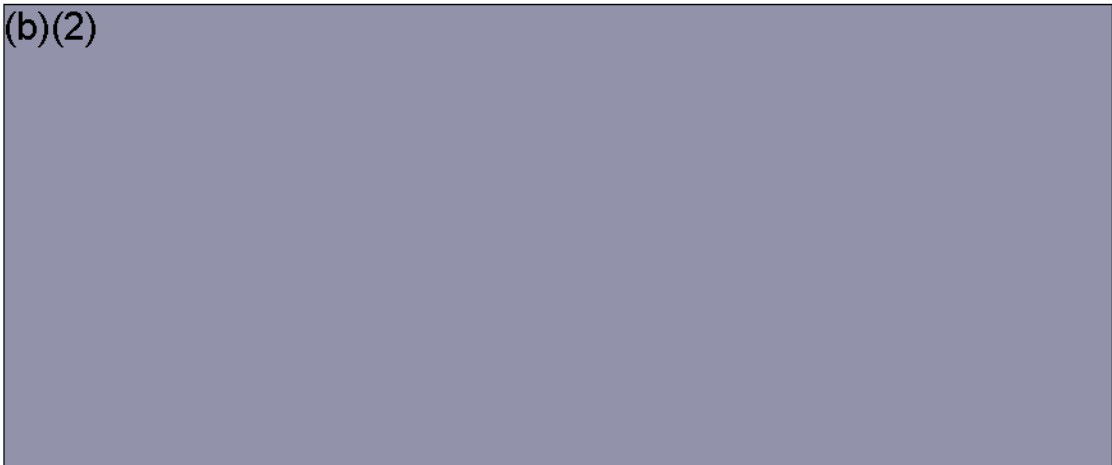
- a. (b)(2)
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5. Discharge the Patient in CHCS via the ADT Menu.

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- i. (b)(2)
- j. (b)(2)

8. (b)(2)
(b)(2)

9. Inpatient Records: When a detainee is discharged from the Detention Hospital, an Inpatient Record Jacket will be created for the patient. Reference (1) outlines the procedures for creating an inpatient record. Be sure to mark "Inpatient Record" on the Record Jacket. Mark the "Category" as "Other". On the blank line next to "Other" write: "D, JTF".

10. Patient Admin will pick up all information found in the Nursing Charts and ensure that the Inpatient Record is placed in proper order. The record will be routed to the Attending and Admitting Physicians for signature.

11. Once the record has been signed, it will be returned to Patient Admin for proper filing and maintenance. The front cover of the record will be marked with the dates of admission. A diagonal line will be drawn across the front of the Record Jacket and the word "CLOSED" will be written on the diagonal line. No further entries will be added to this record. Once the record is closed and filed, only personnel listed on the records access roster will have access to it.

12. A representative from the Detention Hospital will make a run to NAVHOSP GTMO to pick up dictations from Inpatient Records. The dictations will be routed to the originating physician for correction and signature. Once the signed copy is received back in Patient Admin, a copy will be made and sent to Delta Clinic for enclosure into the outpatient record and the original will be retained in the inpatient record.

13. Medical Record Access: Per reference (b), access will be determined by JTF JAG.

- Anyone requesting medical information will be referred to the Detention Hospital Chain of Command.
- Intelligence & Law Enforcement personnel are not allowed to check or sign out medical records or to view medical records in clinical areas.
- Only members of the Behavioral Sciences Consultation Team members may view medical records.

14. Per reference (b), confidentiality between Detainee and Health Care Providers may not fall under the same guidelines as patients who are seen in the United States.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
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Officer In Charge	Date
IMPLEMENTED BY:	
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Director for Administration	Date
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Senior Enlisted Advisor	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO:014
Title: <u>DETAINEE WEIGHT MANAGEMENT AND NUTRITION PROGRAM</u>	Page 1 of 5 Effective Date: 21 Mar 03
SCOPE: Detention Hospital	

Encl: (1) Subjective Global Assessment Guideline
<\\jgfpaf632b11\hospital\working sops\SOP Enclosures and Attachments\SGA.doc>

Background: This section provides an overview of weight management program for the detainees to assure that an appropriate weight is maintained. The appropriate body weight for height, gender, and body size is essential for the optimal health of each detainee.

Policy: This is the first SOP on the weight management program and replaces the previous document on detainee nutrition. The program will be conducted by a medical provider on the JTF staff under the guidance of the Senior Medical Officer and NH GTMO Dietician. Each detainee will be provided with an adequate daily food ration (a minimum 2000 kcal/day) sufficient in calories, protein, and vitamins and minerals to prevent development of malnutrition. Scheduled weight monitoring will occur to assure the appropriate nutrition is being consumed.

Procedures:

I. Weighing of Detainees

- A. Scales will be zeroed prior to measurement and calibration of the scales should occur routinely.
- B. The presence of shackles during the weighing process mandates that 5 lbs be submitted from the total scale weight.
- C. Detainees should be wearing similar clothing and stand in the center of the scale without assistance.

II. In-processing

- A. Upon arrival, the weight and height of each detainee will be determined and recorded on both the history and physical form as well as in the weight management databank.

- B. The body mass index (BMI) will be calculated using the formula: Weight in kg divided by height in meters squared (kg/m^2). Alternatively, (weight in pounds x 704)/(height in inches)².
- C. The weight of the detainee at in-processing will be considered the detainee's usual body weight (UBW).

III. Monthly Weight Determination

- A. Each detainee will be involuntarily weighed each month. This will be performed in the cellblocks by one of the medical corpsmen using a standard bathroom scale.
- B. Weight will be recorded in their health records on DA Form 2664-R as well as into the weight program computer database.
- C. Each detainee's weight and calculated BMI as well as % change from UBW will be entered into the databank and updated monthly. The %UBW is calculated as the current body weight divided by the usual body weight and then multiplied by 100%.
- D. The normal range of (b)(2)

(b)(2)

IV. Out-processing

- A. Each detainee will be weighed during out-processing. The detainee's in-processing and out-processing weights will be noted on the final narrative summary.

V. Evaluation and Management of Detainees (b)(2)

A. General Guidelines:

- 1. (b)(2)
- 2. Each month, the detainees may change their category of BMI or %UBW and each will be evaluated based on their new weight measurements.
- 3. (b)(2)

B. (b)(2)

- 1. If the detainee has a stable weight and the reduction in (b)(2)

(b)(2)

2.

3.

- C. (b)(2)
1. (b)(2)
 - 2.

- D. (b)(2)
1. (b)(2)
 - 2.

VI. Evaluation and Management of Detainees with a BMI \geq 35

- A. Detainees with a BMI \geq 35% are considered overweight (moderate obesity).
- B. A physical examination will be performed looking for any evidence of an endocrinopathy or other cause for obesity as well as any medical consequences of the increased BMI.
- C. A TSH will be obtained.
- D. Based on the history and physical examination, a chemistry panel, fasting blood glucose level, and lipid panel may be obtained.
- E. The detainee will be counseled regarding the medical importance of maintaining a normal BMI (18.5-24.9).
- F. Strategies to reduce his/her weight will be discussed with the detainee including physical exercises within the cellblock and reduction of caloric intake, particularly decreasing the amount of carbohydrates.
- G. Weights will be obtained biweekly.
- H. If there is no evidence of a medical etiology for the obesity and the aforementioned strategies for weight reduction are unsuccessful over a 2-3

month period, involvement of the dietician in the patient's care will be initiated with the approval of the JTF Surgeon on a case-by-case basis.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge

Date

IMPLEMENTED BY:

Director for Administration

Date

Senior Enlisted Advisor

Date

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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 015
Title: MENTAL HEALTH SERVICES TO DETAINEES	Page 1 of 7 Effective Date: Revised 01 Feb 2004
SCOPE: Delta Block	

Ref: Psychiatric Services in Jails and Prisons. 2nd ed., American Psychiatric Association, 2000;
Camp Delta Standard of Procedures, February 2004.

Encl: BHS Organizational chart

1. PURPOSE:

To specify the minimum requirements for the psychiatric evaluation and treatment of mentally ill detainees on Delta Block.

II. BACKGROUND:

1 Delta Behavioral Healthcare Block

Overview

Delta Behavioral Health Block is constructed in two sections. The front Non-Acute section has 22 cells that have been modified with additional safety considerations to house detainees on Behavioral Healthcare Service that are clinically stable but because of their mental illness and/or limited coping skills, are at increased risk of self-harm and are more difficult to manage in the general population.

The rear section, Delta Acute, (b)(2)

(b)(2)

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(b)(2)

Staffing

a. Behavioral Healthcare Service Manager, in conjunction with the Delta Block NCOIC, will have overall responsibility for the daily operations of Delta Block. Accountability will be to CJDOG and to the Chief, Behavioral Healthcare Services. The Behavioral Healthcare Service Chief is a credentialed provider who is responsible for mental healthcare, operations and resource management.

b. (b)(2)

c. (b)(2)

d. (b)(2)

e. (b)(2)

f. JDOG S3 will identify candidates for permanent NCO MP staff assignment to Delta Block; candidates will be interviewed and recommendations for assignment made by Behavioral Healthcare Staff to the JDOG S3.

g. (b)(2)

Watch

a. (b)(2)

b.


Crisis/Mass Casualty Response

a. (b)(2)

b. (b)(2)

c. (b)(2)


(b)(2)



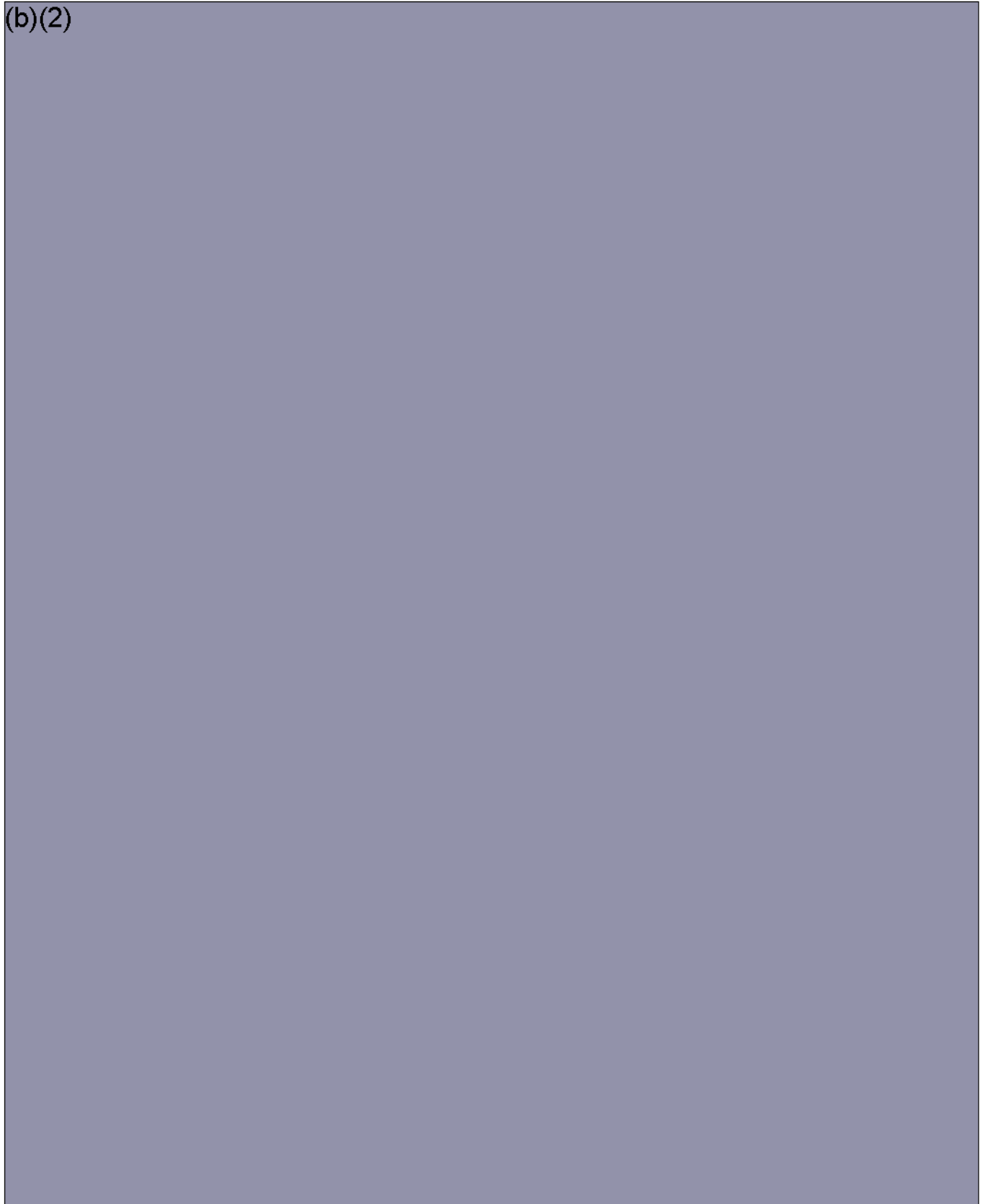
(b) All of personnel are to have original with a copy to the...

Non-Acute Section

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Restraints and Seclusion

I. PURPOSE

To publish policy and guidelines for use of medical restraint and seclusion as a means of assisting a detainee in regaining control of his behavior to protect self, other detainees, guards and other staff.

II. BACKGROUND

a. It is the policy of Detention Hospital, JTF GTMO to deliver proper and humane patient care to all detainees while observing basic human rights. Use of restraint temporarily restricts these rights. Restraint is used only for detainees who are at imminent risk of harming themselves or others. Restraint is to be used only after other less restrictive interventions have proven unsuccessful in efforts to control behavior.

b. Restraint cannot be ordered PRN (as needed).

c. When healthcare staff notes what they consider to be improper use of restraints, jeopardizing the health of a detainee, they communicate their concerns as soon as possible to the Detention Hospital Officer in Charge and the Detention Operations Center.

d. The Chief of Behavioral Health Services is to be NOTIFIED/PAGED IMMEDIATELY ANY TIME A DETAINEE IS RESTRAINED, in order to obtain a formal order for restraints.

III. DEFINITIONS

a. Restraint: any method of physically restricting a person's movement, physical activity, or normal access to his or her body. Restraint is considered involuntary and is used as part of an approved protocol or as indicated by an individual's orders.

(b)(2)

e. Licensed Independent Practitioner (LIP). For the purposes of this directive, a clinician that is permitted by law and by the hospital to provide detainee care services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

(b)(2)

V. PRACTICE AUTHORITY

A licensed independent practitioner orders the use of medical restraints or seclusion. When the LIP is not immediately available, a psychiatric nurse, a registered nurse or a psychiatric technician may initiate the use of restraint or seclusion before an order is obtained from the LIP. As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, a qualified registered nurse notifies and obtains an order (verbal or written) from the LIP and consults with the LIP about the patient's physical and psychological condition.

a. **Attending Physician/Psychologist.** The LIP who is primarily responsible for the patient's ongoing care, or another LIP when the primary LIP is not available, conducts an in-person evaluation of the patient within 4 hours of the initiation of restraint or seclusion for patients ages 16 and older and within 2 hours of initiation for adolescents ages 15 and under.


At the time of the in-person evaluation, the LIP:

- (1) Works with the patient and staff to identify ways to help the patient regain control;
- (2) Makes any necessary revisions to the patient's treatment plan; and
- (3) If necessary, provides a new written order.

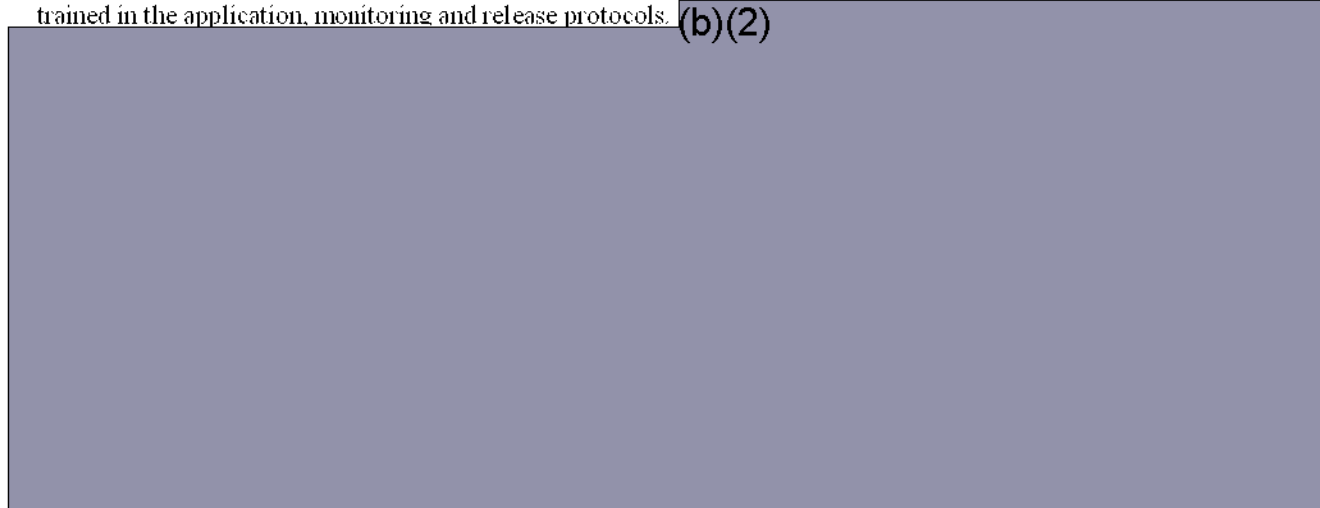
a. The LIP conducts an in-person evaluation of the patient within 24 hours of the initiation of restraint or seclusion, if the patient is no longer in restraint or seclusion when an original verbal order expires.

b. **Registered Nurse.** Responsible for ongoing observation of a restrained or secluded detainee, assessment of the physical and emotional needs of the detainee, re-evaluation of the need for continuation of restraint or seclusion, documentation, and supervision of hospital corps staff.

(b)(2)



b. Application of restraint is done in a humane manner that affords the detainee as much dignity and safety as possible. Guard staff applying the restraint will be knowledgeable in the use of this intervention, familiar with the equipment and trained in the application, monitoring and release protocols. (b)(2)



(b)(2)

(b)(2)

c. Monitoring and Patient Care.

(1) The monitoring process addresses physical and emotional needs of the detainee. This monitoring includes simple observation, vital signs, circulation checks, observation of the extremities, range of motion, emotional and physical response to restraint, food, hydration, and toileting needs. Other monitoring will be done, as needed based on individual needs.

(b)(2)

(b)(2)

d. Documentation.

(1) The documentation requirement for a detainee requiring restraint must incorporate the critical elements of assessment, application and monitoring, and reflect concern for the detainee's human needs and preservation of dignity.

(2) Each time a restraint is applied or seclusion initiated the following will be documented by an RN or Corpsman:

(a) Time and date restraint is applied.

(b) The detainee's behavior, verbalization or actions that lead to the need for external control.

(b)(2)

VII. DOCTOR'S ORDER

a. THE USE OF PRN ORDERS WHETHER INDIVIDUAL OR AS PART OF A PROTOCOL FOR DETAINEES WITH PRIMARY BEHAVIORAL HEALTH NEEDS IS PROHIBITED.

b. A doctor's order for restraint or seclusion must be written or verbally obtained from the LIP within one hour of initiating restraint, and if verbal, must be signed within 4 hours.

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(b)(2)

VIII. TRAINING

a. Initial and ongoing training on restraint and seclusion for block personnel will be conducted as needed by the Behavioral Healthcare Service and Block NCOIC.

IX. PERFORMANCE IMPROVEMENT.

Seclusion and Restraint is a difficult, high-risk patient care intervention. Review of policies and procedures should occur no less than annually. After each incident an After Action Review will take place. This is the ideal forum to address issues and resolve shortcomings.

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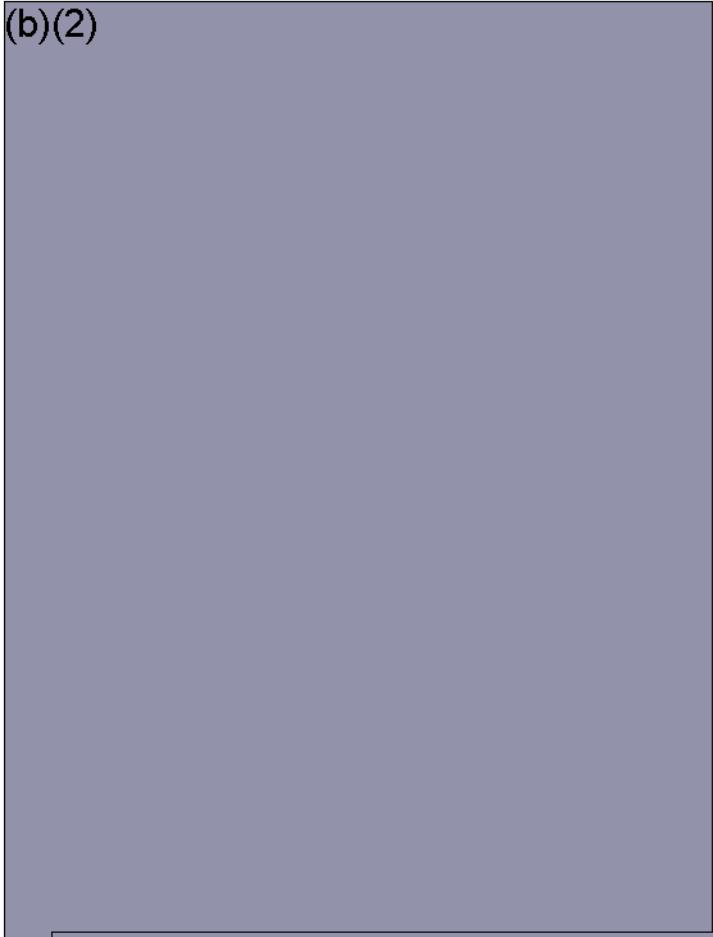
Detainee Behavioral Management Matrix

Detainees with mental illnesses often present with behaviors that are very difficult to manage. They often have poor impulse control, ineffective coping skills and may be at an increased risk for self-injurious behaviors. The Delta Behavioral Healthcare Block Behavior Management Matrix takes this into consideration. The matrix is intended to assist the detainee in maintaining appropriate behavior and to facilitate consistency between the MP's and Behavioral Healthcare Service staff.


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Delta Block Behavior Management Matrix


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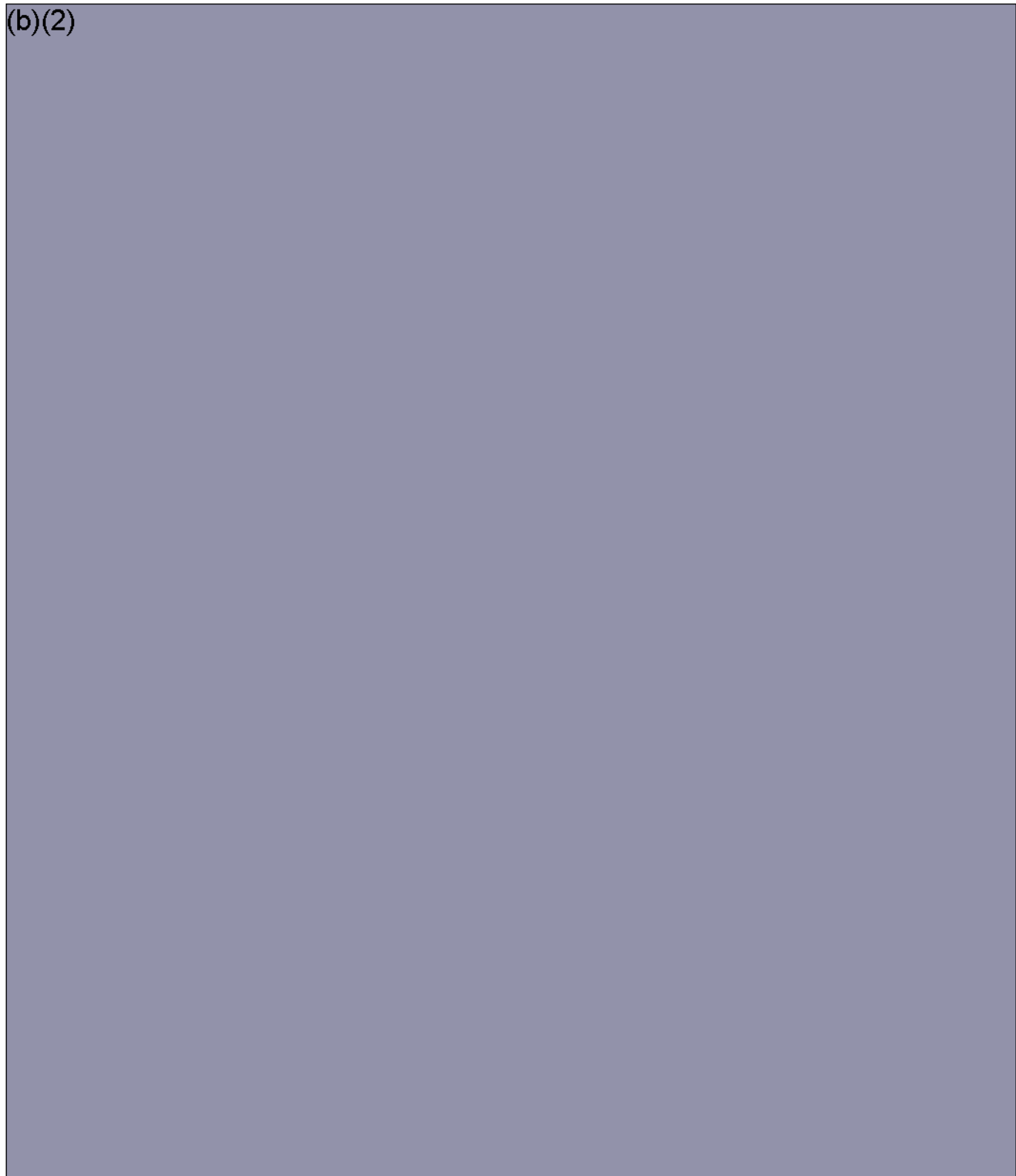
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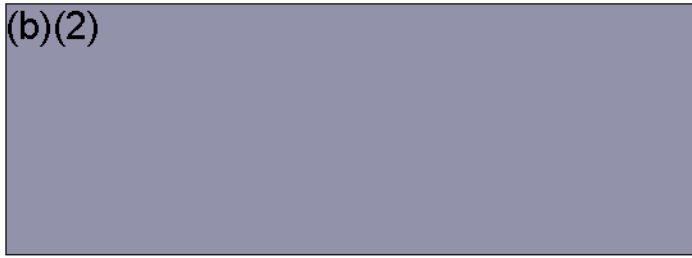
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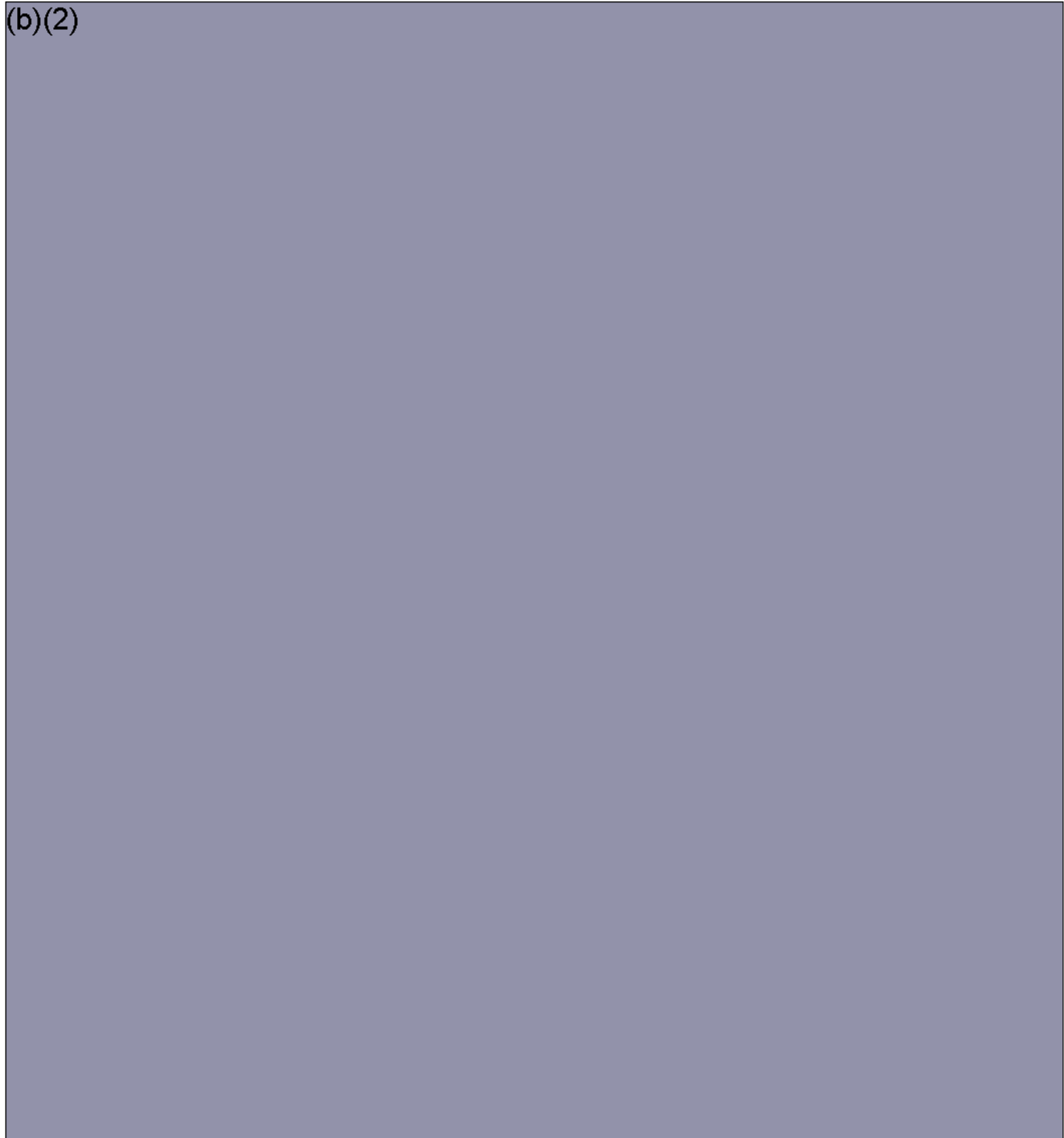
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(b)(2)

Dispensing of Prescribed Medication and Medical Sick call Procedures

- a. Detainees on Delta Block who have prescribed medications will have those medications dispensed to them by Behavioral Healthcare Service staff certified in medication administration. BHS staff will ensure appropriate actions are taken to prevent cheeking of medications. All medication refusals will be documented and brought to the attention of the Unit Nurse. In the case of psychotropic medications the psychiatrist will be contacted within two days of the initial refusal; for non-psychiatric medications the unit nurse will contact the medical clinic nurse or physician for further guidance.
- b. The Block NCO will ensure that all detainees with medical/physical complaints are placed on the Medical Sick call List in DIMS by 0600 each morning. Detainees may be evaluated/treated either in their cell or transported to the Delta Medical Clinic at the discretion of the Medical staff.
- c. For medical issues of a non-routine nature the Unit Nurse may contact the psychiatrist.
- d. For medical issues of an acute or potentially serious nature the Unit Nurse will coordinate transfer to the medical clinic where adequate medical triage can be performed.
- e. Under no circumstances will GF personnel dispense any form of medication.

Medical Records

- a. Medical Records for detainees housed on Delta Behavioral Healthcare Block will be kept in the Nurse's Station.
 - (1) If a particular detainee requires medical care at Delta Medical Clinic or Detention Hospital, the Medical Record will be delivered to the clinic by BHS staff.
 - (2) The Medical Record will be returned to Delta Block by BHS or Medical staff. The Behavioral Healthcare RN will transcribe any necessary doctor's orders.
- b. Medical Records for detainees on Behavioral Healthcare Service, but not housed on Delta Block, will remain at the Delta Medical Clinic.
 - (1) All Behavioral Healthcare documentation will be kept in a convenience record on Delta Block.
 - (2) The Medical Record will be annotated, on the Summary of Care form, to indicate that a particular detainee is on Behavioral Healthcare Service and that a convenience record exists on Delta Block.
 - (3) Behavioral Healthcare Service staff will obtain the Medical Record from the Delta Medical Clinic if needed for Psychological evaluations or for Treatment Team meetings.

Combat Stress Reactions

Guard or behavioral healthcare staff exhibiting signs or symptoms of combat stress reactions will be referred to the Combat Stress Control team. DH behavioral healthcare staff will provide no treatment beyond normal unit leadership. After a Serious Incident, leadership on the block should evaluate the circumstances surrounding the situation to determine if Combat Stress should be notified for soldier counseling.

Interpreters

Every effort will be made to consolidate visits by interpreters through coordination between guard and behavioral healthcare staff.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Camp Delta SOP • 1 February 2004
UNCLASSIFIED//~~FOR OFFICIAL USE ONLY~~

_____ Officer In Charge	_____ Date
IMPLEMENTED BY:	
_____ Director for Administration	_____ Date
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<p style="text-align: center;">DETAINEE HOSPITAL GUANTANAMO BAY, CUBA</p> <p>Title: DETAINEE MEDICAL TRANSPORTS</p>	<p>SOP NO: 017</p> <p>Page 1 of 5 Effective Date: Reviewed: 9 Mar 2004</p>
<p>SCOPE: Detention Hospital –Review of SOP’s</p>	

I. BACKGROUND:

(b)(2)

II. POLICY:

The movement of detainees is a serious process that must always be well coordinated and staffed prior to the movement. (b)(2)

(b)(2)

III. GENERAL PROCEDURES:

□ A senior Petty Officer is designated as the Medical Transport Coordinator and is the primary point of contact for coordination of all detainee movements for medical purposes.

□ After normal working hours, the Command Duty Officer is the point of contact for coordination of all detainee movements for medical purposes.

□ (b)(2)

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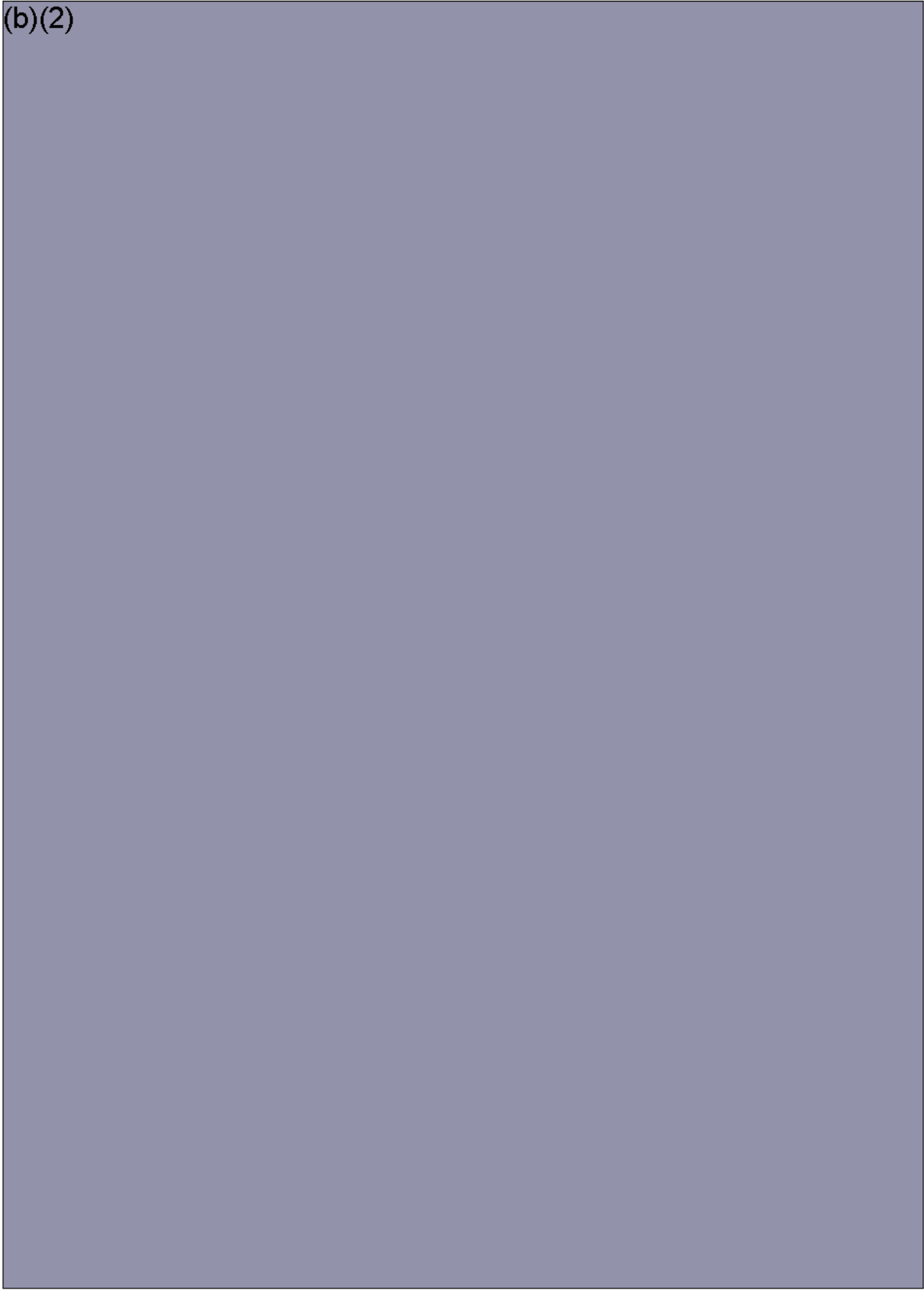
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Specific Procedures for Transport from Camp Delta to Detention Hospital:

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STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 018
Title: DATA COLLECTION AND REPORTING	Page 1 of 3 Effective Date: 17 Jun 03
SCOPE: Detention Hospital	

I. BACKGROUND:

The Detention Hospital has been tasked with complete and accurate reporting of the medical conditions affecting each of the detainees.

II. POLICY:

The data collection procedures described below must be maintained until discontinued or modified by the command element or higher authority.

III. PROCEDURES:

- ❑ CHCS registration of all detainees will be completed during in-processing. All ancillary studies and pharmaceutical needs will be ordered through the CHCS system.
- ❑ KG-ADS recording of diagnostic ICD-9 codes will be completed on all patient visits. A superbill has been designed to aid with the most common diagnoses.
- ❑ A daily situation report will be completed by the Senior Medical Officer at Camp Delta and will be forwarded to the Officer in Charge via the Detention Hospital administrative personnel on disc for compilation into the Detention Hospital situation report.
- ❑ The night duty nurse will complete a daily workload summary for Camp Delta. This report allows for further breakdown of data to include cell versus clinic visits as well as wound care and physical therapy.
- ❑ The following spreadsheets will be maintained on various programs occurring within Camp Delta:
 - Weight Monitoring Program
 - Hunger/Thirst Strike Program
 - Malaria Control Program
 - Latent Tuberculosis Control Program
 - Hepatitis/Other Infectious Disease Monitoring Program

- Immunization Program
 - In-processing Chest X-ray Follow-Up Program
- The individual program managers are responsible for updating these spreadsheets and checking them for accuracy and pursuing further actions indicated clinically on the results contained therein.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
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Officer In Charge	Date
IMPLEMENTED BY:	
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Director for Administration	Date
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Senior Enlisted Advisor	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 019
Title: PROVIDER CREDENTIALS	Page 1 of 2 Effective Date: 27 Jun 03 Updated Date: 04 NOV 04
SCOPE: Detention Hospital	

I. Purpose: To ensure that all clinical providers practicing at the Detention Hospital are properly privileged, and all credentials are current and verified prior to practicing medical care.

II. RESPONSIBILITIES:

Patient Administration Officer will receive ITCB from provider's parent command. Ensure credentials are signed by the privileging authority (Joint Task Force Surgeon) prior to provider performing any procedure at Detention Hospital.

III. PROCEDURES:

a. The information contained on the ITCB will be checked by the Professional Affairs Coordinator, Performance Improvement Office, U.S. Naval Hospital, Guantanamo Bay to ensure that the provider's credential information is current and in good standing.

b. Ensure that ITCB is designated to, "Joint Task Force Surgeon, U.S. Naval Hospital, Guantanamo Bay, Cuba / Detention Hospital."

c. Forward ITCB to Detention Hospital Officer in Charge for verification of skills Needed to perform the assigned procedure.

d. Upon receipt of approved ITCB, from Detention Hospital OIC, place in "Credentials" folder.

e. POC for credentials at NH-GTMO is (b)(6) She can be reached At extension (b)(6)

At extension 7-2760.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 021
Title: INFECTION CONTROL	Page 1 of 4 Effective Date:
SCOPE: Detention Hospital	

Reference: (a) NAVHOSPGTMO Infection Control Manual
 \\nh-gtmo-app\public\Fh20-Riggs\Working SOPs\SOP Enclosures and Attachments\SOP 021 Encl A.doc
 (b) NAVHOSPGTMOINST 6280.1

I. BACKGROUND:

As with other medical facilities, infection control practices exist to protect both the health care worker and the patient from contracting infectious disease. In that regard, infection control policies shall be no different than those outlined in reference (a). However, given the uniqueness of the mission, certain measures need be addressed. Detainees are native to a region plagued by a number of infectious diseases. It is estimated that a number of these detainees will carry one or more of these illnesses upon arrival.

II. POLICY:

Diagnosis, treatment, and prevention of these diseases will be conducted. Operating procedures outlined in reference (a) will be followed where applicable. Infectious waste will be handled in accordance with reference (b).

III. RESPONSIBILITY:

The medical officer-in-charge (MOIC) under the advisement of the public health officer and infectious disease consultant will coordinate this effort. Specifically, the MOIC is responsible for diagnosis and treatment as well as recommending measures for isolation of patients and force health protection. The public health officer is responsible for disease reporting, sanitation, and vector control as well as recommending methods of isolation and requirements for force health protection.

IV. PROCEDURE:

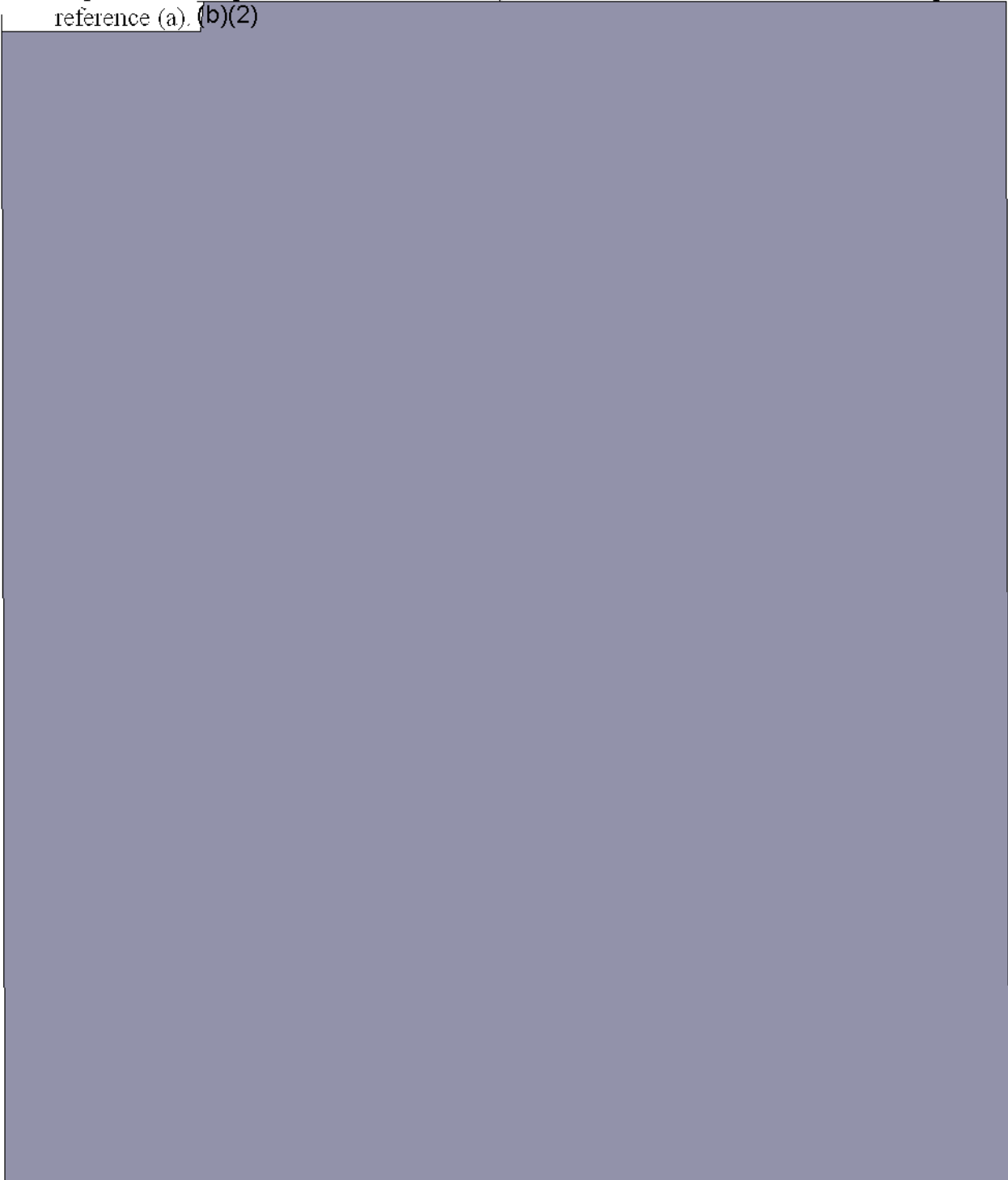
An immunization policy will exist and be continually evaluated. Td and TIG will be given when appropriate per the tetanus prophylaxis protocol. Empiric therapies will include: albendazole 400 mg, mefloquine 1250 mg.

Medical Event Reporting: Reportable medical events will be forwarded to the JTF GTMO Preventive Medicine Officer. Infectious waste, sharps, linens, and disinfecting procedures will be managed per references (a) and (b).

Infection Control Precautions: Standard precautions will be followed for all patients. In addition, until detainees are felt to be free of fecal contamination, skin infestation, and breaks in skin integrity, gloves will be worn. Transmission-based precautions will be used where appropriate.

Body Fluid Exposures

Exposure of JTF personnel to blood or body fluids of detainees should be handled as per reference (a). (b)(2)



Exposure Control Program: (b)(2)

All staff should be immunized against hepatitis B in addition to standard deployment immunizations.

Tuberculosis: Detainees will wear a surgical mask until cleared to remove it by the medical provider performing the in-processing examination. Detainees with highly suspicious chest x-rays or detainees exhibiting signs and symptoms suggestive of tuberculosis will be evaluated early and isolated from the remainder of the detainees. Multiple cases of pulmonary tuberculosis will be confined in one cellblock area and separated from other non-infected individuals. Outdoor air circulation and UV light will reduce communicability. Treatment will begin immediately with a 4-drug regimen if active disease is confirmed. All health care workers will have access to a N-95 respirator to be used when dealing with highly suspicious or confirmed cases when the patient is not masked. Security personnel will be fitted as needed. Masks need not be worn by staff unless coming into close, personal contact with the detainee **FOLLOW THE TUBERCULOSIS CONTROL SOP IN THIS BINDER FOR SPECIFIC ALGORITHM PROTOCOLS.**

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
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Officer In Charge	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 022
Title: LABORATORY OPERATIONS	Page 1 of 4 Effective Date: 04 Jul 03
SCOPE: Detention Hospital and Delta Clinic	

Ref:

(a) Naval Hospital GTMO Laboratory Department Procedures Manual

I. PURPOSE:

This SOP outlines the responsibilities of the JTF laboratory technician (HM-8506) and the procedures for the performance of laboratory examinations.

II. PROCEDURES:

A. Job Overview:

1. The Laboratory Technician (HM-8506) is responsible for specimen processing, test performance, and for reporting results in CHCS of detainee specimens.
2. The technician will perform only those tests that are authorized by the requesting credentialed provider.

B. Specific Duties

1. Phlebotomy of detainees.
 - a. Phlebotomy on detainees should be (b)(2) and have restraints on detainee if necessary.
 - b. At no time will the Lab Tech or any Hospital Corpsman perform phlebotomies (b)(2)
 - c. Each specimen drawn or collected will be labeled properly and legibly with the detainee's ISN/Cell Block number, date and time of collection, type of test(s) ordered and initial of drawer.
 - d. Yellow tubes need to clot then spun down for ten minutes to prevent cell hemolysis.
2. Verify that documentation of received samples is logged into the (b)(2) (b)(2)

(b)(2)

(b)(2) Verify orders in the CHCS prior to bringing specimens to the Naval Hospital.

3. All specimens brought to the naval hospital are to be transported using ice packs and placed in a Styrofoam transport box and properly accessioned. A tech in the Naval Hospital GTMO laboratory department must initial the (b)(2) as received.
4. Run specimens at the Naval Hospital GTMO laboratory. Verify the correct identity of each detainee specimen before releasing results. To do so, verify that the specimen label information (handwritten on tube) matches what is on the printed label.
5. Quality control and maintenance checks must be performed and found to be within the limits of acceptability, prior to releasing patient results.
6. Notify Naval Hospital GTMO laboratory supervisors of any technical problems encountered during specimen processing that cannot be resolved.
7. Maintain pager watch 24 hours per day, seven days per week. Days off (usually weekends) will be coordinated with the laboratory personnel at NH GTMO who will cover during the determined time period. Utilize this pager for any STAT specimens drawn after 1600, weekends and holidays.
8. Pack the following tubes for newly arrived detainees who will each receive seven blood test tubes upon entering medical processing. The tests to be performed are as follows:
 - a. Hepatitis B Surface Antigen (yellow tube)
 - b. Hepatitis B Surface Antibody (yellow tube)
 - c. Hepatitis B Core Antibody (yellow tube)
 - d. Hepatitis C Virus (yellow tube)
 - e. HIV (HIV tube)
 - f. Hepatitis A Total Ig and IgM (red)
 - g. Malarial Smears-both thick and thin (purple)
9. Responsible for infection control, laboratory safety, and proper handling of all hazardous materials and any other duties as assigned by higher authority.

D. IMPORTANT NUMBERS: The following are important numbers to aide in communication:

- a. (b)(2)
 - b.
 - c.
 - e.
 - f.
 - g.
 - h.
 - i.
- 

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantánamo Bay, Cuba

WRITTEN AND PREPARED BY:

(b)(6) _____ Date _____

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date _____

IMPLEMENTED BY:

Director for Administration _____ Date _____

Senior Enlisted Advisor _____ Date _____

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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 024
Title: TETANUS PROPHYLAXIS IN JTF DETAINEES	Page 1 of 5 Effective Date: 21 Mar 03
SCOPE: Detention Hospital	

REF:

- (a) BUMEDNOTE 6230

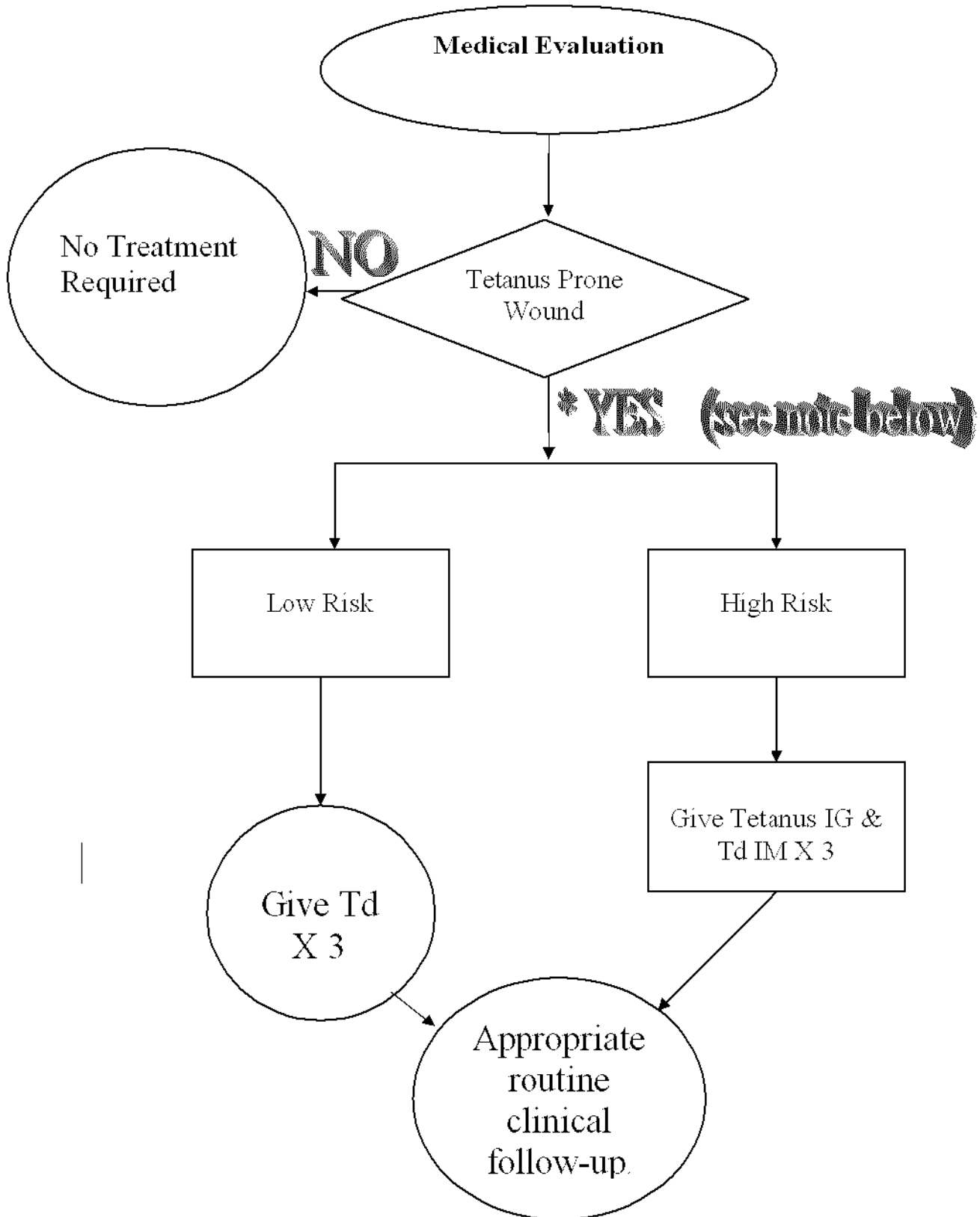
Encl:

- (1) Tetanus Prophylaxis flowchart

1. The purpose of this memorandum is to establish Detention Hospital policy regarding the initial evaluation and isolation of detainees regarding guidance for the use of tetanus prophylaxis in the detainee population.
2. All detainees will be screened for the presence of wounds that would indicate a requirement for the administration of tetanus prophylaxis. Enclosure (1) outlines the policy for the use of tetanus toxiod, tetanus diphtheria, and/or tetanus immune globulin.
3. The following are definitions and amplification of the tetanus prophylaxis flowchart:
 - a. 'Tetanus Prone Wound' – The presence of a tetanus prone wound is normally a significant laceration or other disruption in the skin.
 - b. 'High Risk' – High risk tetanus prone wounds are defined as puncture wounds, gunshot wounds, open fractures, crush injuries, wounds contaminated with dirt-saliva-feces, burns, and frostbite. **This is a clinical judgement and may require prioritization of assets if tetanus immune globulin supplies are limited.** In this case first priority for TIG should be given to detainees sustaining high risk wounds within 3 weeks.
 - c. 'Low Risk' – Low risk tetanus prone wounds would default to all other significant wounds.

- d. 'Td X 3' – Tetanus diphtheria is the adult vaccine containing tetanus toxoid and diphtheria vaccine. The dose is 0.5cc given intramuscularly. Each of the three vaccinations will be separated in time: the 2nd dose given at 1-2 months after the first, the 3rd dose after 6-12 months.
 - e. 'Tetanus IG' – Tetanus Immune Globulin (TIG) provides passive immunity for patients that have tetanus prone wounds with no primary tetanus immunization series. The dose is 250 units intramuscularly.
4. All tetanus toxoid , Td, and TIG given to detainees will be entered in the detainee health record. The entry will include the date, time, dose, route of administration, lot number, manufacturer, and the appropriate information on the health care personnel responsible for the administration.
 5. Three Td vaccinations will be given to detainees as outlined above, with the first dose given during in-processing.

TETANUS PROPHYLAXIS



** NOTE - High risk wounds include puncture wounds, gunshot wounds, open fractures, crush injuries, wounds contaminated with dirt – saliva – feces, burns and frostbite. Symptoms usually appear within 21 days of contamination. First priority for TIG should be given for detainees who have sustained a high risk wound within 3 weeks of arrival to camp X-Ray*

Enclosure (1) dtd 05 MAR

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STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
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DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 025 Revised April 2004 Page 1 of 32 Effective Date: 14 Feb 03
Title: MASS CASUALTY PLAN	
SCOPE: Detention Hospital, JTF GTMO	

Appendices:

- Appendix A - MASS CASUALTY IN CAMP DELTA**
- Appendix B - MASS CAUSALTY OUTSIDE CAM P DELTA**
- Appendix C - TRANSPORTATION**
- Appendix D - COMMUNICATIONS**
- Appendix E - INDIVIDUAL / TEAM RESPONSIBILITIES**
- Appendix F - JOB ASSIGNMENTS AND ACTION SHEETS**

I. MISSION

To provide immediate emergency response and establish coordinated triage/treatment in Camp Delta in cooperation with Camp Delta Security Force and / or provide backup medical support for Naval Hospital Guantanamo Bay in response to a mass casualty outside the perimeter of Camp Delta.

II. OVERVIEW

Emergency response principles must be clearly understood and documented so that medical personnel can respond to a variety of emergency medical situations in or outside Camp Delta. This document will serve as a turnover file and training template for incoming personnel tasked with managing the Detention Hospital Mass Casualty Program. Whether it is responding to one or multiple casualties the principles of the medical response are the same. A mass casualty is defined as a medical emergent situation, including self-injurious behavior, in which current medical staffing resources are overwhelmed by the events.

The attached Appendices will guide you through the event and your responsibilities during a Mass Casualty.

III. References:

- a. Camp Delta SOP- Chapter 32-10, Mass Casualty Incident**
- b. Joint Medical Group Medical Contingency Plan**
 - i. Annex B – Casualty Management**
 - ii. Annex H – Communications, Radio**
 - iii. Annex K – Disaster Outside of Camp America**
 - iv. Appendix 3 To Annex B – Detention Hospital And Detention Clinic Staff**
 - v. Appendix 2 To Annex B - Joint Aid Station (JAS) Medics**

Appendix A

PROCEDURES FOR MCI WITHIN DELTA COMPOUND

In the event of a Mass Casualty Incident (MCI) in Delta Camp involving Joint Task Force personnel or detainees, the following will apply:

1. Medical personnel will:

- The Medical Officer during working hours or the Nurse in Charge after hours, will act as **Medical Commander On Scene (MCOS)**, coordinating all emergency response activities until a more senior officer (Senior Medical Officer on Scene (SMOS) arrives. This includes ensuring all gear and supplies are removed from CONEX boxes and staged at pre-designated areas.
- The Emergency Response Team (ERT) will consist of (b)(2) Any time the assigned personnel are out of the clinic they shall ensure they have a radio and an ERT medical jump bag with them.
- The Medical Commander on Scene (Medical Corps or Nurse Corps) will send out the Emergency Response Team (ERT), consisting of (b)(2) and a response bag.
- The ERT will report to the incident scene. (b)(2) (b)(2)
- The ERT will assess the situation and provide immediate feedback to the Medical Commander on Scene regarding the number of military/detainee casualties and their status.
- The Medical Commander on Scene will assign a Command and Control HM to man the clinic and then report to the designated Triage area, assess the situation, and provide immediate feedback to Command and Control (Part of the DOC) regarding the scene. The Medical Commander on Scene will notify Command and Control (DOC) of the possibility of alerting the Naval Hospital GTMO for medical help.
- The designated Command and Control HM will remain at Delta Medical Clinic to man the radio and phones until relieved by either a Nurse Corps Officer or another Medical Officer.
- (b)(2)

- Should the Emergency Response Team (ERT) find multiple casualties or one casualty in imminent danger of losing life or limb, they will report this immediately to the Medical Commander.

2. Detainee Operations Center (DOC) will:

- If less than five casualties, the Medical Commander will contact the DOC at (b)(2) the Detention Hospital (Detainee Hospital) OIC and the Detention Hospital Senior Medical Officer (SMO).
If greater than five casualties, contact DOC at (b)(2) and the Detention Hospital Petty Officer of the Day (POD) by dialing their home phone number or by pager by dialing (b)(2) and entering pager (b)(2), then the telephone number to be dialed. If contact cannot be made with the Petty Officer of the Day (POD), the OIC should then be notified.
- Then the DOC will announce that a MCI has occurred over the SABRE Radio. They will:
 - Notify camp operations to stay off SABER, use Landline or courier for all camp traffic
 - Maintain SABER net discipline and information flow from SINCGARS
 - Announces via SABER (b)(2) of the following: "ATTENTION CAMP DELTA, ATTENTION CAMP DELTA, A MASS CASUALTY INCIDENT HAS OCCURRED (*Location/MSA*), INITIATE MCI PROCEDURES. ALL NON-EMERGENCY COMMUNICATION WILL BE BY LANDLINE." This announcement will be repeated two times. "ATTENTION CAMP DELTA, A MASS CASUALTY INCIDENT HAS OCCURRED _____ (*Location/MSA*), INITIATE MCI PROCEDURES. ALL NON-EMERGENCY COMMUNICATION WILL BE BY LANDLINE" during an MCI.
- DOC will then activate the IRF Team for the camp affected for an immediate response to the MCI location.
- The On-Duty Company Commander will assume duties as On-Scene Commander. A designated Platoon Leader will assume command and control of the Camp.
- MPs and the manpower pool will provide litter bearers and other personnel.

3. Medical Commander On Scene (MCOS will:

- Once notified on the number of casualties and has authorization from the DOC, the Medical Officer will contact the **DUTY MEDICAL OFFICER** at Naval Hospital Emergency Department at (b)(2) and state:
"This is the Medical Commander on Scene Detention Clinic at Camp Delta, we have had a mass casualty incident beyond the scope of our capabilities and require Naval Hospital assistance, please activate your Mass Casualty Recall Roster." Provide as much information as possible, i.e. number of suspected deaths, wounded, etc.

4. The Detention Hospital Petty Officer of the Day (POD) will:

- Notify Detention Hospital OIC, Senior Medical Officer and Mass Casualty Coordinator Officer
- Activate the Mass Casualty Recall Roster and page all Hospital and J6 pagers.
- The POD will initiate, if possible, a door-to-door recall in the housing area.
- If the bus is available, muster all personnel on the bus and continue to the (b)(2) Joint Aid Station (JAS).
- Personnel will respond to the recall by taking the Ambulance bus or any other means of transportation and muster at the JAS.
- Advise the personnel that the point of muster is at the (b)(2) Joint Aid Station and the personnel will wait at the (b)(2) JAS until notified that help is requested.

5. Arriving recalled Medical personnel will:

- Muster at the (b)(2) Joint Aid Station. Personnel will be assigned to teams or to the Manpower Pool. The bus will be utilized to send the initial group of medical responders to the scene of the Mass Casualty whether inside Camp America or outside Camp America (See Section IV).

6. Medical personnel at Camp Delta will:

- Perform initial triage at the scene and send victims by litter to the triage area based on the location of the MCI where the Triage Officer will triage each victim into one of the four categories: (b)(2)
- After being triaged, the victims will be moved to one of four areas to await transport. The immediate area will be marked with a red flag and the Immediate Category Leader will be wearing a red vest. The delayed area will be marked with a yellow flag and the Delayed Category Leader will be wearing a yellow vest. The minimal area will be marked with a green flag and the Minimal Category Leader will be wearing a green vest. The expectant area will be marked with a black flag and the Chaplain will be in this area.
- The Triage areas are located at the following areas:
 - (b)(2)
 -
 -

7. Casualty Transportation:

- During the triage process casualties are tagged with their corresponding category tag and tracked by the Medical Regulator. The Litter Bearer Coordinator, the MP Litter Bearer NCOIC, and the Transportation Coordinator then direct casualty transportation to the treatment team locations as indicated in the chart above.
- The Medical Regulator then radios Command and Control with all pertinent casualty data.

- (b)(2)
-

8. Ambulance Transportation:

- After triage by the Triage Officer, the Litter Bearer and Transportation Coordinator directs transportation to treatment team locations as indicated in the chart above.
- (b)(2)

Designated treatment teams, locations and transportation modes are listed in the chart below these areas are not set in stone but are dynamic depending on the situation at hand:

(b)(2)



10. Litter Teams:

1. (b)(2)
- 2.
- 3.
- 4.
- 5.
- 6.

11. Staging Areas:

- (b)(2)
- 

- (b)(2)

12. Responsibilities:

- Job Action Sheets will be found in the Mass Casualty Admin box located in each conex box. These sheets are also located at the Nurses station of the Detention Hospital, Delta Clinic, and Delta Block. These sheets are designed to be used by responding personnel as a quick reference or checklist of primary duties for a specific mass casualty job, but are not all inclusive of the duties/actions that will be required during a mass casualty incident. The Medical Commander will assign personnel these jobs. The list of jobs and responsibilities are located in Responsibilities Section V.

13. Teams:

- Command and Control team will consist of (b)(2)
- Medical Commander On Scene (MCOS) is responsible for all medical operations at the site. He will wear a blue vest and consist of one officer. If an administration assistant is available, they will assist the MOSC.
- Medical Liaison Navy Officer (LNO) will assist the Medical Commander On Scene by being stationed at the DOC. The LNO for Camp Delta is usually the Director for Administration. The LNO will liaison with the MCC and contact NAVBASE hospital requesting ambulance support to Camp Delta, to include entry and exit points.
 - When ambulances are dispatched, the LNO will be responsible to relay the vehicle number and other information to the Infantry and the DOC. This will allow the ambulances, trucks with staff members, etc. access into the TCP (check point) unhindered. The LNO will provide the MCC information on the type and number of casualties and the location where they're being transported.
 - NAVBASE Hospital will contact the JOC and let them know which ambulance is responding by bumper number.
- Emergency Response Team (ERT) will consist of (b)(2)
- Triage team will consist of (b)(2)
- Staging Team for Military and Detainee Immediate Casualties will consist ideally of (b)(2) Team to be supplemented by MD/IDC/PA if needed as they arrive from NH GTMO.
- Staging Team for Military and Detainee Delayed Casualties will consist of ideally (b)(2) Casualties in this staging area are (b)(2)

- (b)(2) Team to be supplemented by MD/IDC/PA if needed as they arrive from NH GTMO.
- Staging Team for Military and Detainee Minimal Casualties will consist of (b)(2) (b)(2)
- (b)(2)
- Detention Hospital Teams will consist ideally of an Immediate Team (b)(2) (b)(2)
- Staging Team for Military and Detainee Expectant Casualties will consist ideally (b)(2)
- Litter Bearer Team will consist ideally (b)(2) Bearers will be designated MP escort teams.
- Manpower Coordinator will be a corpsman or any Detention Hospital staff member.
- Traffic Coordinator will be any available personnel.

14. Psychiatric Services:

- (b)(2)
- Mental Health / Psychiatric providers will also be available after initial emergency response and treatment.

15. Supplies:

- Three Mass Casualty CONEX boxes are located in Camp Delta. (b)(2) (b)(2)

16. Notes

- License plate bumpers numbers in red identify ambulances. (b)(2) (b)(2)
- DOC NCOIC notifies Camp Delta Sally ports of inbound ambulances.
- First/most qualified on scene should take charge until relieved by more qualified personnel.

Appendix B

MASS CASUALTY OUTSIDE OF CAMP DELTA

1. Purpose:

The purpose of this is to describe how the JTF HQ/SG and Joint Aid Stations (JAS), Detention Hospital (DH) and Navy Hospital (NAVHOSP) will manage patients/casualties during a contingency operation **outside** of Camp Delta. This section outlines the responsibilities/makeup of the Triage teams, Primary/Secondary Response Teams, JAS, DH and NAVHOSP Medics.

2. Overview:

- The JTF HQ/SG is comprised of two Joint Aid Stations manned with 22 infantry medical personnel; a Detention Medical Response is manned with 95 medical personnel, and six Combat Stress Center personnel.
- The mass of personnel constitutes all levels of medical provider status from corpsman to medical and psychiatric physicians.
- The JTF has the ability to call upon the NAVHOSP GTMO for further assistance and emergency services to include a fully working emergency room, physicians, medical technicians, ambulance response, all ancillary services, and aero medical evacuation.
- The NAVHOSP provides for inpatient, surgical, or limited specialty care of patients.
- The JTF HQ/SG Joint Aid Stations are equipped to treat minimal patients and have made provisions to send patients who are categorized with more serious medical conditions to NAVHOSP GTMO medical facility for inpatient requirements.
- For decontamination, the Installation Fire Department and Preventative Medicine Department (when applicable) will proceed with initial decontamination of all patients to make it possible to move them.

3. Primary response:

- The initial call occurs after a 911 call is received by the NAVBASE dispatcher, or when the Joint Operations Center receives notification of an emergency and in turn notifies any or all of the following: the Detention Operations Center, the Medical Control Center, or the NAVHOSP Emergency Operations Center (EOC).
- The entity, which receives the notification in turn, initiates a recall of appropriate personnel (limited or full), to include MCC, JAS and NAVHOSP.
- If the primary response team requires additional assistance, they will call for subsequent response through the Medical Control Center (MCC), for Navy Hospital Emergency Room and Ambulance support, which is a 24-hour operation and manned with all levels of medical expertise.

4. Primary Response to INCIDENT OCCURRING INSIDE CAMP DELTA DURING MASS CASUALTY OUTSIDE CAMP DELTA

- If the primary response team is responding to the emergency outside Camp Delta, the Delta Clinic will respond to any emergencies that will come up in Camp Delta.
- First/most qualified on scene should take charge until relieved by more qualified personnel
- Minimum manning for the Delta clinic is one shift leader, six corpsmen, one medical doctor, and one registered nurse.
- Minimum manning for the Detention Hospital will be one registered nurse.
- Minimum manning for the Delta Block will be one registered nurse and two psych technicians.
- The corpsmen are broken down into Emergency Response Teams (ERT), each consists of two corpsmen. One team will respond initially to each occurrence. If the initial ERT team requires help, the team leader will radio back for help.
- The Shift leader will send another team out to assist. The clinic, at minimum manning, has the capability to handle incidents that involve up to five detainees before it becomes a mass casualty.
- If the Delta Clinic is overwhelmed by the circumstances, the Medical Doctor or Registered nurse (DDO) will notify the DOC. The DOC will then take the required appropriate action and request medical help from the JAS.

5. Rally (Muster) Response:

Upon notification of a recall from the Joint Operations Center (JOC) and/or Medical Control Center (MCC):

- Members of the Joint Aid Station (JAS), Detention Hospital/Clinic, Combat Stress Center and the Naval Hospital Ambulance (when dispatched) will respond to the call, by reporting to, and rallying at the Kittery Beach JAS.
- At the point of convening an adequate number of medics, directions/instruction regarding the disaster will be provided to the Senior Medical Commander On Scene (highest ranking medical officer at the JAS) by MCC personnel (whom have monitored the situation via JOC communication and radio).
- The Senior Medical Commander On Scene will in turn determine appropriate personnel to fill the Transportation, Triage, and Medical Treatment Team Leader positions gather team personnel and depart to the scene.

6. Subsequent Response To The Site:

Once on site and the scene has been determined to be **safe**:

- The Senior Medical Commander On Scene coming from the JAS via the ambulance bus will take control of the AXP, patient care, and any subsequent transportation logistics.
- The appropriate primary response teams (triage, immediate, minimal, delayed and Combat Stress Center/CSC) will determine AXP (Ambulance Exchange Points) location and set-up.
- The teams will prepare the areas; Immediate, Minimal, Delayed and find a distant location for Expectant by setting up supplies, litters, and any additional needs.

- The teams will consider ingress and egress routes for AXP traffic flow.
- At incidents outside of Camp America the Navy Base (NAVBASE) Fire Department Chief is in control of the scene.
- The Medical Response Teams (JAS, DH/DC, and NAVHOSP when applicable) and applicable Triage teams will receive direction/information from MCC, JOC or POD and travel/report to the disaster scene as needed.
- Teams that are not sent to the scene will stay at KB JAS and prepare for incoming wounded patients or deployment to other possible mass casualty incidents.

7. Secondary Response At The Site:

If the Primary Response team needs additional back-up, either because of the number and type of casualties or the situation:

- They will call the Medical Control Center via secure radio or secure telephone device for assistance from a Secondary Response Team which will come from the remaining Joint Aid Station Medics, Detention Hospital/Clinic Medics, Combat Stress Center Teams and/or NAVHOSP Ambulance crews and medical personnel who have remained at KB JAS.
- Secondary response is placed on standby after the Primary Response team arrives at the scene and assesses the need for added personnel.
- If the MCC is not activated, Secondary Response is at the discretion of the NAVHOSP CDO, and/or Senior Medical Officer or member responding with the Primary Response members, and will occur via secure radio/telephonic communication network with the NAVHOSP Emergency Operations Center (EOC).

8. Joint Aid Station (JAS) Medics:

The Joint Aid Station (JAS) Medics will:

- Provide care for minimally injured patients with the intent of returning them to duty in the shortest amount of time on scene and at KB JAS.
- If numbers or types of casualties are too many or severe, additional Joint Aid Station (JAS) Medics will augment as necessary.
- Minimally injured casualties will be treated and returned to duty when possible, or transported to an Ambulance Exchange Point and subsequently transferred to Joint Aid Stations for further treatment and/or monitoring.
- Those more seriously injured will be moved from AXP for transportation to NAVHOSP GTMO.

9. Detention Hospital And Clinic Corpsmen

The Detention Hospital (DH) Corpsmen will:

- Provide care for minimally injured patients along with JAS medics at the AXP, and/or KB JAS. DH Corpsmen (previously identified as non-essential to minimal manning) will function within an appropriate team IAW scope of practice guidance.

- DH Corpomen will treat injuries with the intent of returning them to duty in the shortest amount of time. Joint Aid Station (JAS) Medics and DH medics will augment scene, AXP sites, and JAS as needed.
- Minimally injured casualties will be treated and returned to duty when possible, or transported to an Ambulance Exchange Point and subsequently transferred to Joint Aid Stations for further treatment and/or monitoring.
- Those more seriously injured will be moved from the casualty point to Ambulance Exchange Point I for transportation to NAVHOSP GTMO

10. Ambulance Support:


- (b)(2)
-
-
- (b)(2)
- Designated treatment teams, locations and transportation modes are listed in the chart below:

(b)(2)



11. Radio Communication

The Senior Medical Officer and Transportation officer will:

- Coordinate the expeditious transfer of casualties from the site to medical treatment facility (NAVHOSP, JAS or MEDEVAC).
 - Communication coordinating this travel will occur via the MCC. The “five liner” is used as a means of communicating patient sensitive information.
 - (b)(2)
- 

12. Casualty Treatment At The Site:

Patients will be triaged, stabilized and transported from the site to NAVHOSP by one of the following methods:

- Teams, which are comprised of personnel from the JAS, DH, and any NAVHOSP personnel at KB, JAS will send patients IAW their status and injury category by NAVHOSP ambulance, JAS Ambulance, or DH ambulance.
- The teams will rapidly move patient to the Ambulance Exchange Point (AXP-1) for pickup via NAVHOSP Ambulance and transport to NAVHOSP or Medical Evacuation to another medical facility best equipped to handle their injuries may be applicable at a point during the contingency.
- Minimals will be transported to the nearest AXP and/or the JTF HQ/SG KB Joint Aid Station and all others would be treated and returned to duty as soon as feasible.

13. Casualty Treatment At The Joint Aid Stations:

The Joint Aid Station and Detention Hospital Medics will:

- Form and treat patients triaged as minimal. The goal is to return these patients to duty as quickly as possible.
- In the case where casualties would come to the Joint Aid Station on their own by privately owned vehicles, the Team would assess the patient and decide if the injuries were serious enough to warrant transfer to the NAVHOSP GTMO and arrange this through the MCC.
- If the patient were minimally injured, the Team would take care of the patient.
- If the patient was transported and received treatment at the JAS yet, categorically deteriorates to a worsened condition, immediate transport via a JAS Ambulance, or NAVHOSP ambulance is the correct course of action.
- Minor lacerations and burns will be treated in the KB JAS designated treatment or minor procedure room areas.
- Minor orthopedic injuries will first be assessed, sent to NAVHOSP GTMO radiology if necessary, and then treated accordingly.
- Other minimal patients will be evaluated and treated as needed in the individual exam rooms and pre-set up staging and treatment areas of the KB JAS.
- Any mental health patients will be escorted to the Combat Stress Team and receive further treatment as needed.
- All patients awaiting treatment will wait in the waiting area and re-assemble there after treatment for transportation.

Appendix C

TRANSPORTATION OF PERSONNEL

1. Notification

Upon notification recall or personal recognition of a disaster with a potential for injuries outside or inside Camp Delta, DH personnel who, at the time of the recall are in East Caravella housing or outside Camp America in the general population of Naval Base, GTMO (I.e. BX, library, liberty center, etc.) will:

- Report to KB JAS by DH Bus (normally located at East Caravella housing area), by Emergency response vehicle, Government Owned Vehicle, Privately Owned Vehicle or some other form of transportation in the most expeditious and safe manner possible.
- The recalled personnel coming from the East Caravella Housing area will muster by the Ambulance Bus in the housing area for the ride to the Joint Aid Station (JAS) located on Kittery Beach Road.
- The bus will make one trip from the East Caravella Housing area to the JAS and then be reassigned as necessary. The bus will depart East Caravella Housing 15 minutes after the initial recall.
- Any personnel left or arriving after the initial recall will, by any means, make their way to the JAS.
- If Delta Clinic/Detention Hospital and Delta Block personnel are called upon to provide backup medical support for Naval Hospital Guantanamo Bay in response to a mass casualty outside the perimeter of Camp Delta, the personnel working in the Delta Clinic, , and Detention Hospital will respond by going down to minimal manning.
- The responding Delta Clinic and Detention Hospital personnel coming from Camp Delta will gather their MCI supplies, load up two ambulances, and make their way to the JAS.
- All personnel who are assigned to Psychiatric Services, Detention Hospital, will be contacted and expected to report to the Joint Aid Station. They will be utilized for their medical expertise initially until otherwise directed
- Once at the JAS, all personnel will be assigned to the Manpower Pool and allocated to response teams.

2. Transport to Scene:

- Senior Medical Officer on Scene (SMOS) and the Transportation Officer reviews Transportation Officer checklist (Job Action Sheet) and ensures adequate numbers of vehicles for scene are being staged
- Once an appropriate (per situation/disaster) number of medics are rallied at KB JAS, teams (Triage, Immediate, Delayed, Minimal and Expectant) will

form, load supplies and self into vehicles (on site and available), receive instruction from MCC and/or SMOS and proceed to disaster site

3. Upon Arrival To Disaster Scene:

- The teams depart vehicle, set up AXP areas, and prepare supplies IAW the disaster scene report via NAVBASE FD Chief
- Senior Medical Officer on Scene (SMOS), Transportation Officer and Triage Officer will immediately meet with FD Chief/incident Commander (wearing orange vest), and receive initial report and “Orange Vest” marked with the reflective wording “Medical”, “Transportation”, “Triage”
- SMOS and FD Chief will identify communications capability and plan for casualty reporting, patient transportation, routing and any additional resources needed on scene. The Transportation officer will coordinate with FD Chief and SMOS to prepare and maintain a smooth traffic flow. The Ambulance traffic will check in at the Entry Control Point and proceed once a loaded ambulance has departed the scene.

- (b)(2)
-

- Civilian minimal/delayed category patients will report to, or be transported to NAVHOSP Emergency Room, via NAVHOSP Ambulance, NAVHOSP Emergency Response Vehicle, JAS Ambulance or Emergency Response Vehicle, DH Ambulance or Emergency Response Vehicle, or DH Bus, JAS/DH GOV

- (b)(2)
-

(b)(2)



Appendix D

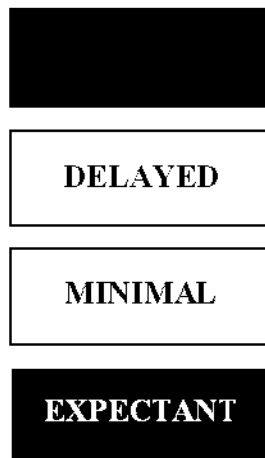
COMMUNICATIONS

1. Colored Mass Casualty Boxes/Signs/Flags:

If any predetermined site is determined unsafe, the Medical Commander and the Senior Command Post Personnel will designate an alternate safe site.

Color-coded flags will mark triage category sites.

The flags are colored as follows: IMMEDIATE: **RED**, DELAYED: **YELLOW**, MINIMAL: **GREEN**, and EXPECTANT: **BLACK**



2. Radios:

Radios, located in Delta Medical Clinic, will be utilized to facilitate communication between all component team leaders. The following team leaders will be issued a radio:

1. Medical Commander
2. ERT
3. Triage Team Medical Regulator
4. Litter Bearer Leader
5. Transportation Coordinator
6. Immediate Category Leader
7. Delayed Category Leader
8. Command and Control 2 Radios (Will have 1 radio on (b)(2) to monitor DOC and 1 radio on (b)(2) to receive or pass medical info)

3. Means of communication outside Camp America:

When the MCI is located outside of Camp America, the Senior Medical Officer and Transportation officer will coordinate the expeditious transfer of casualties from the site

(b)(2)



4. Telephones:

Telephones will be used to relay information between Command and Control, the Joint Aid Station, the Detention Hospital and Naval Hospital GTMO and to communicate to any other appropriate facility. Use of phones for purposes other than mass casualty care is highly discouraged during the incident.

XI. CRITICAL LOCATIONS

(b)(2)



(b)(2)



(b)(2)



(b)(2)



3. Job Action Sheets:

Job Action Sheets will be found in the Admin boxes located in the Mass Casualty CONEX boxes staged near CP1 and CP2 sally ports. These sheets are designed to be used by responding personnel as a quick reference or checklist of primary duties for a specific mass casualty job, but are not all inclusive of the duties/actions that will be required during a mass casualty incident. The Medical Commander/DDO via the Manpower Pool Coordinator will make these assignments as qualified personnel muster at Sally Port

JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA

TRANSPORTATION OFFICER

- ___ Report to scene and obtain briefing from Medical Commander
- ___ Obtain Transportation Officer portfolio
- ___ Don the Transportation Officer command vest and review items in portfolio
- ___ Coordinate personnel assigned to the transportation area
- ___ Make sure keys of ambulances are on clipboard; pass to ambulance drivers
- ___ Provide and coordinate casualty transport
- ___ Consult with Medical Commander and establish ambulance loading zone
- ___ Consult with Fire Commander (fire fighters) and establish landing site for air support units, notify Medical Commander of location
- ___ Request ambulances as needed from the Staging Officer
- ___ Coordinate routing of casualties to proper ambulances
- ___ Maintain Hospital Transportation Log; ensure triage tags are used, make sure tag is filled out accurately and completely, keeping one corner or section of tag
- ___ Advise receiving hospital of unit responding, number of casualties in unit, brief description of casualties by triage category, estimated time of arrival of unit
- ___ Update hospital capability and casualty tally sheet as casualties are transported
- ___ Ensure keys are returned and placed on clip board once MCI is secured

**JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA**

TRIAGE OFFICER

- ___ Obtain briefing from Medical Commander
- ___ Obtain Triage Officer and triage supplies portfolios
- ___ Don Triage Officer vest and review items in portfolios
- ___ Determine equipment and personnel needs of triage area: request needed Manpower and equipment from the Medical Commander
- ___ Coordinate personnel assigned to the Triage area
- ___ Ascertain from the Medical Commander if it is safe to begin triage
- ___ Begin triage operations
- ___ Advise Medical Commander of number of casualties as soon as possible
- ___ Request personnel and litters from the Litter Bear Team Leader to transfer casualties to treatment areas for evacuation
- ___ Check all areas around mass casualty incident scene for potential casualties, walk-always, ejected casualties, etc.
- ___ Advise Medical Commander when initial triaging and tagging operations are complete
- ___ Report to Medical Commander for reassignment upon completion of task

JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA

DELAYED TEAM LEADER

- ___ Obtain radio
- ___ Receive briefing from Medical Commander
- ___ Review job action sheet
- ___ Don Delayed Team Leader vest
- ___ Ensure treatment supplies are in Delayed treatment area
- ___ Prepare the Delayed treatment area to receive casualties
- ___ Notify Medical Commander when Delayed treatment area is ready to receive casualties
- ___ Document diagnosis, treatment, and disposition on treatment forms/tags
- ___ Maintain communications with Command and Control to ascertain additional needs and relay casualty flow information as appropriate
- ___ Report to Medical Commander when casualties are ready for transport
- ___ Notify Medical Commander when all delayed treatment is complete
- ___ Upon completion of incident all team members will clean, dispose of all used/unused items and establish a rough inventory of supplies used to assist with area re-supply

**JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA**

EXPECTANT TEAMLEADER

- ___ Receive briefing from Medical Commander
- ___ Review Expectant job action sheet
- ___ Ensure all Expectant staff members are present
- ___ Ensure supplies are in Expectant area
- ___ Prepare Expectant area to receive casualties
- ___ Notify Medical Commander when Expectant Team is ready to receive casualties
- ___ Report to Medical Commander with number of casualties
- ___ Maintain communications with Command and Control to ascertain additional needs and relay casualty flow information as appropriate
- ___ Upon termination of incident team members will clean, dispose of used/ unused items and establish a rough inventory of supplies used to assist with area re-supply

JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA

IMMEDIATE TEAM LEADER

- ___ Obtain radio
- ___ Receive briefing from Medical Commander
- ___ Review Immediate job action sheet
- ___ Don Immediate Team Leader vest
- ___ Ensure Immediate Team supplies are in Immediate treatment area
- ___ Prepare the Immediate treatment area for receiving casualties
- ___ Notify Medical Commander when Immediate area is ready to receive casualties
- ___ Document diagnosis, treatment, and disposition on treatment forms/ tags
- ___ Maintain communications with Command and Control to ascertain additional needs and relay casualty flow information as appropriate
- ___ Report to Medical Commander when casualties are ready for transport
- ___ Report to Medical Commander with deaths and number of casualties
- ___ Notify Medical Commander when all immediate care has been completed
- ___ Upon termination of incident team members will clean, dispose of used/ unused items and establish a rough inventory of supplies used to assist with area re-supply

**JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA**

LITTER BEARER TEAMLEADER

- ___ Report to scene and receive briefing from Medical Commander
- ___ Obtain radio
- ___ Report to Triage Staging area to coordinate casualty transportation
- ___ Coordinate MP litter teams to and from Triage and casualty staging areas

JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA

MEDICAL COMMANDER

- ___ Receive initial report of incident from CDO or Delta Duty Officer
- ___ Ensure CDO made notifications to 911, NH GTMO and initiated the recall of all personnel
- ___ Coordinate incident scene with Fire Department incident commander and JDOG Duty Officer
- ___ Brief all team leaders of current incident situation as they arrive
- ___ Ensure responders know the safe route to enter into the incident area
- ___ Depending on safety of the situation, either put the teams on standby or activate them accordingly
- ___ Coordinate with Manpower Pool to fill positions as needed
- ___ Periodically request team leaders report status of their areas by radio
- ___ Coordinate all casualty movement
- ___ Report all casualty movement to Command and Control for tracking
- ___ Task JDOG to place and turn on flood lights
- ___ Have JDOG turn flood lights on if extra lighting is needed

JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA

MEDICAL REGULATOR

- _____ Receive Sabre radio, triage tags, triage tapes, and casualty tracking forms
- _____ Muster with Triage Officer and prepare to tag and track casualties to staging areas determined by the Triage Officer
- _____ Radio Command and Control all casualty movement and triage category, identify casualties by triage tag number. Document casualty's ISN (if detainee) from bracelet/bbcard/# printed on forehead, or SSN and name (if Mil Per) from dog tags/ID card/name tag. Note: if ISN/dog tags/ID card/name badges are not readily obtainable, do not spend time searching so as to not interfere with delivering emergency treatment.
- _____ Supplement other areas at the direction of the Medical Commander following triage of all casualties

**JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA**

MINIMAL TREATMENT TEAM LEADER

- ___ Receive briefing from Medical Commander
- ___ Review Minimal job action sheet
- ___ Don Minimal Team Leader vest
- ___ Ensure Minimal treatment supplies are in Minimal treatment area
- ___ Assemble team members in the Minimal treatment area
- ___ Prepare Minimal treatment area to receive casualties
- ___ Notify Medical Commander when Minimal treatment area is ready to receive casualties
- ___ Treat casualties, returning those capable to duty, and provide continuous monitoring to those requiring observation
- ___ Document diagnosis, treatment, and disposition on treatment forms/ tags
- ___ Maintain communications with Command and Control to ascertain additional needs and relay patient flow information as appropriate
- ___ Upon completion of the incident all team members will clean, dispose of all used/ unused items and establish a rough inventory of supplies used to assist with area re-supply

**JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA**

COMMAND and CONTROL OFFICER

- ___ Page CDO (b)(2)
- ___ Inform CDO there has been a Mass Casualty Incident and to activate the recall roster
- ___ If unable to contact CDO page OIC
- ___ Call Detention Hospital (b)(2) and inform them there has been a Mass Casualty Incident and to prepare to receive casualties
- ___ If during normal working hours (Monday - Friday 0800-1700 or Saturday - Sunday 0800-1200) call the Admin building (b)(2) and inform them there has been a Mass Casualty Incident
- ___ Call Naval Hospital GTMO (b)(2) to assure they are aware there is a Mass Casualty Incident; relay approximate number of casualties if this information is available
- ___ Obtain and stage tracking board from Trauma Bay in clinic
- ___ Obtain Mass Casualty radio from Med room and utilize (b)(2) for further (b)(2)
- ___ Note on tracking board number of casualties, status, and transportation status as information is relayed to you

**JOB ACTION SHEET
DETENTION HOSPITAL
JOINT TASK FORCE
GUANTANAMO BAY CUBA**

MANPOWER POOL COORDINATOR

Primary: Senior Psych Tech

Alternate: Admin YN

- ___ Muster in Manpower Pool.
- ___ Receive briefing from Medical Commander
- ___ Obtain radio
- ___ Make assignments of the following personnel:
 - ___ 1st provider to Triage (if not already filled)
 - ___ 2nd provider to Immediate
 - ___ 3rd provider to Delayed
 - ___ Medical Regulator to Triage
 - ___ (b)(2)
 - ___ Transportation Coordinator
 - ___ (b)(2)
 - ___ Immediate Team (b)(2) Senior Nurse acts as Team Leader
 - ___ Delayed Team (b)(2) Senior Nurse acts as Team Leader
 - ___ Minimal Team Leader (b)(2)
 - ___ Litter Bearer Team Leader (1)
 - ___ Immediate Team Leader Det.Hosp. (b)(2)
 - ___ Expectant Team Leader (b)(2)
 - ___ Assign Ambulance drivers (b)(2)
- ___ Maintain accountability of manpower staffing from manpower pool
- ___ Coordinate excess personnel to needed areas

Appendix F

MASS CASUALTY IN CAMP 5

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge

Date

IMPLEMENTED BY:

Director for Administration

Date

Senior Enlisted Advisor

Date

ANNUAL REVIEW LOG:

By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____

SOP REVISION LOG:

Revision to Page: _____ Date: _____
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Revision to Page: _____ Date: _____

ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 026
Title: RADIOLOGY DEPARTMENT	Page 1 of 5 Effective Date: 25 Jul 03
SCOPE: Detention Hospital	

- Encl:
- (1) Technique Chart
 - (2) Manufacturers and addresses for ordering film and chemicals
 - (3) Guidelines for ordering CT Scans studies
 - (4) CDC TB Report, dated 20 Aug 02

I. PURPOSE:

To define policies and procedures for scheduling and obtaining Diagnostic Radiographs.

II. RESPONSIBILITIES AND AUTHORITIES:

A. Personnel

- 1. Director for Clinical Support Services; Medical Corps, Nurse Corps or Medical Services Corps Officer
- 2. Hospital Corpsman, NEC 8451 and NEC 8452, Basic and Advanced Radiology Technicians

B. Hours of Operation

- 1. Normal working hours (0745 to 1600) 7 days per week
- 2. After hours (1600 to 0745) 7 days per week.
- 3. Watch Standing
 - (a) Watch begins at the end of normal working hours and lasts until 0745 the following morning.
 - (b) Watch standers must remain within a 1-mile radius of housing.
 - (c) Watchbill must be submitted to Director for Ancillary Services monthly.

C. X-ray Machine Standard Operating Procedures

1. Turn on x-ray machine and allow it to run for thirty minutes, and then make three exposures using “ low techniques”.
2. For more guidance consult operators guide, Enclosure (1).

D. X-Ray Processor Operations and Maintenance

1. Ensure CADI Pack and Processor have water supply before turning the X-ray processor on.
2. Check chemical supply in CADI Pack
3. Turn Processor on let the developer temperature reach 94 degrees.
4. Run two 14X17 to films to clean rollers.
5. Ensure processor returns to standby mode after films are processed, as it will not shut off automatically and it will continue to pump chemicals into processor.

E. Processor Cleaning

1. Crossovers: Daily
2. Rollers: Weekly
3. Deep Tanks: Monthly
4. Use cleaning materials that will not adhere to rollers.
5. Consult the operator’s guide for more information.

F. Request for Radiographic Procedures

1. The JTF Detention Hospital or the X-ray Department, NH GTMO credentialed medical providers will generate request for radiographic procedures.
2. The requesting medical provider must enter all requests in CHCS.
3. The radiology technician will ensure that all examinations will be arrived, departed and have a work sheet made in CHCS.

G. Radiologist X-ray Film Reading

1. Radiology technician collect all examinations after wet read by ordering clinician.
2. Take examinations to NH GTMO to be mailed to Portsmouth Naval Hospital for official Radiology Department X-ray film reading.
3. All official X-ray readings will be entered in CHCS by the radiology technician.

H. Creating and Filing X-ray Folders

1. All X-ray files folders must have the following information:
 - (a) PT identification number
 - (b) Date performed.
 - (c) Type of examination.
2. Filing system. Files are filed numerically using the primary, secondary and tertiary Social Security number (SSN) numbering system utilized for medical records.
3. Films must be returned to Radiology within 24 hours.

I. Supplies

1. All supply order requests are submitted by email to the Detention Hospital Supply Department.
2. Maintain a 30-day supply of critical items as the supply orders may take more than three weeks to fill.
3. Manufacturers and addresses for ordering film and chemicals are found in Enclosure (2).

J. Silver Recovery and HAZMAT

1. All exposed film and the silver recovery cell must be turned over to NH GTMO Supply Department quarterly.
2. When ready to harvest cell, notify NH GTMO Supply Department LPO to retrieve the material.
3. All used fixer solution must be tested for silver content prior to being discharged into the sewer system.
4. Maintain the silver-testing logbook.

K. Special Radiology Procedure

1. Credentialed medical providers will order the special radiology procedure in CHCS and inform Radiology Technician to schedule the procedure.
2. The Transport Coordinator will coordinate transport according to JDOC and NH-GTMO protocol.

L. CT Scan Examinations

1. Credentialed medical providers will order CT Scan examinations in CHCS and schedule with the NH GTMO CT Scan technician.
2. Further guidance may be found in Enclosure (3).
3. The requesting ward or clinic is (b)(2)

(b)(2)

M. Detainee Processing

1. Detainees are brought to the in-processing station.
2. Detainees height, weight and demographics are recorded in the medical record on the physical examination form, SF 93.
3. PA Chest will be performed on Detainee.
4. The TAD radiologist will wet read the X-ray films and assign one of five interpretations per CDC TB Program guidance, Enclosure (4).
 - (a) No Active Disease (NAD)
 - (b) Low probability for TB disease
 - (c) Medium probability for TB disease
 - (d) High probability for TB disease
 - (e) Abnormalities, not otherwise specific for TB disease
5. Repeat procedure until all Detainees have been processed.

N. Radiation Safety. The Radiation Safety Program is administered through NH GTMO. The Thermal Luminescent Devices (TLDs) are turned over to the Radiation Safety Petty Officer every 6 weeks. For more information contact Radiology Technician, or the Radiation Safety Representative, Radiology Department, NH GTMO at (b)(2)

O. Operation Manuals. A thorough review of the equipment operation manuals is required for safe and appropriate use of the equipment.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantánamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
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SOP REVISION LOG:	
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ENTIRE SOP SUPERSEDED BY:	
Title: _____	
SOP NO: _____	Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 028
Title: CDO WATCHSTANDER GUIDE	Page 1 of 3 Effective Date: 15 Oct 03 Updated: 04 Nov 04
SCOPE: Detention Hospital	

I. SCOPE AND GUIDELINES

- The CDO is the direct representative and responsible to the OIC of Detention Hospital.
- Ensure Safety and Security of all medical personnel at Camp Delta at all times.
- Communication is the key. Establish positive communication with clinical staff and be ready to support medical mission. Make rounds and introduce yourself to duty delta officers at DH and Delta Medical Clinic.
- CDO Hours: (b)(2) After hours, take the pager home. The CDO will carry a pager at all times while on watch.
- (b)(2)
- (b)(2) schedule is included in the CDO watch schedule. All rounds should be documented in the logbook.
- The CDO should be familiar with emergency procedures, fire plan, Bomb threat, Mass Casualty plan and all other pertinent SOPs. The CDO is responsible to ensure that an updated staff recall is available.
- All changes of Duty (i.e. swaps) will only be approved with a special request chit. Both members performing swap and the CDO coordinator (bottom-line approval) must sign the special request chit. (b)(2)
- (b)(2)

II. JOB SUMMARY:

1. Duty as the Detention Hospital Command Duty Officer (CDO) commences at (b)(2) unless otherwise arranged by current and relieving CDO. The CDO must keep the pager with them at all times.
2. The CDO will make (b)(2) rounds of Detention Hospital buildings and assets when on Camp Delta. At a minimum, this includes Detention Hospital and Delta Clinic at approximately every 3 hours and before departing Camp Delta. Check for the following:
 - A) (b)(2)
 - B)
 - C)
 - D)
3. Log any event out of the ordinary in the CDO Logbook
 - A) Visits from VIP's, SECDEF, and Commanding General.
 - B) Power outages.
 - C) Staff admitted to Hospital (notify OIC and Department Head or SEA if enlisted)
 - D) Security called to housing.
4. CDO will be notified of any Public Works issues if they arise. (Generator out, toilet stopped up, etc). CDO will notify R&U for utilities problems and Burns & Roe for power outage to the Detention Hospital.
5. CDO has access to a vehicle in case he/she is needed at Detention Hospital.
6. (b)(2)
 - A) (b)(2)
 - B)
 - C)
 - D)
7. Mass Casualty recalls. If the CDO is contacted by the Delta Clinic Duty Nurse to activate the Mass casualty recall roster the following procedures in SOP 073 apply.

III. SAMPLE LOG ENTRY OVER A DUTY PERIOD

(b)(2)



STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
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ENTIRE SOP SUPERSEDED BY:	
Title: _____	
SOP NO: _____	Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 029
Title: NURSING	Page 1 of 14 Effective Date: 03 Oct 03
SCOPE: Detention Hospital	

I. PURPOSE:

To provide Nursing staff with guidelines to assist with the nursing care provided at Camp Delta. The in-depth Nursing Procedures manual for Camp Delta is the Lippincott Manual of Nursing Practice (7th Edition) kept at the nurse's station at the Detention Hospital and Delta Clinic. Consult this resource for review of nursing procedures. Additional nursing resources are available at Naval Hospital, GTMO.

II. NURSING DUTIES AND RESPONSIBILITIES:

- Coordinate and administer patient care activities.
- Facilitate all steps in the medical in-processing of detainees including, CHCS registration, ordering of lab and radiological studies, set up of medical records.
- Ensure that all medical contacts (in-processing, follow up, sick call, and cell visits) are entered in the SITREP Log.
- Enter Walk-in Appointments, for every detainee clinic and cell visit (except medication rounds).
- Coordinate the movement of detainees into and out of the medical compound for evaluation, follow up and sick call visits with Escort Control at the Camp Delta Detainee Operations Center (DOC).
- Oversee the daily assignments of the Hospital Corpsmen; Provide nursing care oversight, ensure safety and accountability at all times.
- Update the pass down log for oncoming shifts to ensure that pertinent information is passed.
- Provide quality-nursing care to detainees admitted to the Detention Hospital.
- Perform triage, physical assessments, i.e. vital signs, neuro-vascular checks and assessment of pain and skin breakdown.
- Administer scheduled and PRN medication as ordered.
- Supervise the administration of medications by hospital corpsmen.
- Co-sign every Medication Administration Record transcribed by the corps staff.
- Administer treatments such as dressing changes, etc.
- Transcribe physician orders for all outpatients and in-patient.
- Verify order transcription via daily chart verification (q 24 hour chart review) after 2400 each day.
- Obtain a current detainee Alpha roster from DOC after 2400 each day.
- Ensure all procedures and findings are documented on appropriate forms.

- Co-sign all corps staff medical record entries.
- Supervise Hospital Corpsmen assigned to Camp Delta.
- Ensure monthly weights are completed on all detainees on the first of every month. Document monthly weights in the detainee's medical record. Additionally all detainees that are determined to be malnourished are weighed on the fifteenth of the month.
- Complete daily SITREP report and the 24-hour clinic report daily. Deliver one copy to the Detention Hospital Admin staff and second copy to DNS each morning before 0800.
- Complete Vulnerability Assessment for clinical area (DH, Delta Clinic and DACU) each shift.

The Following sections are designed to assist new personnel in performing nursing duties and responsibilities in a safe and effective manner.

DETAINEE IN-PROCESSING (Review In-processing Manual)

Prior to Detainee Arrival

- The Delta Clinic Division Officer (DO) is designated as the Point of Contact (POC) for all in processing issues at the Camp Delta Clinic. The Leading Petty Officer (LPO) is designated as the back up POC in the absence of the DO.
- Upon notification of incoming detainees, the DO will contact the S1 at the Joint Detainee Operations Group (JDOG). The DO will request a list or manifest with the names and ISN numbers for the new detainees. (Note: this information classified Secret).
- The DO or a designee will register each new detainee in the CHCS system following the step-by-step procedure found in the Nursing SOP for Camp Delta Medical Clinic. Each detainee will be registered using the ISN number as a social security number.
- After doing the mini registration in CHCS, enter the set of standing in-processing doctors order for each new detainee. The SMO will be entered as the ordering physician. The labs are ordered as part of an Order Set labeled 'Detainee Orders' which contains the following individual orders:
 1. Hepatitis B Surface Antigen
 2. Hepatitis C Virus
 3. HIV
 4. Hepatitis A Antibody
 5. Hepatitis Core Antibody,
 6. Hepatitis B Surface Antibody Titer
 7. Radiograph, Chest PA
 8. Mefloquine 250 mg PO, 3 tabs at in processing and 2 tabs at 0600 the next day
 10. Albendazole 200 mg PO, 2 tabs at time of in processing
- The Detention Hospital Lab Tech will accession all lab orders and pre-print lab labels.
- A new medical record will be established for each new detainee at the in processing initial medical screening. See the In-processing Manual and Camp Delta Nursing SOP for medical chart organization.

- Place a tracking checklist on top of each chart.

Physical set up for the detainee in processing : Refer to In-processing manual

- Set up three to four phlebotomy stations.
- Set up three to four physical exam rooms.
- Place a small white board with the list of new detainee numbers in the admin office for tracking of chest films and medical issues (NAD means no active disease/TB).

Det #	Done	Read
8888	Yes	NAD

- Set up each exam room with a thermometer, BP cuff, stethoscope, reflex hammer, otoscope/ophthalmoscope, unsterile gloves, surgi lube, dressing material, and bacitracin ointment.
- The Lab techs and Pharmacy techs will work in the pharmacy/lab room.
- The Pharmacy tech will ensure adequate supply of medications are on hand for in processing and will dispense Albendazole and the mefloquine for each detainee.
- The Lab tech will remain in the pharmacy/lab room to process collected specimens, assist with venipunctures and connect to the Portsmouth Naval Hospital lab via the Internet.
- In processing stations are:
 - 1) Check in , ID verification, Medical Record Issue
 - 2) Chest x-ray
 - 3) Phlebotomy, medication, immunizations & history taking station (include key mental health screening questions)
 - 4) Physical Exam room
 - 5) Height and weight
 - 6) Record and order review, Quality Assurance station.

The sequence of medical in processing flows as follows:

1. Detainee enters medical section of building from Army in-processing side accompanied by 2 MP's and a linguist. Detainee will continue to wear surgical face mask through out the medical processing stations (as TB protection for staff) until chest radiograph cleared by radiologist.
2. Verify detainee ID wristband and issue/ initiate medical record only after ID band verified.

IMPORTANT: To facilitate the final medical processing QA , each station will check off their section of the tracking sheet attached to the front of the medical record once the detainee has completed the station.

3. Chest radiograph.
4. Phlebotomy, 6 tubes of blood are required, 3 marble/red top (may substitute green, or yellow), 1 HIV, 1 lavender and 1 yellow serum tube.
5. A brief history of past and current illness, injuries, allergies, medications and mental health screening questionnaire is taken at the phlebotomy station.
6. Detainee is taken to an exam room for his physical exam.

7. Vitals are done & medications are given (Mefloquine, Albendazole) before the detainee leaves the exam room.
8. Tetanus and influenza vaccines are administered and PPD placed on forearm
9. Height and weight taken and recorded (BMI calculated later).
10. Radiologist reads chest x-ray before detainee leaves the building and if 'No Active Disease' (NAD) noted surgical face mask may be removed and disposed of. Also remove the scopolamine patch from behind ear (used to prevent airsickness during transit).
11. Perform quality assurance check on medical record. Verify that the detainee has stopped at each station, by checking the tracking sheet, before allowing the detainee's departure.
12. Detainee leaves the building through the medical side exit escorted by 2 MP's.

Personnel requirements:

- 1 HM to check in detainee, verify ID band, and initiate/issue medical record
- 3-4 Physicians (for physical exams, this is the most time consuming section of medical processing)
- 1 Radiologist to review and read chest films (will be brought in TAD for event).
- 3-4 History takers /3-4 phlebotomists (not the lab techs)
- 2 lab techs (1 to process specimens, 1 for computer access to NMC Portsmouth)
- 2 Radiological techs (1 processes while the other shoots)
- 1 HM for Height and weight station
- 1-2 pharmacy techs to dispense the medications
- 1 HM to arrange for transport in the event of an admission to Detention Hospital
- 1 HM to perform medical record QA and compile consult list.

After detainee in-processing is completed:

- All new detainees will be added to the 0600 medication pass for their second dose of mefloquine.
- All new records are screened for active issues, follow-ups, additional labs, and consults.
- Any additional orders are taken and signed off by the nurse on duty.
- Verify all orders are entered in CHCS.
- All BMIs are calculated and entered into the medical record and in the weight management database.
- Any detainee with a BMI of less than 20 will be added to the Weight Program for weekly weight checks and will receive Ensure supplements TID.
- All detainees in processed will be added to the sitrep log as a new visit, entered in CHCS as a walk in appointment, the End of Day and the ADS completed.

DETAINEE OUT-PROCESSING

When a detainee is transferred off the island the Senior Medical Officer will ensure the completion of : a physical exam and medical summary, personal medical history sheet (in English & native language) and Southwest Asia Disease Information sheet (in English and Native language). These forms are forwarded in the medical package to the JTF Surgeon's office via the OIC. The original medical record is delivered to the DH Patient Admin for processing then forwarded to JTF Surgeon's office for archiving.

Cell Visits and Treatment (Emergent & Routine)

When Medical receives a call from the cell blocks or DOC that a detainee is acutely ill or has other sudden or emergent medical problem, a nurse, if available, or copsmen will take a "Jump Bag" (located in the supply room) and go to the detainee's unit and assess the need of medical treatment. This includes subjective and objective data analysis. (b)(2)

(b)(2)

Routine sick call may be conducted in the cellblocks by the assigned copsmen. Each copsmen will have with them the minimal sick call equipment and standard order medications when making rounds in their assigned blocks. They will document every patient encounter in the patient's chart on the Progress notes in SOAP format. The exception to this is when standard order medications are administered in the cellblocks, and then it is documented only in the patient's MAR.

In any case mentioned above, the SITREP Log and database must be filled out (Enclosures 6 and 7). A walk in appointment should be generated in CHCS per Enclosure 4 and a SOAP note must be written in the nursing note section of the patient's chart. This note will contain the chief complaint, subjective and objective data collected, analysis or problem identified, treatment given if any and plan of follow up care. All cell visits should be reported to the duty medical provider. **Once the walk in appointment is completed, entering the ADS data per enclosure 5 will complete the visit.**

The same documentation is required for scheduled cell visits for treatments such as wound care. Remember when in doubt chart it.

Tuberculosis Protocol and Documentation

All detainees will receive a chest x-ray and a PPD skin test during in-processing. The PPD will be administered in the left forearm. The documentation for detainees receiving a PPD is as follows: record the PPD on the second page of the Record of Immunization (SF 601). Ensure the date given and person who placed the PPD is charted. The PPD is read for results in 48 to 72 hours, it must be properly read by measuring area of redness and or induration. Documents results of the reading in millimeters on the SF 601.

All detainees presenting with a suspicious chest x-ray and/or other signs and symptoms of TB (persistent cough, bloody sputum, fevers, weight loss) will be placed in respiratory isolation in a laminar flow room at the Detention Hospital or if both respiratory isolation rooms at the Detention Hospital are occupied they will be admitted to the DACU or Respiratory Isolation Tent. All Respiratory isolation rooms will be tested by the Preventive Medicine Department (smoke test) prior to use and intermittently while in use. Detainees placed in respiratory isolation will have **three consecutive morning sputum samples collected for AFB smears**. Please note that in the collection of this sputum, the detainees must produce the sample by coughing. Production of saliva is not acceptable for this test (refer to sputum collection instructions posted in Detention Hospital, consult with assigned Respiratory Therapy tech if sputum induction is required).

SITREP Log

The SITREP log is the primary record of all patient interactions with medical staff. It is crucial that every patient interaction, sick call, follow-up, dressing change, or any other

interaction (other than passing scheduled medications) be recorded. This provides an accurate account of patient care and workload. Once the log is filled out (example in enclosure 6), the data must be entered into the SITREP database. This is used to permanently track the number of interactions and can be used to show trends in detainee interactions with medical staff. To fill out this database, utilize enclosure 7.

Corpsman Duties and Responsibilities

During the daily operations, corpsmen shall be responsible for passing detainee medications under the supervision of an RN, performing field assessments and relaying findings to the duty nurse and provider. The duty nurse and provider will determine care priorities and "triage" the sick call requests for the day.

Corpsmen assigned to work the day shift will have specific blocks assigned to them. Each HM will be responsible for all the medical issues within their assigned blocks including dressing changes, sick call, medication passes, & weights. All corps staff must be competent at passing medications as evidenced by the successful completion of the Medication Administration Qualifications. No corpsmen will be allowed to pass medications until properly trained by the medication training RN. Remain cognizant of the seven rights of medication administration:

RIGHT PATIENT, RIGHT MEDICATION, RIGHT DOSE, RIGHT ROUTE, RIGHT TIME, RIGHT DOCUMENTATION AND RIGHT PERSON PASSING MEDICATIONS.

Corps staff must not pass any medication they are not familiar with. They should know what the medication is, what it is used for, the proper dosing, and be knowledgeable of possible interactions, incompatibilities, side effects and adverse reactions.

If at any time a corpsman is not familiar with an assigned procedure or task he or she is expected to request the appropriate training from the nurse or provider before attempting.

Proper documentation is required for any detainee interaction. Be sure to enter why the interaction occurred, the subjective and objective findings made, the name of the provider notified of the interaction, the treatment administered if any and the response to the treatment. This documentation should be made in a SOAP format on the detainee's Progress Notes (SF509). Ensure that a medical provider or RN co-signs all entries. DO NOT FORGET TO DOCUMENT PAIN ASSESSMENT. Log all patient visits into the SITREP Log and as well as the SITREP Database.

24-Hour Medical Record Review and Daily SITREP Report

In order to prevent the inadvertent omission of orders transcribed to the Patient MAR, The night nurse will conduct a medical record review of all detainees seen at Camp Delta Clinic in the preceding 24-hour period. For all new orders, pull the MAR and ensure that all orders were transcribed correctly. Once completed, the nurse will write "CHART VERIFIED" below the last order entry and draw a horizontal line below the entry with a highlighter. Also verify the detainee's current cell location on the front of the chart and MAR with the daily updated Alpha Roster obtained from DOC (do this in pencil). New Alpha rosters are picked up from DOC each am, place previous day's Alpha roster in a Burn Bag for proper disposal.

Once the night nurse has verified all records, complete the daily SITREP report. To do this, utilize enclosure 11 and provided hard copy to: Senior Nurse, the Admin Chief by 0700 each morning (needed to completed JTF SITREP to SOUTHCOM).

Appointments and Follow-ups

Each morning the night shift Charge Nurse will pass down in report a list of detainees scheduled for follow up for that day. The detainees requesting sick call will be identified by block NCOs on the block sick call list entered via DIMS. The DOC will provide the block sick call lists to Delta Clinic prior to AM clinic. The lists is triaged by the RN and/or Provider on duty to determine patient care priorities. To aid in this process, pull the charts for those detainees that will be seen. All medical clinic or in the cell visits will have walk-in appointments booked through CHCS. To do this follow enclosure 4 and in the Reason for appointment area write in what the detainee was being seen for. Again make sure these visits are logged in the SITREP Database and CHCS per enclosures 7 and 4 respectively. After the appointment complete CHCS entry showing the result of the appointment and diagnosis ICD9 data (utilize enclosure 5.)

Every detainee clinic visit should have a set of vital signs taken (blood pressure, pulse, respiratory rate, temperature, pain assessment, and a pulse oximetry reading when indicated). Document vital signs on the SF509 filed on the right side of the record.

Transfers to Detention Hospital

Delta Medical Officer's have admitting privileges at both Detention Hospital and to the DACU at Naval Hospital GTMO. (b)(2)

(b)(2)

Hunger / Thirst Strikes (refer to complete Hunger strike SOP)

In the event of a detainee hunger / thirst strike, DOC will notify medical when a detainee has refused hydration for (b)(2) or has not eaten in (b)(2). Otherwise, medical will be notified as detainees become symptomatic secondary to dehydration or starvation. (dizziness, lethargy, syncope or near-syncope episode, or inability to ambulate). In either case above, the detainee is brought to medical for medical screening. This screening includes a physical exam by a medical provider per Hunger and/or Thirst Strike Medical Evaluation Sheet (Enclosure 22). A Hunger / Thirst Strike Medical Flow Sheet (Enclosure 23) is also established. This form is used to document heart rate, mental status, status of detainee's eating / drinking, urinary output and weight. The detainee is educated on the risk of starvation / dehydration per enclosure 24. Note that this sheet is in English and a translator may be required. If after being educated on the risks of the hunger / thirst strike, the detainee still refuses to eat and/or drink, the detainee will be asked to sign the Refusal to Accept Food or Water/Fluids as Medical Treatment form (Enclosure 25) file in the SF 509 section of the detainee's medical record. Reassessment is performed every 24 hours.

Outpatient Medical Record

Medical record keeping and documentation of care delivered are important elements of the detainee medical mission.

Medical Records

It is recommended that forty pre-made records be kept readily available for processing new detainees.

To compile a new record (a go-by record is available in the file cabinet)

Obtain a new record jacket (located in the file cabinet)

The left side of the record shall have the following forms arranged from bottom to Top:

RECORD OF IMMUNIZATION (SF601 PAGE 2)

RECORD OF IMMUNIZATION (SF601 PAGE 1)

WEIGHT REGISTER (DD 2644)

STANDING ORDERS FOR DETAINEES

DOCTORS ORDERS (SF508)

PROBLEM SUMMARY LIST (NAVMED 6150/20)

c. The right side of the record shall have the following forms arranged from bottom to top:

REPORT OF MEDICAL EXAMINATION (SF88)

REPORT OF MEDICAL EXAMINATION (SF88 BACK PAGE)

*Note that this form has been altered with preprinted question for the TB protocol on the right side middle of the page.

REPORT OF MEDICAL EXAMINATION (SF88 PAGE 1)

INITIAL MEDICAL PROCESSING SCREENING

PROGRESS NOTES (SF509)

In addition to the basic record requirements, A **MEDICATION ADMINISTRATION Record (MAR)**, and a **DETAINEE CUSTODY FORM (DA4237 Page 2)** shall be placed loosely in the center of the record. These forms will be completed during in-processing and filed in a separate location. The MAR will be filed in the MAR Book located by the medication lockers (The MARs are filed by cell block). The Detainee Custody Forms are collected after in-processing and turned in to the Army's in-processing office at the other end of the medical clinic.

Laboratory and Radiology Studies

Any printed out laboratory or radiological study results shall be filed behind the SF88 on the right hand side of the record. In the event a detainee has previously been admitted to the DACU, or Detention Hospital, copies of the detainee's inpatient record shall be filed on the right hand side of the detainee's outpatient record behind the laboratory results.

Transcribing Doctors Orders

Due to the high volume of detainees and the various treatment plans involved, accuracy in transcribing Doctors Orders is a critical element. Refer to Enclosures 9, 10A, and 10B for the transcribing of doctors orders onto the MAR (NAVMED 6550/8) and Enclosures 9. Please note that all orders should be initialed line for line on the Doctors order sheet (SF508) as noted to ensure no order is missed.

When taking off orders for medication, the order must be complete and include the medication name, dose, route, frequency and the period of treatment in number of days. Schedule any needed follow up appointments in the appointment book "To Be Done Book".

Physicians will place new orders in the 'New Orders' slot. The RN will read each order and carry it out before signing it off. All orders will be verified to be in CHCS when appropriate, i.e. labs, medications, radiological studies, etc. Any thing that goes in the 'To be done' book will be written in it by the nurse taking of the orders, i.e. follow up appointments, dental consults, optometry consults, labs to be drawn, etc.

A. Medication Administration Record (MAR)

The Medication Administration Record (MAR) is used to document the administration of all scheduled, PRN and one-time medications. To transcribe orders to this form from Doctors Orders (SF 508) utilize Enclosures 9, 10A, and 10B.

Enclosure 10A Section A is to be used to document scheduled medications. Ensure that the order date is filled out. This section should have the medication name, dose, route, frequency and treatment duration. If more than one medication is ordered, Draw a red line between each medication. When transcribing a MAR for the continuation of a medication, review the original order to verify transcription is correct. Never will a MAR be transcribed from another MAR without verifying the original order.

To ensure continuity of medication times the following frequency times are suggested to be used when transcribing orders to the Patient Profile and MAR:

TIMES TO BE GIVEN CAMP 4, Alpha block have specific times (see addendum)

QD	0600
BID	0600 AND 1800
TID	0600, 1400, 2200
QID	0600, 1200, 1800, 2200
Q4	0400, 0800, 1200, 1600, 2000, 2400
Q6	0600, 1200, 1800, 2400
Q8	0800, 1600, 2400
QAM	0600
QPM	1800
QHS	2200
QAC	0700, 1100, 1700

NOTE MEDICATIONS THAT ARE PRONE TO CAUSE GI UPSET SHOULD BE GIVEN WITH FOOD. SCHEDULE ACCORDINGLY. Meals are delivered to detainees at 0800, 1200, and 2000.

MAR section B is to be completed by each person who delivers any medication to the patient. If the signature is not legible, print the name to the right side of the block.

MAR section C is to have the detainee's name and pseudo social security number. (D.JTF0***** on top, 888-0*-***** on the bottom).

MAR section D is used to document one time medication. Be sure to date and time this section upon completion of administering medication. As with section A, place a red line between each order.

MAR section E is used to Document PRN medication. In addition to completing the appropriate boxes in this section, a nursing note should be written to document the effects of the medication such as pain level decrease.

MEDICATIONS GIVEN BY THE IM OR SQ ROUTE IS ALSO DOCUMENTED IN THE MEDICAL RECORD WITH LOCATION OF THE INJECTION, PATIENT RESPONSE AND ANY ADVERSE REACTIONS.

Note: If the patient is in the clinic and the provider orders a one-time dose of medication, it can be documented on the SF 600. This will alleviate transcribing the order to a MAR.

Narcotics

Narcotic inventory is completed at each shift change. Professional nurses will account for and sign that all narcotics are present on Narcotic and Controlled Drug Inventory – 24 hour (NAVMEED 6710/4). Each time a narcotic is used it will be logged out on the appropriate Narcotic and Controlled Drug Record (NAVMEED 6710/1). In cases where only a partial dose is needed, annotate the drug, amount given, the amount wasted and the detainee's identification number on the back of the 6710/1.

III. Administrative Notes

A. Supplies

Supplies are ordered through the designated supply Petty Officer. Each shift leader is responsible for ensuring that required supplies are ordered and picked up in a timely fashion. The Leading Petty Officer is responsible to train all personnel regarding the supply ordering and tracking process. Further information about supplies can be found in the Detention Hospital Supply SOP.

B. Labs

Procedure for Procuring and Submitting Lab Specimens

1. Verify orders are in CHCS *before* going out to cell blocks to collect specimens.
2. Collect all supplies, take out to cell, and collect specimen using proper technique.
3. While still at cell, label specimen with Det. # and date/time (**time must be accurate**).
4. Upon return to clinic spin down all yellow & tiger top tubes 10 minutes @ highest speed.
5. Label all specimens (save unused left over labels and take to lab @ FH with specimens).
6. Log in all specimens (**complete all sections of log**).
7. Notify Lab tech of specimens.
8. If after hours, place specimens in designated lab refrigerator. Inform lab tech of all specimens placed in the refrigerator page lab tech if specimen in a "stat". Page duty driver to courier specimen to NH GTMO lab so that tech can perform needed test.

LAB KEYS FLOW CHART

Use this sequence ONLY when the labs have not been ordered and ONLY if drawing the lab immediately, preferably in the clinic.

- Do the ?? to get to the menu that allows you to choose LAB
- LAB
- shift ^OLG
- Enter patient's name
- Requesting Location (Enter Camp Delta, select #3 for Primary Care)
- Action: (select N for new orders)
- Select HCP: (enter doctor requesting the test)
- Order origin: (select H for handwritten orders)
- Order set: (default is NO just hit enter)
- Date/time: (enter N for now or enter correct date & time)
- Collection Method: (enter W for ward/clinic collection)
- Collection Priority: (default is ROUTINE just hit enter)
- Processing Priority: (default is ROUTINE just hit enter)
- Order comment: (at this time enter any comments that you would like to add or just hit enter)
- Select test: (enter test to be ordered, once done just hit enter to exit screen)
- Action: (enter Q to quit and activate the orders)
- Hit enter until you get to the printer prompt: Enter delta-lab and you are done.

When labs are ordered & you only want labels: (should be most common one used)

- Lab
- shift ^LGO
- Enter Detainee number
- (all lab orders will come up) select tests you want labels for
- Enter
- Type date & time of collection , example: 24May@1310 (important that the time be accurate)
- Type comment if needed, if not, just enter
- Type Delta-lab for printer selection

If you have to re-print labels:

- Lab
- shift ^PLI
- Enter Detainee number
- Enter (default for today)
- type in an earlier date (ex. 22may2002)
- Enter (highlight should be at 'go')
- Find labs you want labels for & copy down Accession area (letters) & accession number
- Move highlight to 'exit'
- Move highlight to 'exit' a second time
- Shift ^RSL
- At 'Accession area- type in the 2 or 3 letter code
- At "accession number" type in the number
- Type in Delta-lab for printer

C. Pharmacy

When a provider writes an order for a medication they will simultaneously enter the order into CHCS. Nurses will verify CHCS order entered when transcribing orders. It can take up to 1600 the following day for routine medications to be delivered from Naval Hospital GTMO to the clinic, so if the order is to start immediately, or the order is STAT page the Detention Hospital Pharmacy Technician.

Note: Floor stock can be ordered by calling the Detention Hospital Pharmacy Tech. Also, a daily 'Not in Stock' (NIS) list is to be generated by clinic staff and given to the Pharmacy Tech for action and follow up.

Listing of Enclosures

Medical Record Jacket Front Cover.....	Enclosure 1
Go-By For Utilizing Mini-registration Into CHCS.....	Enclosure 2
How To Order Detainee Order Set (In-Processing).....	Enclosure 3
How To Enter A Walk-In Appointment Into CHCS.....	Enclosure 4
ADS Entry Into CHCS.....	Enclosure 5
SITREP Log.....	Enclosure 6
SITREP Database Entry.....	Enclosure 7
Doctors Orders.....	Enclosure 8
MAR (Front).....	Enclosure
9A	
MAR (Back).....	Enclosure 9B
Patient Profile (Front).....	Enclosure
10A	
Patient Profile (Back).....	Enclosure
10B	
How To Enter SITREP Report.....	Enclosure 11
How To Run A Batch Report From CHCS.....	Enclosure 12
Lab Request Utilizing CHCS.....	Enclosure 13
Ordering Radiological Studies Utilizing CHCS.....	Enclosure 14
How To Review Clinical Results Utilizing CHCS.....	Enclosure 15
Reviewing Laboratory Results Utilizing CHCS.....	Enclosure 16
Reviewing Radiology Reports Utilizing CHCS.....	Enclosure 17
Viewing Medication Profiles Utilizing CHCS.....	Enclosure 18
How To Run CHCS Workload Report.....	Enclosure 19
Radio Protocol.....	Enclosure 20
Infirmery Safety Check List.....	Enclosure 21
Hunger And / Or Thirst Strike Medical Evaluation Sheet.....	Enclosure 22
Hunger / Thirst Strike Medical Flow Sheet.....	Enclosure 23
Starvation / Dehydration Information Handout.....	Enclosure 24
Refusal To Accept Food Or Water / Fluids As Medical Treatment Form.....	Enclosure 25
Laboratory Test/Tube Color List.....	Enclosure

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____ Officer In Charge	_____ Date
IMPLEMENTED BY:	
_____ Director for Administration	_____ Date
_____ Senior Enlisted Advisor	_____ Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
SOP REVISION LOG:	
Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
ENTIRE SOP SUPERSEDED BY:	
Title: _____	
SOP NO: _____	Date: _____

<p style="text-align: center;">DETAINEE HOSPITAL GUANTANAMO BAY, CUBA</p> <p>Title: MEDICAL INTERVENTION FOR HELMINTHIC INFECTIONS</p>	<p>SOP NO: 030</p> <p>Page 1 of 3 Effective Date: 21 Mar 03</p>
<p>SCOPE: Detention Hospital</p>	

REF:

- (a) AFMIC MEDIC CD-ROM
- (b) Control of Communicable Diseases Manual, 17th Edition, 2000

I. PURPOSE:

To establish Detention Hospital policy regarding the initial evaluation of detainees and interventions to treat potential helminthic infections in the detainee population.

II. PROCEDURE:

1. After review of data available found in references (a) and (b) it is reasonable to expect that a number of the detainees will arrive at Detention Hospital with helminthic infections. It is also reasonable to expect that treatment of these helminthic infections may benefit the general health of the detainee population. The improvement in nutritional status could improve wound healing and ability to resist potential infections. Therefore, all detainees will be treated for the potential of helminthic infections. Detainees will have stool collected for ova and parasite screening prior to treatment in order to better assess the epidemiological validity of this treatment protocol.
2. Treatment for potential helminthic infections will consist of a single dose of 400mg of oral albendazole.
3. All detainees will be requested to provide a stool sample for screening for ova and parasites. If the detainee is unable to provide a sample, processing will continue. The screening for ova and parasites is not to collect clinical data on the specific detainee. The screening of the stool specimens for ova and parasites, collected from the subset of detainees able to provide a stool sample, are intended to provide epidemiological validation of the treatment protocol.

4. Results of the screenings for ova and parasites will be maintained in a database by the Preventive Medicine Detachment. Data will include the percentage of detainees that provide stool samples, and the percentage of samples screened positive for helminthic infections.

5. All medications received by detainees will be entered appropriately in the detainee medical record.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge Date

IMPLEMENTED BY:

Director for Administration Date

Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____

SOP REVISION LOG:

Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____
Revision to Page: _____ Date: _____

ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 031
Title: LATENT TUBERCULOSIS MANAGEMENT	Page 1 of 10 Effective Date: 16 Jul 03
SCOPE: Detention Hospital	

- Encl:** (1) Latent Tuberculosis Infection Management Algorithm
(2) Initial/Annual Tuberculosis Patient Questionnaire
(3) Guidelines for Liver Function Test monitoring While on INH Therapy
(4) INH Therapy Monthly Patient Questionnaire
(5) INH Therapy Medical Provider Review

I. BACKGROUND:

Identification and treatment of latent tuberculosis infection (LTBI) in detainees offers improved Force Health Protection for Joint Task Force personnel in close contact with the detainee population by decreasing the probability of tuberculosis disease among detainees, and protects other detainees from the potential spread of disease between detainees. The policies and procedures stated in this SOP have been coordinated with the Centers for Disease Control (CDC) and the United States Public Health Service.

II. POLICY:

This is a revision of the Latent Tuberculosis Infection Management in Detainees SOP dated 21 Mar 03 and supercedes that document. This SOP should be used in concert with the SOP for Active Tuberculosis Management. Exceptions to this policy must be based on compelling clinical evidence and will be discussed with the Infectious Disease staff physician prior to implementation.

III. PROCEDURES:

- As per the Active Tuberculosis Management SOP, all detainees will be screened for clinical and radiological evidence of active tuberculosis; this includes placing a Tuberculin Skin Test (TST). The plan for identification, evaluation, treatment, and monitoring of LTBI in detainees is demonstrated in enclosure (1). Detainees that have been ruled out for active tuberculosis disease will enter the LTBI flowchart at the point where previous evaluations ended.

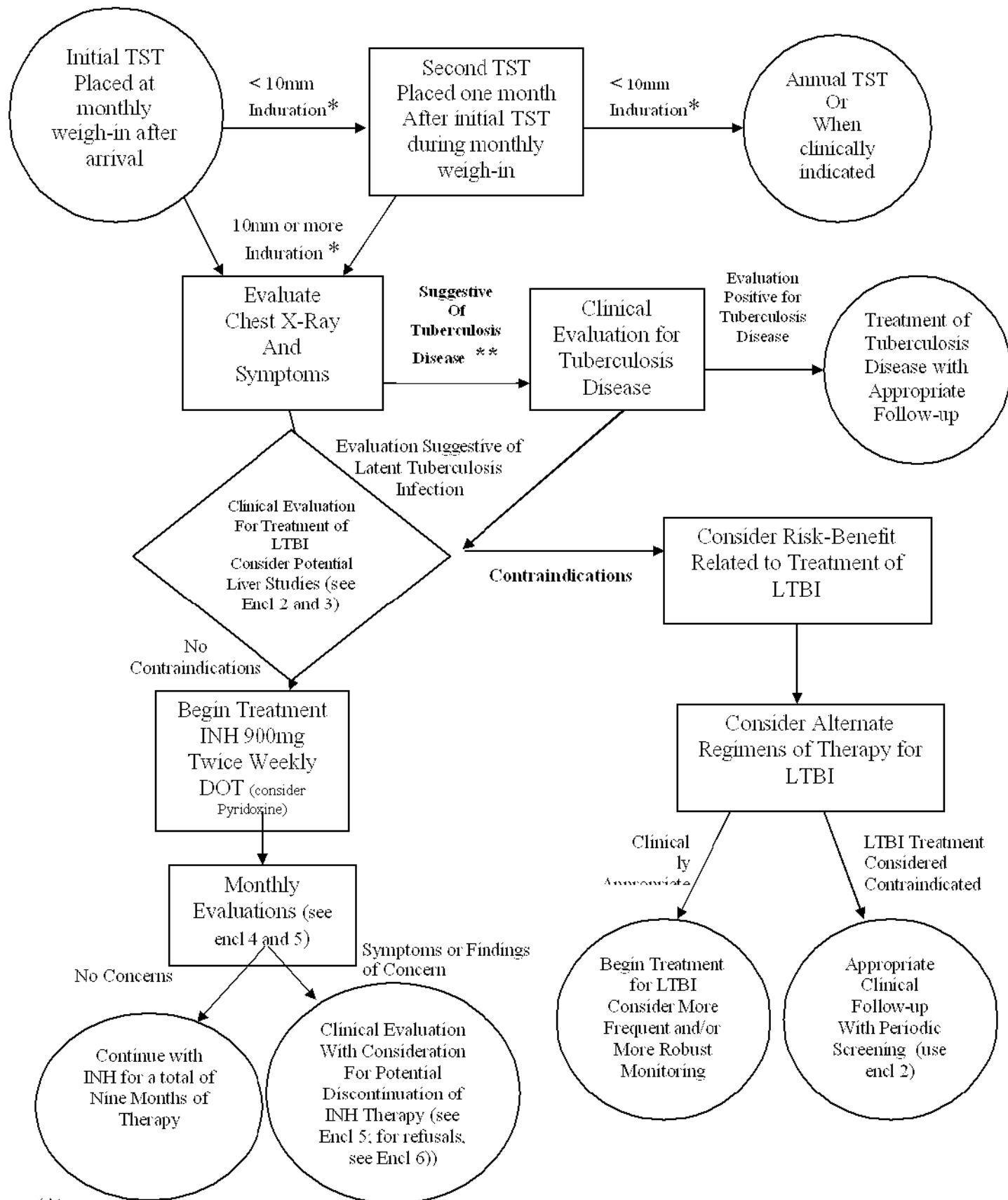
- The following sections deal with the description, definitions, and amplification of the Latent Tuberculosis Infection Management flowchart. The areas involved in current operations and many of the potential areas considered as possibilities for future operations have high incidences of tuberculosis. Foreign-born persons that migrate to the U.S. continue to demonstrate incidences of tuberculosis that reflect the level of the country of origin for as long as five years after migration. This would result in a number of cases of tuberculosis disease in the detainee population with subsequent potential exposure of JTF personnel. Identification and treatment of LTBI in detainees will decrease this potential.
- All detainees will receive a TST in conjunction with inprocessing upon arrival. TST screening will use 5TU of Purified Protein Derivative (PPD) in the standard Mantoux method. The medical staff responsible for detainee healthcare should insure that all personnel placing and reading the PPD are trained adequately and understand the importance and limitations of this test.
- The classification of the PPD reaction depends on the clinical situation of the detainee. Most detainees are recent arrivals from high-prevalence countries and will be considered abnormal with a reaction of 10mm or more. Detainees considered positive at 5mm of induration should have the reason for this deviation from standard documented in the health record. For example, detainees with chest x-ray findings of fibrotic changes consistent with old healed tuberculosis, those with recent active TB contacts, and those with HIV infection or other immunocompromising conditions should be considered PPD abnormal with induration of 5 mm or more.
- Detainees with a negative PPD on initial testing will have the PPD repeated at the next monthly weigh-in. Implementation of the 'two-step PPD' will identify detainees with prior tuberculosis infection and is standard for persons enrolled in a periodic PPD screening program. Two-step testing is used to reduce the likelihood that a boosted reaction will be misinterpreted as a recent infection. If the reaction to the first test is classified as negative, a second test should be done. An abnormal reaction to the second test probably represents a boosted reaction (past infection or prior BCG vaccination). On the basis of this second test result, the person should be classified as previous infected and cared for accordingly. This would not be considered a skin test conversion. If the second test result is also negative, the person should be classified as uninfected. In these persons, an abnormal reaction to any subsequent test is likely to represent new infection with *M. tuberculosis* (skin test conversion). Two-step testing should be used for the **initial** skin testing of adults who will be retested periodically.
- Detainees with the second PPD classified as negative will be enrolled in an annual PPD program. This does not preclude the routine clinical use of the PPD as an adjunct to appropriate clinical evaluations.
- Detainees classified as having a positive PPD on initial or second testing,

normally ≥ 10 mm induration will be evaluated for signs and symptoms suggestive of tuberculosis disease [enclosure (2)].

- If there is suggestion of tuberculosis disease, the detainee will undergo an appropriate clinical evaluation as outlined in the Active Tuberculosis Management SOP. If evaluation is not suggestive of tuberculosis disease or if the clinical evaluation for active tuberculosis disease is negative, the detainee is evaluated for treatment of LTBI.
- Evaluation for LTBI treatment should include an attempt to document any history of treatment for LTBI or disease. This history may be difficult to obtain and unreliable. Determine if there are any preexisting medical conditions that are a contraindication to treatment or are associated with an increased risk of adverse effects of treatment. Review current and previous drug therapy for potential adverse reactions or interactions. Baseline laboratory testing is not routinely indicated for all patients at the start of treatment for LTBI. Baseline hepatic measurements of serum AST (SGOT) or ALT (SGPT) and bilirubin are indicated for patients whose initial evaluation suggests a liver disorder. Baseline testing is also indicated for persons with a history of chronic liver disease (e.g., hepatitis B or C, and others who are at risk of chronic liver disease). Testing should be considered on an individual basis, particularly for patients who are taking other medications for chronic medical conditions [see enclosure (3)]. Active hepatitis and end-stage liver diseases are relative contraindications to the use of isoniazid or pyrazinamide for treatment of LTBI. Use of these drugs in such patients must be undertaken with caution.
- If there are no contraindications for LTBI treatment, the standard course for detainees will be isoniazid, INH, 900mg, twice weekly for nine months. Peripheral neuropathy, caused by INH's interference with metabolism of pyridoxine, is uncommon at a dose of 5 mg/kg. However, in this detainee population, where some may be malnourished, treatment with pyridoxine could be considered (i.e. Pyridoxine 100 mg twice a week given with INH). In persons with conditions in which neuropathy is common (e.g., diabetes, uremia, alcoholism, malnutrition, and HIV infection), pyridoxine should be given with INH.
- All detainees on LTBI treatment will be monitored at least monthly [see encl. (4 and 5)]. This evaluation will include screening for signs and symptoms of active TB disease, and signs or symptoms of hepatitis. Routine laboratory monitoring during treatment of LTBI is indicated for persons whose baseline liver functions test are abnormal and for other persons with a risk of hepatic disease [see enclosure (3) for further details]. There should be laboratory testing, such as liver function studies for detainees with symptoms compatible with hepatotoxicity or a uric acid measurement to evaluate detainees who develop acute arthritis, to evaluate possible adverse reactions that occur during the treatment regimen.

- Discontinuation of INH should be considered for detainees with liver functions three times normal levels with symptoms, liver functions five times normal levels without symptoms, or when otherwise clinically indicated.
- Please refer to encl. (5) concerning detainee refusals of medication. After completion of LTBI treatment detainees will be screened annually [encl. (2)].
- Detainees with contraindications for LTBI treatment should be re-evaluated. The risk-benefit of LTBI treatment must be considered. Alternate regimens, per reference (b) should be considered. If clinically appropriate, treatment should proceed. These cases may require more frequent or more robust monitoring. If LTBI treatment is contraindicated, these contraindications will be documented in the detainee health record. The detainee will be followed with annual screenings. A sample questionnaire for these annual screenings can be found in enclosure (2).
- Application of the Latent Tuberculosis Infection Management program will require tracking of PPDs, medications, and monitoring in a database/spreadsheet that will provide reports to the JTF Surgeon periodically on the status of the program.
- For detainees who refuse medication for LTBI, the following considerations will be used in determining the appropriate course of action:
 - There is no risk of inducing INH resistance in detainees who periodically refuse INH. The goal of therapy is to have the detainee take at least a total of 52 doses in 9 months or 76 doses in 12 months. If the total number of doses meets these guidelines, therapy is considered to be complete.
- Detainees continually refusing medications will not be required to take INH per SOUTHCOM policy. They will be screened annually with a medical screening questionnaire on the yearly anniversary of their negative chest x-ray, generally obtained at their in-processing date.

LATENT TUBERCULOSIS INFECTION MANAGEMENT



(*) Varied clinical situations recommend LTBI Treatment a different parameters of induration. Ten millimeters is the level for most of the detainees received.

(**) In cases where signs and symptoms are highly suggestive of tuberculosis disease, begin treatment concurrent with laboratory evaluation and confirmation.

Detainee Number: _____ Age of Detainee: _____ Date: _____

Initial/Annual Tuberculosis Patient Questionnaire

Are you experiencing any of the following problems:

- | | | | |
|--|-----|----|----|
| Fever for more than 7 days | Yes | or | No |
| Cough for more than 2 weeks in a row | Yes | or | No |
| Sweating at night for more than 7 days | Yes | or | No |
| Coughing up bloody phlegm | Yes | or | No |

Medical Provider Review:

History of TB, previous treatment for TB, or BCG vaccine in past? _____

History of liver disease/hepatitis/jaundice? _____

Date and Result of Last PPD (no need to repeat once positive) _____

Results of hepatitis/HIV screening at inprocessing _____

Current Medications: _____ Allergies: _____

Medical officer evaluation (if indicated from above symptoms): _____

Are repeat/new LFT monitoring recommended? _____

Date drawn _____ Results _____

Is a repeat CXR needed (if annual screening, repeat is recommended)? _____

Ordered? _____ Result of CXR? _____

Have AFB smears/cultures been or are being collected? _____ Results: _____

Further actions required/Medications Prescribed? _____

Enclosure (2)

Guidelines for Liver Function Test Monitoring While on INH Therapy

Baseline LFTs for:

- History of liver disease
- Hepatitis B surface Antigen positive or Hepatitis C Antibody positive
- Concurrent therapy with other possible hepatotoxic medications
- Signs or symptoms of liver disease
- HIV Infection
- Pregnancy/Less than 3 months post-partum

Monthly LFTs indicated for:

- History of elevated LFTs at baseline (discontinue monitoring if asymptomatic and LFTs normalize)
- Persons at risk for hepatic disease (i.e. persons with Hep B/C with elevated LFTs at baseline, h/o chronic liver disease, etc.)

All persons should be screened monthly for signs of hepatotoxicity [see INH Therapy Monthly Patient Questionnaire enclosure (2)]. The medical officer in charge of the LTBI program will complete or review the INH Therapy Medical Provider Review [enclosure (3)]. Persons identified as having signs or symptoms of possible hepatotoxicity will be evaluated further by a medical officer to decide whether further testing and/or discontinuance of the medication is indicated.

Detainee Number: _____ Age of Detainee: _____ Date: _____

INH Therapy Monthly Patient Questionnaire

Are you experiencing any of the following problems:

- | | | | |
|--|-----|----|----|
| Fever for more than 7 days | Yes | or | No |
| Cough for more than 2 weeks in a row | Yes | or | No |
| Sweating at night for more than 7 days | Yes | or | No |
| Coughing up bloody phlegm | Yes | or | No |
| Nausea or vomiting for more than 7 days in a row | Yes | or | No |
| Abdominal pain for more than 7 days in a row | Yes | or | No |
| Yellow discoloration of skin | Yes | or | No |

Detainee Number: _____ Age of Detainee: _____ Date: _____

INH Therapy Medical Provider Review:

MAR Review: Number of doses refused in last month? _____

Does their course of medication need to be extended? _____

Signature of staff modifying the MAR _____

Medical officer evaluation (if indicated from above symptoms): _____

Are repeat/new LFT monitoring recommended? _____

Date drawn _____

Results _____

Is a repeat CXR needed? _____ Ordered? _____

Result of CXR? _____

Further actions required? _____

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
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ENTIRE SOP SUPERSEDED BY:	
Title: _____	
SOP NO: _____	Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 032
Title: Emergency Response Teams (ERT)	Page 1 of 5 Effective Date: 23 Jan 2004 Reviewed 8 Mar 2004
SCOPE: Detention Hospital	

Background: The Detention Hospital (DH) is responsible for emergency response 24/7 at Camp Delta, Camp Echo and Camp V. This requires a skilled and coordinated effort by all medical staff (b)(2)

(b)(2) The personnel making up the ERT teams will come from the staff assigned to the Delta Medical Clinic. The ERT team exists to provide immediate response to any medical emergency that takes place in Camp Delta. The ERT is also utilized to provide standby medical support in the event of mobilization of the JDOG Force Cell Extraction Team. On the occasion of a detainee needing to be engaged by the IRF teams, Delta Medical Clinic will dispatch an ERT team to the incident. Ongoing training for all Delta Medical Clinic staff regarding emergency response is essential to ensure readiness.

General Procedures:

- At the beginning of each shift the Shift Leader shall assign (b)(2) (b)(2) to both ERT teams with one team responding to any emergency (Code Blue) that could happen at the Detention Hospital. Any time the assigned personnel are out of the clinic they shall ensure they have a radio and an ERT medical jump bag with them.
 - ERT team members shall inventory the ERT medical jump bags and restock any missing supplies at the beginning of each shift.
- **Responding to IRF**
- Once the IRF is activated, the ERT member will immediately respond to the scene notifying Delta Medical Clinic that they are enroute. A Gator vehicle may be utilized for travel.
 - Upon arrival, the ERT will make contact with the Guard Commander and notify Delta Medical Clinic that the ERT has arrived on station.
 - The ERT shall assess the scene and provide appropriate treatment on scene to both guards and detainees. If in their assessment they determine additional medical assets (i.e. personnel, supplies or emergency vehicles) are necessary, they shall send all requests through the Delta Medical Clinic.

- The ERT shall remain on scene until secured by the Guard Commander. Once properly secured the ERT shall notify the Delta Medical Clinic that the IRF has been secured and report back to Delta Medical Clinic for debrief, to restock any used supplies, and to write a note in the Medical Record regarding any interventions.

□ **Responding to Medical Emergency/Self Harm**

- The ERT team will respond to any and all medical emergencies at Camp Delta. When a call is received in the Delta Medical Clinic, phone or mobile radio, an ERT team will respond with an ERT medical jump bag and be ready to provide emergency medicine and, if necessary, transport to the Delta Medical Clinic.

- In the event of a Self Harm (Snowball), or attempted Self Harm, an ERT team will respond. Spine boards and cervical immobilization devices are located in the Emergency Response locker located in each causeway. *C-spine precautions must be maintained with any hanging or detainee found unresponsive and until cleared by appropriate medical personnel.* (b)(2)

(b)(2)

- **Personal safety is paramount.** (b)(2)

(b)(2)

□ **Assignment to ERT:**

- All personnel working in the Delta Medical Clinic will require orientation to the ERT. Everyone will receive a PQS to ensure understanding of the requirements and procedures for this assignment.
- Only upon completion of PQS and signature of Delta Clinic LCPO will any Corpsman be assigned to such duty.

□ **Training:**

- The Section Leader shall conduct ERT PQS training at the start of their first shift of the 2-day rotation. The scheduled training shall focus on the above outlined procedures; communication procedures, C-spine precautions, and nature of injuries expected to be encountered i.e.; human bites, pepper spray, trauma, unresponsiveness, and self-harm.
- All training will be recorded on standard in-service documents and forwarded to the admin office to be filed in member's training record.
- All completed PQS forms will be kept filed with training record in admin office.

Emergency Response Team
Performance Qualification Standards (PQS)

Name: _____ **Date:** _____

Rank: _____

Initials/Date

- ____/____ Universal Precautions
- ____/____ Infection Disease Issues
- ____/____ Personal Safety Criteria
- ____/____ Orientation to Radio Procedures.
- ____/____ Orientation and Jump Bag Check off
- ____/____ Familiarization of Delta Blocks
- ____/____ Airway Management ____/____ Nasal Airway Placement ____/____
 Oral Airway Placement ____/____ BVM Technique ____/____
 O2 use ____/____ Non-Rebreather ____/____ Nasal Cannula ____/____
- ____/____ Hemorrhage Control
- ____/____ Splinting

I have read and understand the policy for being assigned to the ERT. I further understand my responsibilities to myself and my partner to ensure our safety at all times. I fully understand the above covered Procedures and Medical Interventions.

Signed: _____ Date: _____

Two-Day Orientation:

Trainer: Day 1: _____
Signed Printed Name and Rank

Day 2: _____
Signed Printed Name and Rank

Emergency Response Bag Check-Off Sheet

- BVM (1) _____
- Adult Mask (1) _____
- Pocket Face Shield (1) _____
- BP Cuff (1) _____
- Clean Gloves (6 pr) _____
- Stethoscope (1) _____
- C-Collar (1) _____
- Surgilube (1 tube) _____
- Oral Airway – sizes 9,10,11 (1 ea.) _____
- Nasal Airway (1) _____
- 5cc Syringe (2) _____
- 10cc Syringe (2) _____
- Epi-Pen Exp ____/____
- Sharps Container (1) _____
- Trauma Scissors (1) _____
- Kerlex (2) _____
- 4 x 4 Gauze (4) _____
- Cravat (3) _____
- IV NS (2) Exp ____/____
- IV Tubing (2) _____
- 18ga IV Catheter (2) _____
- 16ga IV Catheter (2) _____
- Alcohol Pads (10) _____
- Tourniquets (2) _____
- 1" Tape (1) _____
- 2 x 2 Gauze (4) _____
- Tegaderm (4) _____
- O₂ Tank PSI _____
- Adult Nasal Cannula (1) _____
- O₂ Tubing (1) _____
- Adult Mask (1) _____

Print Name: _____

Signature: _____

Discrepancies: _____

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Medical Officer of Delta Clinic	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
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Title: _____	
SOP NO: _____	Date: _____

<p style="text-align: center;">DETAINEE HOSPITAL GUANTANAMO BAY, CUBA</p> <p>Title: Medical Department Training</p>	<p>SOP NO: 034</p> <p>Page 1 of 3 Effective Date: 05 Feb 03 Reviewed: 22 Apr 04 Updated: 04 NOV 04</p>
<p>SCOPE: Detention Hospital</p>	

I. BACKGROUND:

Mission readiness is our priority and effective training remains central to that effort. The Detention Hospital provides medical treatment and healthcare services for detainees in support of Operation Enduring Freedom, as part of the JTF mission here in Guantanamo Bay. Safety and Security is the number one priority before any medical treatment is rendered to the detainee population. We work as a team with the MP's to accomplish our medical mission and constant training and vigilance is essential to ensure we remain mission focused, safe and effective as we conduct our daily operations in this maximum-security environment.

II. POLICY:

Our top priority is to maintain a trained and ready medical staff. Our training is focused on our mission essential tasks and are designed to prepare us for Mass Casualty, Emergency Response, and daily healthcare operations in the maximum-security environment of Camp Delta.

III. GENERAL PROCEDURES:

- a.** The DNs will assign one Med/Surg nurse and one corpsmen to be the Training Officer and Petty Officer and are the primary points of contact for coordination of all training evolutions.

- b.** The Training Officer, in coordination with directorates and OIC is responsible for developing a formalized six-week required training schedule for all Detention Hospital personnel. Training will be conducted every Thursday from 0900-1100 for all Hands. Clinic schedules will be adjusted to ensure maximum participation in the weekly training. The training plan will include command training (for all Hands) which will include General Military Training (GMT), and tactical/operational training to better prepare the corpsman for field activities.

- c.** Training topics will be selected to maximize situational awareness, emergency response and readiness at Camp Delta realizing that constant effective training is the key to our mission success.
- d.** The Training Officer will maintain training files and training database to accurately reflect completion of scheduled training.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
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Title: _____	_____
SOP NO: _____	Date: _____

<p style="text-align: center;">DETAINEE HOSPITAL GUANTANAMO BAY, CUBA</p> <p>Title: GUIDELINES FOR ROLE OF INDEPENDENT DUTY CORPSMEN</p>	<p>SOP NO: 035</p> <p>Page 1 of 4 Effective Date: 04 Mar 03</p>
<p>SCOPE: Detention Hospital</p>	

Ref:

- (a) OPNAVINST 6400.1B
- (b) BUMEDINST 4651.3 Series
- (c) US Naval Hospital, Guantanamo Bay, IDC Physician
Supervisor Handbook
- (d) OPNAVINST 6400.1B, Appendix A
- (e) Authorized Prescribing List for Independent Duty Hospital Corpsmen

I. PURPOSE:

To establish policy and assign responsibility for the re-certification, training and use of Independent Duty Hospital Corpsmen (IDCs) per reference (a).

II. BACKGROUND:

IDCs are integral and important components of the Navy Health Care Team whose mission is to care for Sailors and Marines independent of a Medical Officer. In addition, they also routinely fill leadership, training and administrative positions.

III. APPLICABILITY AND SCOPE:

This instruction applies to all Detention Hospital Guantanamo Bay IDCs IAW reference (a).

IV. POLICY:

IDCs will be assigned to clinical duties consistent with their skills, expertise, experience and needs of the command. Training must be ongoing and designed to prepare them to fulfill this challenging role. Enclosure (1) outlines the periodic evaluations required for each IDC.

(a) Prior to assignment to clinical duties with indirect supervision, all IDCs will complete the initial evaluation period IAW reference (a). Upon satisfactory completion of clinical training and direct supervision, each IDC will be re-certified.

(b) The Physician Supervisor will document all training (CEU's, correspondence courses and college credits) on the quarterly report that is sent to the IDC Program Director. Additionally, the IDC Physician Supervisor will review enclosure (1) to determine what clinical competencies have been completed and the IDCs progress towards completing all clinical competencies prior to detaching the MTF for a PCS transfer.

(c) IDCs are required to complete 12 CEU's annually. Reference (b) provides guidance as to how this may be accomplished. The Command will make every effort to allocate sufficient funds to allow IDCs the opportunity to attend professional conferences. The Staff Education and Training Department will advise the IDC Program Director of training opportunities.

V. APPOINTMENTS:

The Commanding Officer will appoint in writing the IDC Program Director, IDC Program Manager, a Physician Supervisor and alternate Physician Supervisor. The qualification and responsibilities of these persons are itemized in reference (a). Additionally:

(a) The IDC Program Director will conduct quarterly review of the IDC program to ensure compliance with applicable directives.

(b) The IDC Program Manager will ensure IDCs have completed re-certification and appropriate letters and Page 13 entries are made.

(c) The IDC Physician Supervisor ensures quality care is provided by the IDC as per Ref.1.

VI. ACTION:

The following is a list of duties and responsibilities for all IDCs assigned to the MTF.

(a) After completing the initial evaluation period IDCs may attend to patients following the defined level of supervision.

- (1) Active Duty: Indirect supervision.
- (2) All others: Direct supervision.

(b) IDCs will prescribe medication authorized by the formulary in accordance with enclosure 1. A copy of the Authorized Prescription List will be placed in the IDC training record.

(c) For a non-active duty patient presenting at the Medical Liaison Office, the IDC will contact the Physician Supervisor before implementing or changing a regimen of care except in cases of dire emergencies.

(d) IDCs will not give over the phone consultation.

Authorized prescribing list for Independent Duty Hospital Corpsmen

You are authorized to prescribe medication from the hospital formulary **except** for the following general classes of medications:

Disease modifying anti-rheumatics
Intravenous antibiotics and intravenous antifungals
Anti-coagulants and other hematological agents **excluding** aspirin
General anesthetics, intravenous sedatives, and neuromuscular blocking agents
Antidotes
Systemic obstetrical and gynecologic agents **excluding** birth control
Androgens, pituitary hormone agonists and antagonists
Antineoplastics
Chapter 2 Cardiovascular Agents **excluding** antihypertensives and diuretics
Immunoglobulin
Chapter 3 Neurologic agents **excluding** migraine therapy
Chapter 4 Ophthalmic steroids and glaucoma agents
Psychiatric agents **excluding** nicotine, zolpidem, and disulfiram
Schedule II medications

You should not prescribe any medication clearly outside your clinical expertise or ethical practice.

Enclosure (3)

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Chapter 5 Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
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SOP NO: _____	Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 036
Title: GUIDELINES FOR ROLE OF PHYSICIAN ASSISTANTS	Page 1 of 10 Effective Date: 04 Mar 03
SCOPE: Detention Hospital	

Ref:

- (a) SECNAVINST 1120.813
- (b) SECNAVINST 1301.4
- (c) MANMED Chapter 2
- (d) MANMED Chapter 21
- (e) BUMEDINST 6550.12
- (f) BUMEDINST 6320.6613
- (g) MANMED Chapter 15

Encl:

- (1) Officer-in-Charge Ltr to Physician Assistant
- (2) Authorized medication list
- (3) Letter of Appointment, Primary Physician Supervisor
- (4) Letter of Appointment, Secondary Physician Supervisor

I. PURPOSE:

Per references (a) through (g), this instruction establishes guidelines for the role of Physician Assistants (PAs) at Detention Hospital, Guantanamo Bay, Cuba.

II. BACKGROUND:

The selection and training of PAs for the purpose of improving primary care roles was undertaken as a result of a shortage of primary care medical officers. In July 1971, the decision was made to train a cadre of PAs for the purpose of improving patient access to the primary care system and lessening the use of highly trained specialists in primary care roles. Since that time, PAs have become an integral part of the Navy health care team, contributing a valuable admixture of comprehensive and relevant training, substantial experience with the military and the military health care delivery system, and a practical and highly effective approach to patients' problems. PAs are now a part of an entirely new level of health care providers. Although the status of PAs has changed, the fundamental objective of the PA community has not changed: to enhance the delivery of quality care to our beneficiaries in a cost-effective manner.

III. DEFINITIONS:

a. Physician Assistant (PA). Per reference (e), PAs are health care professionals who have successfully completed a physician assistant training program recognized by BUMED, and are certified by the National Commission on the Certification of Physician Assistants. PAs are credentialed and privileged to practice medicine with physician supervision. Common services provided by a PA include taking medical histories and performing physical examinations; ordering and interpreting laboratory tests; diagnosing and treating illnesses; assisting in surgery; prescribing and dispensing medication; and counseling patients. PAs are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs. Because of the close working relationship PAs have with physicians, they are educated in the medical model designed to complement physician training. Upon graduation, PAs take a national certification examination developed by the National Commission on Certification of Physician Assistants (NCCPA) in conjunction with the National Board of Medical Examiners.

b. Primary Care. Primary care is a type of health care delivery, which emphasizes first contact care and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. This personal care involves a unique interaction and communication between the patient and the health care provider. Primary care is comprehensive in scope and includes the overall coordination of the patient's health care, whether this is preventive or curative, and where the sphere of involvement is biologic, behavioral, or sociologic. Appropriate use of consultants and community resources is an important part of effective primary care.

IV. DUTIES AND RESPONSIBILITIES OF PAs:a. General

(1) Although PAs exercise a substantial degree of independence in the performance of their duties, they must, by definition, function with the supervision of a doctor of medicine or osteopathy when performing medical services.

(2) PAs are qualified by training and experience to provide primary care and should be so assigned.

(3) In addition to the PA core privileges, the OIC may grant PAs specialty supplemental privileges when the need for the PA's services in that specialty exists, and when the credentials for that PA confirm current competency for supplemental privileges. A PA may obtain competencies by completing a post baccalaureate degree in that specialty or by completing a formalized training program within a medical treatment facility.

(4) PAs may be granted admitting privileges under reference (e). However, under the current setting of detainee care, there is currently no mechanism for PAs to admit or assist in the care of inpatients.

(5) PAs may perform physicals following reference (g).

(6) PA's will adhere to JTF GTMO uniform standards for Detainee Operations; woodland camouflage uniform with sewn on devices worn with sleeves rolled down and name tapes covered when working with detainees.

(7) PAs must sign the medical record of each patient examined, treated, or referred for treatment, and print or stamp his or her name, grade, title, and the last four numbers of the social security number, beneath the signature.

(8) Evaluation of the quality of care provided by every PA in a clinical billet should be included in every fitness report submitted.

(9) PAs must maintain close ties with the Medical Service Corps (MSC) community to remain competitive in their corps. This is best accomplished by participating in scheduled MSC meetings and functions.

b. Specific

(1) Each PA will be granted clinical privileges following the provisions of reference (f).

(2) PAs are authorized to write prescriptions under the provisions contained in reference (d). Enclosure (2) defines prescribing guidelines for this facility.

V. FACILITY PA PROGRAM RESPONSIBILITIES:

A program director (generally the senior PA) will be appointed to coordinate the PA program. Responsibilities include:

a. Ensure primary and alternate physician supervisors are assigned by the OIC and that letters of appointment are generated.

b. Review the newly arriving PA's duties and responsibilities with them to ensure clarity.

c. Provide a structured orientation for assigned physician supervisors.

d. Monitor compliance of the program with the pertinent instructions.

e. Monitor compliance with the required peer reviews.

f. Review pertinent instructions annually for currency.

VI. SUPERVISION OF PAs:

The PA should be fully integrated into the primary care team and should be expected to exercise a substantial degree of clinical judgment in ordering studies, requesting consultations, rendering diagnoses, and formulation and initiation of treatment plans. An open, informal exchange of information between PA and physicians is necessary. The formal requirement for supervision and review of the clinical work of a PA by a specific physician derives from many sources and is reaffirmed by reference (e).

a. A physician must be appointed in writing, utilizing enclosure (3), to supervise and formally review the patient care rendered by each PA. Continuity of supervision must be ensured. An alternate physician will be

appointed, utilizing enclosure (4), to assume the supervisory responsibilities in the absence of the regularly appointed supervisor.

b. When the PA is involved in watch standing duties (e.g., after hour acute care clinic) the physician in charge of the watch area will assume supervisor duties.

c. A physician will not be appointed responsibility for supervision of more than three nonphysician providers.

d. Physicians assigned supervisory responsibility must be fully credentialed and privileged and actively engaged in the same category of health care delivery as the PA to be supervised.

e. The supervising physician will conduct random record reviews and peer review the quality of care provided. A minimum of 10 records per month will be reviewed via established peer review processes and each record reviewed will be co-signed. A copy of all reviews will be forwarded to the PA Program Director who will ensure the PA receives a copy. Documentation of the record reviews will also be forwarded for retention by the Credentials Committee of the PAs home command.

f. Physicians appointed supervisory responsibility will be provided a structured orientation by the PA program Director. The orientation will describe the training, experience and background of Navy PAs as well as the general duties and responsibilities of PAs. It will also clearly define all related administrative and professional supervisory and review responsibilities of the supervisor.

g. The supervising physician must participate in the initial granting and subsequent reappraisal of clinical privileges. He or she must be advised of credentialing action taken in the case of the PAs being supervised and must communicate promptly through the chain of command to the Credentials Committee any concern that credentials granted may not be appropriate.

VII. CONTINUING MEDICAL EDUCATION (CME) AND PA CERTIFICATION:

Each PA must attain and maintain national certification through the NCCAP. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for recertification every six years. CME may be obtained through in-service training, correspondence course programs, and continuing education conferences in the command. Active membership in appropriate professional organizations is encouraged.

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (PA)

Subj: ASSIGNMENT OF PHYSICIAN ASSISTANT DUTIES AND SUPERVISOR

Ref (a) NAVAMBCARECENNPINST 6322.3C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.66B

1. You are being assigned to the Delta Clinic and will perform general primary care duties per reference (a).
2. During this assignment, (Primary Supervisor) has been designated to serve as your Primary Physician Supervisor per references (a) through (c). (Alternate Supervisor) has been designated as your Alternate Physician Supervisor per references (a) and (c) and will serve in the absence of your Primary Supervisor.
3. Your designated Physician Assistant Supervisor has been directed to provide ongoing review of, and assistance with, your delivery of health care to detainees at this facility. Your supervisor has been specifically directed to meet with you on a periodic basis and review your clinical practice and medical record documentation.
4. The Physician Assistant Program Director will meet with you and your assigned supervisors to review the Physician Assistant Program, provide a copy of reference (a) and review the authorized medication list from which you may prescribe.
5. You must be familiar with the provisions of reference (a) to ensure that all of the supervision and review requirements of this directive are fulfilled.

(OFFICER IN CHARGE)

Enclosure (1)

MEMORANDUM

From: (PA Program Director)

To: Officer in Charge

Via: Chairman, Pharmacy and Therapeutics Committee

Subj: AUTHORIZED MEDICATION LIST FOR PHYSICIAN ASSISTANT (PA)

1. (PA) will have full access to the Detention Hospital formulary with the following recommended exceptions:

PROHIBITED DRUGS (MAY NOT BE PRESCRIBED)

ALCOHOL	BETHANECHOL
BUSULFAN (MYLERAN)	CLOMIPHENE (CLOMID)
CYCLOPHOSPHAMIDE (CYTOXAN)	FLUCYTOCINE (ANOCOBON)
FLUROURACIL (EFUDEX)	HEPARIN SODIUM (HEPARIN)
HYDROXYUREA (HYDREA)	LITHIUM (ESKALITH)
MELPHALAN (ALKERAN)	QUINA CRINE
VINCRISTINE	TUBOCURARINE CHLORIDE
SUCCINYOCHOLINE CHLORIDE	PROTAMINE SULFATE

DRUGS WHICH MAY BE INITIATED WITH COUNTERSIGNATURE OF A LICENSED PHYSICIAN AND REFILLED WITHOUT COUNTERSIGNATURE

AMPHOTERICIN (FUNGIZONE)	CHLORAMEPHENO COL (CHLOROMYCETIN)
DIGITALIS TYPES	PHENYTOIN (DILANTIN)
ETHAMBUTOL (MYAMBUTOL)	FUROSEMIDE (LASIX)
THYROID	GENTAMICIN (EXCEPT OPHTHALMIC)
GUANETHIDIDE (ISMELIN)	PROCAINAMIDE (PRONESTYL)
PROPYLTHIOURACIL (PTU)	QUINIDINE
RESERPINE	INSULIN
ISOPROTERENOL (ISOPREL)	ISOSORBIDE DINITRATE (ISORDIL)
METHIMAZOLE (TAPAZOLE)	METHOTREXATE
METHYSERGIDE MALEATE (SANSERT)	NITROGLY CERIN
PHENOBARBITAL	RIFAMPIN (RIMACTANE)
STREPTOMYCIN	PREDNISONE *
OPHTHALMIC STERIODS	ANDROGENS
BROMOCRIPTINE	WARFARIN SULFATE (COUMADIN)

Enclosure (2)

Subj: AUTHORIZED MEDICATION LIST FOR PHYSICIAN ASSISTANT (PA)

*** Prednisone is limited to short term use but may be initiated without countersignature for control of inflammatory and allergic reactions**

All other drugs may be initiated and refilled

2. (PA) may also have access to non-formulary items in medication categories not otherwise excluded by paragraph 1.

3. Once approved, copies will be distributed in accordance with reference (a) by the Physician Assistant Program Director.

(PA PROGRAM DIRECTOR)

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (Physician)

Subj: ASSIGNMENT AS A PRIMARY PHYSICIAN ASSISTANT SUPERVISOR

Ref: (a) NAVAMBCARECENNPINST 63223C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.6613

1. Per references (a) through (c), you have been assigned as the Primary Physician Assistant Supervisor for (PA). The Alternate Physician Supervisor is (physician), who will assume your responsibilities in your absence.
2. As the Primary Physician Assistant Supervisor, you must supervise and formally review the patient care rendered by (PA) per reference (a) requirements.
3. The Physician Assistant Program Director will provide a formal orientation for you regarding your responsibilities. At that time, you will receive a copy of reference (a) that defines the Physician Assistant Program at this facility and a copy of (the assigned PA) clinical privileges and authorized medication list. You should become thoroughly familiar with these and keep them on file for ready reference.
4. In a separate letter of assignment, the Physician Assistant is notified of your assignment as the Primary Physician Supervisor.

(OFFICER IN CHARGE)

Enclosure (3)

From: Officer in Charge, Detention Hospital, Guantanamo Bay, Cuba
To: (Physician)

Subj: ASSIGNMENT AS AN ALTERNATE PHYSICIAN ASSISTANT
SUPERVISOR

Ref: (a) NAVAMBCARECENNPTINST 6322.3C
(b) BUMEDINST 6550.12
(c) BUMEDINST 6320.6613

1. Per references (a) through (c), you have been assigned as the Alternate Physician Assistant Supervisor for (PA).
2. As the assigned Alternate Physician Assistant Supervisor, you must supervise and formally review the patient care rendered by (PA) in the absence of (Physician), his/her Primary Supervisor.
3. The Physician Assistant Program Director will provide a formal orientation for you regarding your responsibilities. At that time, you will receive a copy of reference (a) that defines the Physician Assistant Program at this facility and a copy of (the assigned PA) clinical privileges and authorized medication list. You should become thoroughly familiar with these and keep them on file for ready reference.
4. In a separate letter of assignment, the Physician Assistant is notified of your assignment as the Alternate Physician Supervisor.

(OFFICER IN CHARGE)

Enclosure (4)

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
SOP REVISION LOG:	
Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
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Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
ENTIRE SOP SUPERSEDED BY:	
Title: _____	
SOP NO: _____	Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 037
Title: IN-PROCESSING MEDICAL EVALUATION	Page 1 of 11 Effective Date: 24 Sep 03 Revised: 10 July 05
SCOPE: Detention Hospital	

Encl: (1) In-processing Order Sheet
(2) Report of Medical Examination
(3) BHS Screen
(4) Stations
(5) Tracking Sheet

Ref: Camp Delta SOP chapters 3 and 4

I. BACKGROUND. Detainees arrive from highly endemic areas for infectious diseases including tuberculosis, malaria, and parasitic infections. This section provides a detailed description of the medical screening and treatment for incoming detainees.

II. POLICY. Treatment and care provided will be humane and will follow the guidelines provided by the articles of the Geneva Convention. Specifically, each detainee will undergo screening and treatment for diseases common to the Middle East region.

III. GENERAL PROCEDURES:

A. Upon arrival to Camp Delta, each detainee will be searched, showered, and administratively processed. Hair may or may not have been cut prior to transfer to Guantanamo Bay, thus a hair inspection for lice will be completed. Treatment for cutaneous infestations will be administered as needed.

B. Each detainee will be brought into the medical clinic individually accompanied by a security force escort team. The specific order of detainees will be based on triage-performed prior to administrative in processing. Detainees will be placed in a higher triage category if their condition deteriorates prior to arrival at medical.

C. The detainee will receive a pre-made medical record with the following forms:

1. Report of Medical Examination (*see enclosure 2*)
2. SF 508 (blank order form and preprinted sick call prn medications.
3. SF 600 (Blank form and preprinted Inprocessing lab follow up form
4. SF 601: Immunization Record
5. DA 2664-R: Weight Register
6. NAVMED 6150/20: Detainee Medical Profile.
7. BHS Inprocessing form
8. Blank MAR
9. Tracking Sheet

A CHCS medical record number will be assigned beginning with 888-0X-XXXX. The name will be recorded as D, JTFXXXXX. The patient category will be K66.

D. A history and physical examination will be recorded on the Report of Medical Examination on enclosure (2). The physical exam serves both as a general screening exam and a confinement physical. A separate record of body weight including body mass index calculation will also be maintained (DA 2664-R). Please refer to weight management and nutrition program (SOP 014).

E. Psychiatric screening during the initial medical examination will be performed by a Psych Tech, Psych Nurse, Psychologist or Psychiatrist using the standard form (Encl. 3). Protocols for referral and evaluation prior to leaving In-processing are included in Encl. 3.

F. A dental record will be established, and the detainee will be evaluated by a dental tech or a dentist. Dental conditions will be identified and a plan of treatment /follow up will be established.

G. Detainees with a visual complaint will be screened for visual acuity and referred for optometry consultation.

H. Immunizations administered will include Td (tetanus-diphtheria), and influenza vaccines (during the appropriate season) to all detainees. Those with tetanus-prone wounds may also receive TIG (tetanus immunoglobulin) as per SOP # 024. A PPD will also be placed during this station. MMR (if HIV negative) and Hepatitis vaccines may be administered at a later date once laboratory results are available.

I. Laboratories obtained include a Hepatitis A IgG, Hepatitis B surface antigen (HbSAg), Hepatitis B surface antibody (HbSAb), Hepatitis B core antibody (HbCAb), Hepatitis C serology, HIV ELISA and malaria smears. The malaria smears will be screened at NH GTMO, and results confirmed at NH Portsmouth. An extra serum sample will be drawn and held for future use.

J. Each detainee will receive a screening chest X-ray and a PPD to assess for signs of tuberculosis (See SOP's #002 and 031). A repeat PPD will not need to be performed if a prior positive PPD is documented on the transfer summary.

K. Left hand and wrist radiographs will be obtained after approval by the JTF Surgeon on new detainees meeting the following two criteria:

1. The detainee states his/her age is less than 16 years, and
2. Based on the physical examination, the detainee has clinical characteristics that suggest that he/she is less than 16 years of age.
3. Regarding the clinical findings, each health care provider performing physical examinations will be provided with a copy of the Tanner staging to estimate the detainee's maturity. It is recognized that the Tanner staging provides a clinical measure of age between 9 and 15 years and that clinical finding of sexual maturity are quite uniform above the age of 15 years. It is also recognized that Tanner staging assumes genetic, racial, and nutritional background similar to the study group that this staging was based on, and that endocrine abnormalities may influence the time of maturation.
4. Bone radiographs obtained will be digitally forwarded to the AFIP for reading using the Greulich and Pyle standards of bone age determination.

L. Each detainee will receive empiric treatment for intestinal helminthes (albendazole 400 mg once) and malaria (mefloquine 1250 mg, split into 2 doses). Please refer to SOP 030 for details.

M. Upon completion of the above, treatment of any condition requiring immediate attention will be addressed.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
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Revision to Page: _____	Date: _____
ENTIRE SOP SUPERSEDED BY:	
Title: _____	_____
SOP NO: _____	Date: _____

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each page)</i>
JTF, JMG, Medical Department, Guantanamo Bay, Cuba 09593 (updated 24 September 2003//sed)	

STANDARD INPROCESSING ORDERS FOR DETAINEES:

1. Mefloquine 750 mg PO now, 500 mg PO in 12 hours
2. Albendazole 400mg PO once
3. Chest X-ray: PA and lateral

4. **LABS:**

Hep A IgG

Hep B surface antigen and antibody

Hep B Core antibody

Hep C

HIV

Malaria Smear (pre-screen at NAVHOSP GTMO prior to mail out to NII Portsmouth)

Serum (draw 1 extra red top)

Immunizations

1. Td .5ml IM once
2. PPD – read in 48 to 72 hours
3. Influenza 0.5 ml IM once (If in-processed during flu season)
4. MMR 0.5 ml SC once HIV result is negative

Consults: (circle as needed)

Needs reading glasses? Y or N

Optometry

General Surgery

Psychiatric Services

Orthopedic Surgery

Additional Orders Circle if indicated

1. AFB Smear Q AM x 3
2. If age may be < 16 years old: confer with JTF Surgeon for approval to
Obtain Left hand & wrist x-rays for bone age determination.

Staff Signature: _____ Provider: _____

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

*Typed Form in lieu of SF-600

NAME:**SSN:****STATUS:****DOB:****Enclosure (1)**

Standing Orders for routine sick cell complaints at Camp Delta Clinic.

The following medications may be dispensed by NC or HM Corps Staff at Camp Delta Clinic. * **IMPORTANT** Consult MO if detainee requires more than 4 doses in a 1 week period.

Complaints of minor aches, pains, headache:

*Tylenol (acetaminophen) 650 mg or 500mg PO q 4-6 hr PRN

Contraindications/cautions: Impaired liver or renal function, caution if G6PD deficiency.

Complaints of heartburn, indigestion.

*Mylanta (aluminum hydroxide/magnesium hydroxide) 15 – 30 ml PO q 4 hr PRN

Complaints of rhinorrhea, sneezing, watery eyes, itchy rashes.

Benadryl (diphenhydramine) 25 – 50 mg PO q 6 hr PRN

Contraindications/ cautions: acute asthma, CV disease, increased IOP

Complaints of moderate pain, headache:

*Motrin (ibuprofen) 400 mg – 800 mg PO TID PRN

Contraindications/cautions: Hx of ulcers/UGI bleed, HTN, kidney disease

Complaints of foot tinea pedis (athlete's foot), tinea cruris (jock itch)

Tinactin (tolnafate) 1% cream topical AAA BID x 2 weeks **do not repeat 2 weeks without consulting the M. O.**

Complaints of nasal congestion.

*Sudafed (pseudoephedrine) 30 – 60 mg PO QID PRN

Contraindications/cautions: HTN, CAD, Diabetes.

Complaints of sore throat.

*Cepacol Lozenges dissolve 1 lozenge in mouth q 4- 6 hours PRN

Complaints of inflamed itchy rashes, inflamed bug bites:

Hydrocortisone Topical 1% Cream, Apply to affected area 3 times a day, X 2 weeks

Complaints of heartburn, acid indigestion, occasional constipation.

*Milk of Magnesia As antacid – 1 – 3 teaspoons (with water) up to 4 times/day

As laxative – 2 – 4 teaspoons (with 8oz of water)

Complaints of sore muscles/ body aches.

*Bengay (Analgesic Balm) Apply to affected area 3 times a day for 7 days.

Complaints of flaky, itchy scalp.

Selsun Shampoo, small amount to hair then rinse after 15 minutes, no more than twice per week.

MO Signature _____ Staff Signature _____

DETAINEE IDENTIFICATION:

Typed Font in Lieu of SIGNATURE FORM 008

ISN:

MEDICAL RECORD	Report of Medical Examination	DATE OF EXAM _____
1. LAST NAME-FIRST NAME-MIDDLE NAME		2. IDENTIFICATION NUMBER
3. COUNTRY OF BIRTH	4. AGE	5. SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
6. PRIMARY LANGUAGE		7. SECONDARY LANGUAGE

History of Present Illness

Currently have/ever had: *(please circle, leave blank if unknown)*

Asthma	Yes	No	Hyperlipidemia	Yes	No
Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Malaria	Yes	No
Hepatitis	Yes	No	Mental Illness	Yes	No
HIV	Yes	No	Renal Disease	Yes	No
Other:			Tuberculosis	Yes	No

Family History of: *(please circle, leave blank if unknown)*

Asthma	Yes	No	Hepatitis	Yes	No
Cancer	Yes	No	Hyperlipidemia	Yes	No
Diabetes	Yes	No	Hypertension	Yes	No
Heart Disease	Yes	No	Mental Illness	Yes	No
Other:			Renal Disease	Yes	No

Ever Been Hospitalized? No ___ Yes ___. Explain:

Current Health: Good ___ Fair ___ Poor ___
Any special health requirements? No ___ Yes ___, list:

Current Medication(s):

Known allergies to medication(s):

Other Allergies:

Chemical Dependence? (alcohol, drugs)

Tobacco use? No ___ Yes ___, amount:

Do you have any pain? No ___ Yes ___
If Yes: Where? How often does it occur?

Transfer PPD results: Negative ___, Positive ___ (number of mm)

Transfer CXR results: No acute disease ___, Abnormal ___

Comments:

Review of Systems

Do you experience any of the following: *(please circle)*

General: fever chills night sweats weight loss

Skin: rash skin discoloration

Respiratory: cough duration? hemoptysis sputum

Cardiovascular: chest pain

Gastrointestinal: nausea vomiting abdominal pain diarrhea

Neurologic: headache seizure dizziness

Psychiatric: suicidal/homicidal tendencies hallucinations

Comments:

PHYSICAL EVALUATION

MEASUREMENTS AND OTHER FINDINGS

HEIGHT	WEIGHT	BMI	HAIR COLOR	EYE COLOR	BUILD
					<input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE

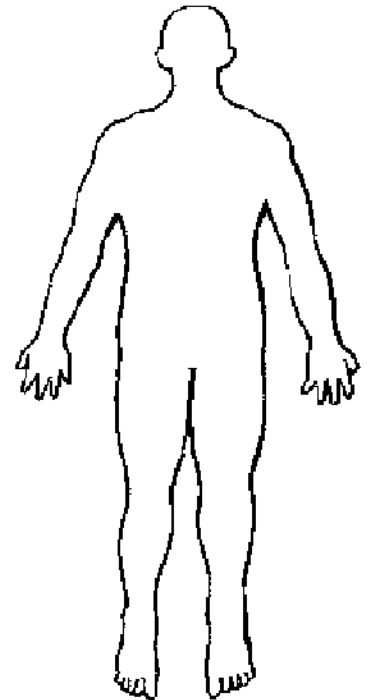
Temperature: _____ Respirations: _____ Pulse: _____ Blood Pressure: _____

CLINICAL EVALUATION

	Normal	Abnormal	Not Done		Normal	Abnormal	Not Done
A. HEAD				I. ABDOMEN			
B. EYES				J. RECTAL			
C. EARS				K. PROSTATE			
D. NOSE				L. GENITALS			
E. MOUTH AND THROAT				M. UPPER EXTREMITIES			
F. NECK				N. LOWER EXTREMITIES			
G. LUNGS AND CHEST				O. SKIN/LYMPH			
H. CARDIOVASCULAR				P. NEURO			
				Q. PSYCH			

Comments: *(Describe every abnormality in detail. Enter pertinent item letter before each comment. Use additional sheets if necessary)*

SUMMARY OF ASSESSMENT AND PLAN



TYPED OR PRINTED NAME OF PROVIDER

SIGNATURE

TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 038
Title: HEPATITIS B MANAGEMENT	Page 1 of 4 Effective Date: 11 Mar 03
SCOPE: Detention Hospital	

I. ENCL:

- (1) Hepatitis B Evaluation and Treatment Data Sheet
\\nh-gtmo-app\public\Fh20-Riggs\Working SOPs\SOP Enclosures and Attachments\Encl (1) Hepatitis B .doc
- (2) Chronic Hepatitis B, AASLD Practice Guidelines
\\nh-gtmo-app\public\Fh20-Riggs\Working SOPs\SOP Enclosures and Attachments\Encl (2) Hep B.pdf

II. BACKGROUND:

Hepatitis B is endemic to certain areas of the world including the Middle East. All detainees are screened for serologic evidence of hepatitis B for both the identification of this disease in this population and for the Force Health Protection of the Joint Task Force personnel in close contact with the detainee population so that appropriate preventive measures are taken after exposure to a hepatitis positive detainee. All detainees testing positive for HbsAg may represent ongoing active hepatitis, which may be both contagious and may lead to progressive liver damage to include cirrhosis, liver failure, and the development of hepatocellular cancer.

III. POLICY:

Each detainee found to be HbsAg (hepatitis B surface antigen) positive will be offered further evaluation at the medical clinic. Each detainee will be given the appropriate information regarding hepatitis B to make a decision regarding accepting/declining the evaluation and possible treatment of his/her hepatitis. Both the evaluation and treatment will be completely voluntary. The information collected on the evaluation is found on the enclosed data form. The policy thus stated in this SOP has been coordinated through consultation with the Gastroenterology Division, Naval Medical Center San Diego.

IV. PROCEDURES:

- The following sections deal with the description, definitions, and elaboration of the Hepatitis B Evaluation and Treatment Data Sheet. Screening for hepatitis B occurs upon arrival of the detainee at Naval Base Guantanamo Bay, NBGTMO.

- Those found to be positive for Hepatitis B surface antigen represents a possible case of active hepatitis B.
- The detainee with active hepatitis is infectious to other detainees and JTF personnel via contact with the detainee's blood. Saliva, vomitus, feces, and perspiration are not usually contagious unless these secretions contain blood.
- Information regarding the hepatitis B status of each detainee is useful such that if a blood exposure does occur, the hepatitis B status of the detainee may be assessed and appropriate preventive therapy (vaccination and/or immunoglobulin) can be offered in a timely manner.
- Hepatitis B infection may result in resolution of the infection by the immune system or may lead to persistent active hepatitis, which may lead to progressive liver dysfunction. Therefore, each detainee with a positive HbsAg will be offered further evaluation of this medical condition.
- The appropriate work-up will be initiated among those detainees who desire evaluation of their hepatitis B including serologies for hepatitis A, B, C as shown on the data collection sheet. Each detainee will also be asked about potential symptoms related to hepatitis B and undergo a physical examination. Liver function tests, PT/PTT/INR, and hepatitis B DNA viral load will also be obtained.
- A liver biopsy will be offered to those with elevated liver function tests and a high viral load (>100,000 copies/ml). If the detainee refuses this procedure, therapy will still be offered in appropriate cases.
- Based on the results of the aforementioned tests, each case will be discussed with a board-certified infectious diseases and/or gastroenterologist in regards the initiation of therapy.
- If the detainee meets indications for treatment, the patient will be offered either treatment with adefovir if there is no evidence for renal dysfunction ($\text{CrCl} > 60$ and $\text{Cr} < 1.0$) or lamuvidine. If the patient has or develops renal insufficiency, the patient will be offered therapy with lamuvidine. Therapy for hepatitis B will be administered for a minimal of one-year if the patient complies and desires therapy.
- The patient will be closely monitored for potential side effects of the therapy at routine clinic visits.
- Since the standard of care for the evaluation and therapy of hepatitis B is evolving, the diagnostic testing and drugs may change over time. Detainees should continue to obtain the standard-of-care of hepatitis B management.

- ❑ Detainees refusing therapy will be followed with routine medical clinic visits including liver function test approximately every 6 months or as clinically indicated.
- ❑ All patients with active hepatitis B, will also be offered vaccination against hepatitis A which is a 2-dose vaccine given at baseline and again in 6-12 months.
- ❑ Detainees with evidence of chronic active hepatitis will be offered screening for hepatoma with an alpha-fetoprotein (AFP) and/or right upper quadrant ultrasound every 6-12 months.

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
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SOP REVISION LOG:	
Revision to Page: _____	Date: _____
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Revision to Page: _____	Date: _____
ENTIRE SOP SUPERSEDED BY:	
Title: _____	
SOP NO: _____	Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 039
Title: HEPATITIS C MANAGEMENT	Page 1 of 4 Effective Date: 11 Mar 03
SCOPE: Detention Hospital	

I. ENCL:

- (1) Hepatitis C Evaluation and Treatment Data Sheet
\\nh-gtmo-app\public\Fh20-Riggs\Working SOPs\SOP Enclosures and Attachments\Encl (1) Hepatitis C Data Sheet for Evaluation and Treatment.doc
- (2) NIH Consensus Statement on Hepatitis C
\\nh-gtmo-app\public\Fh20-Riggs\Working SOPs\SOP Enclosures and Attachments\Encl (2) Hep C NIH2002.pdf

II. BACKGROUND:

All detainees are screened for serologic evidence of hepatitis C to identify infection among this population. The prevalence rate of hepatitis C has been approximated as 2% and depends on the prevalence of drug use, blood transfusion, and unsafe medical practices. Hepatitis C is a major cause of cirrhosis, liver failure, and liver cancer. Treatment of hepatitis C may decrease the risk of progressive liver dysfunction and may prolong life.

III. POLICY:

Each detainee found to be hepatitis C positive by the ELISA screening test will be offered further evaluation at the medical clinic. Each detainee will be given the appropriate information regarding hepatitis C to make a decision regarding accepting/declining the evaluation and possible treatment of his/her hepatitis. Both the evaluation and treatment will be completely voluntary. The information collected on the evaluation is found on the enclosed data form. The policy thus stated in this SOP has been coordinated through consultation with the Gastroenterology Division, Naval Medical Center San Diego.

IV. PROCEDURES:

- The following sections deal with the description and elaboration of the Hepatitis C Evaluation and Treatment Data Sheet. Screening for hepatitis C occurs upon arrival of the detainee at Naval Base Guantanamo Bay, NBGTMO.

- Those found to be positive for hepatitis C by the screening ELISA test represent a possible case of active hepatitis C.
- The detainee with active hepatitis C is infectious to other detainees and JTF personnel via contact with the detainee's blood. Saliva, vomitus, feces, and perspiration are not contagious unless these secretions contain blood. Since there is no current preventive therapy for those exposed to potentially contagious secretions of a hepatitis C patient, information regarding the hepatitis C status of each detainee will be used to follow those exposed to monitor for the development of the infection.
- Hepatitis C infection may result in resolution of the infection by the immune system in 15-40% of cases or may lead to persistent active hepatitis in 60-85%, which may lead to progressive liver dysfunction. Therefore, each detainee with a positive hepatitis C ELISA test will be offered further evaluation of this medical condition.
- The appropriate work-up will be initiated among those detainees who desire evaluation of their hepatitis C including assuring that serologies for hepatitis A, B, C are obtained. Each detainee will be asked about potential symptoms related to hepatitis C and undergo a physical examination. Liver function tests, PT/PTT/INR, hepatitis C RNA viral load, and genotype will also be obtained as shown on the data collection sheet (see Enclosure 1).
- Detainees with a positive hepatitis C ELISA and positive hepatitis C viral load will be diagnosed with active hepatitis C. Those with a negative hepatitis C viral load will be re-evaluated at 4-6 months with a repeat viral load measurement; those negative on both viral load tests will be classified as a false-positive ELISA test or someone who has resolved hepatitis C. This later group will not be further evaluated and do not require therapy.
- Those who are potential candidates for therapy will be referred to Behavioral Health for an initial evaluation to identify early any psychiatric problems which may preclude therapy with interferon.
- A liver biopsy will be offered to those with active hepatitis C. If the detainee refuses this procedure, therapy will still be offered in appropriate cases.
- Based on the results of the aforementioned tests, each case will be discussed with a board-certified infectious diseases and/or gastroenterologist in regards the initiation of therapy.
- If the detainee meets indications for treatment, the patient will be offered treatment with peg-interferon and ribavirin. Therapy for hepatitis C will be

administered for 6-12 months depending on the genotype and response to therapy; this assumes that the patient complies with and tolerates the therapy.

- ❑ The patient will be closely monitored for potential side effects of the therapy at routine clinic visits. Psychiatry will also follow the detainee while he/she is treated with peg-interferon.
- ❑ Since the standard of care for the evaluation and therapy of hepatitis C is evolving, the diagnostic testing and drugs may change over time. Detainees should continue to obtain the standard-of-care of hepatitis C management.
- ❑ Detainees refusing therapy will be followed with routing medical clinic visits including liver function test approximately every 6 months or as clinically indicated.
- ❑ All patients with hepatitis C, will also be offered vaccination against hepatitis A which is a 2-dose vaccine given 0 and 6-12 months and hepatitis B which is a 3-dose vaccine at 0,1 and 6 months for all those not already immune.
- ❑ Detainees with evidence of hepatitis C cirrhosis will be offered screening for hepatoma with an alpha-fetoprotein (AFP) and/or right upper quadrant ultrasound every 6-12 months.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 041
Title: VACCINATIONS	Page 1 of 7 Effective Date: 15 Oct 2003
SCOPE: Detention Hospital	

I. REFERENCES:

- (1) Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings. MMWR, January 24, 2003, vol 52, RR-1. SOP Enclosure Hepatitis
- (2) Measles, Mumps, and Rubella – Vaccine Use and Strategies for Elimination of Measles, Rubella and Congenital Rubella Syndrome and Control of Mumps. MMWR, May 22, 1998, vol 47, No. RR-8. SOP Enclosure MMR
- (3) Prevention and Control of Influenza, MMWR, 2003, vol 52, RR-08. SOP Enclosure Influenza
- (4) Prevention of Pneumococcal Disease, MMWR, 1997, vol 46, RR-08. SOP Enclosure Pneumococcal Vaccine
- (5) Vaccine Management: Recommendations for Handling and Storage of Selected Biologicals, Centers for Disease Control and Prevention, Jan 2001. SOP Enclosure Vaccine Management
- (6) Recommended Adult Immunization Schedule – United States, 2002-2003, JAMA 2002, vol 288, p 2258-60.

II. BACKGROUND:

Detainees arrive from areas in which childhood vaccinations may not have been received, making them susceptible to several infectious diseases, including tetanus, diphtheria, measles, mumps and rubella. In addition, within the close living conditions of a detention environment, detainees may be at risk for the aforementioned diseases as well as hepatitis, influenza, and pneumococcus. These diseases can cause outbreaks in non-immune populations making the need for mass immunization an important public health measure.

III. PURPOSE:

To define policies and procedures for detainee vaccinations, both during in-processing and during their time within the camp.

IV. PROCEDURES:

A. Tetanus-diphtheria:

1. Each detainee will receive a single dose of Tetanus-diphtheria (Td) upon arrival, which will occur during the in-processing evolution (See SOP 037: *In-processing Medical Evaluation*).
2. Two additional doses of Td will be given to detainees at 1-2 months after the first shot and then again 6-12 months later.
3. Dose is administered IM (intramuscularly).
4. Detainees deficient in the number of Td injections (<3 doses obtained) will be given a dose of Td during out-processing if the vaccine is due at that time.
5. Detainees sustaining a tetanus prone wound will be assessed by medical per SOP 024: *Tetanus Prophylaxis in JTF Detainees*.
6. A Td booster every 10 years will be offered for those completing the 3-dose primary series.

B. Hepatitis:

1. Immunity to hepatitis A and B for each detainee will be ascertained during in-processing by drawing a Hepatitis A IgG level and Hepatitis B core and surface antibody tests.
2. Those found to be immune to both hepatitis A and B will not receive hepatitis vaccination.
3. Those immune to hepatitis A, but non-immune to hepatitis B will receive the 3-dose hepatitis B vaccine series given at 0, 1, and 6 months. This will be given in an involuntary manner to protect detainees from acquisition of hepatitis B.
4. Those immune to hepatitis B, but non-immune to hepatitis A will receive the 2-dose hepatitis A vaccine series given at 0 and 6 months. This will be given in an involuntary manner to protect detainees from acquisition of hepatitis A.
5. Those non-immune to both hepatitis A and hepatitis B will receive the 3-dose hepatitis A and B vaccine (twinrix) series given at 0, 1, and 6 months. This will be given in an involuntary manner to protect detainees from acquisition of both hepatitis A and B.
6. Hepatitis B vaccine is given by IM injection into the deltoid (not in buttocks). Hepatitis A vaccine and twinrix (combined Hepatitis A and B vaccine) are also given IM.
7. Titers for response will not routinely be checked.
8. Possible side effects of hepatitis A vaccination include soreness at the injection site, headache, and malaise; no serious reactions have been

reported. Giving the vaccine to a person who is already immune to hepatitis A does not appear to increase the risk of side effects.

9. Contraindications for hepatitis A vaccination include an adverse reaction to prior hepatitis A vaccination.
10. Possible side effects of hepatitis B vaccination include soreness at the injection site, fever, and anaphylaxis (1/600,000). No deaths have been reported. Giving the vaccine to a person who is already immune to hepatitis B does not appear to increase the risk of side effects.
11. Contraindications for hepatitis B vaccination include an adverse reaction to prior hepatitis B vaccination.
12. Those with a serious adverse reaction to vaccination will be reported to Vaccine Adverse Events Reporting System (VAERS) and the vaccine series will be discontinued.
13. For further information regarding hepatitis vaccinations see Encl 1.

C. Measles-Mumps-Rubella (MMR):

1. Detainees from developing countries are unpredictably vaccinated and documentation of prior natural infections is not available; hence, detainees may remain at risk for these infectious diseases unless vaccinated. The CDC recommends that adults without documentation of receipt of MMR vaccine should receive one dose of MMR vaccine.
2. Each detainee who does not have a contraindication for vaccination will receive a single-dose of MMR (0.5ml subcutaneously) on an involuntary basis for protection of measles, mumps and rubella. This is important for the individual protection of detainees as well as the public health of the camp.
3. The MMR vaccine is a live-virus vaccine and is contraindicated in pregnant females and the immunocompromised. Additional considerations for this vaccine are as follows:
 - a) Each detainee will be screened for HIV upon arrival using a HIV ELISA test. Those who are seronegative and do not have other contraindications for vaccination (immunosuppressed, chemotherapy, steroids or other immunosuppressants) will receive a dose shortly after entrance into the camp.
 - b) Any detainee who received immune globulin or blood transfusion should wait 3-11 months for vaccination since these products may blunt the immune response to MMR.
 - c) PPD's should be placed prior to or simultaneously as vaccination with MMR, since the MMR can interfere with the immune response to PPD. Otherwise, the PPD should not be placed for 4-6 weeks after MMR vaccination.

- d) Allergies to neomycin or gelatin are contraindications to MMR vaccination; each detainee should be asked about previous severe reactions to vaccinations.
4. Potential adverse events to vaccination may include local pain or edema in the area of the vaccination, fever, rash, or local temporary lymphadenopathy. Uncommon reactions would be joint pain or reactions such as a seizure caused by fever. Extremely rare reactions may include anaphylaxis (<1 case per 1 million doses administered), low platelets (1:100,000), or meningitis/encephalitis (1 case in 2 million doses). See Encl 2.
5. Each medical personnel should be aware of these potential side effects when assessing detainees during the 1-2 weeks after vaccination. Serious reactions will be reported to the chain of command and to VAERS.

D. Influenza:

1. Each detainee will involuntarily receive a single-dose of influenza vaccine during in-processing.
2. Each detainee will also involuntarily receive annual vaccinations during the months of October-December.
3. Dose is 0.5ml IM.
4. Side effects include local pain or swelling; fever and myalgias may occur. Very rarely anaphylaxis has been reported. Allergic reactions are uncommon and may be related to an allergy to eggs.
5. Contraindication to vaccination includes significant adverse reactions to a prior influenza vaccine or allergy to eggs.
6. For further information, see Encl 3 and the CDC Influenza vaccine information at www.cdc.gov/nip/flu.

E. Pneumococcal:

1. Those detainees meeting the Advisory Committee on Immunization Practices (ACIP) criteria to receive the pneumococcal vaccination will be offered this vaccine on a voluntary basis.
2. Indications for vaccination include age ≥ 65 years, chronic medical conditions involving the heart, lung, liver, kidneys (ESRD, nephrotic syndrome) as well as diabetes, cancer, sickle cell disease, immunodeficiency, and asplenia.
3. Dose is 0.5 ml subcutaneously as a single dose.

4. Side effects are typically mild and may include local soreness, erythema or edema. Rarely fever and myalgias may occur. Very rarely anaphylaxis has been reported.
5. Revaccination x 1 after 5 years of the initial dose will be offered to those who are greater than age 65 years, immunocompetent patients with anatomic/functional asplenia, as well as to immunocompromised persons due to HIV-infection, malignancy, or nephrotic syndrome.
6. Contraindication includes prior adverse reaction to the pneumococcal vaccine.
7. See Encl 4 for further information.

F. Vaccine Adverse Reactions:

1. Medical personnel will immediately assess any detainee having a possible adverse reaction to vaccination.
2. Serious reactions will reported to Vaccine Adverse Events Reporting System (VAERS) [1-800-822-7967] and the vaccine series will be discontinued.
3. Reactions to vaccines will be clearly recorded within the detainee's medical record and the chain of command will be notified of the adverse event.

G. Strategies to facilitate vaccine administration in Camp Delta include:

1. Usage of the ID database to track required vaccines for each detainee since not all detainees receive the same shots at the same times. Included in this database is the date of administration and lot number of vaccine, which is also recorded in the medical record. The Internal Medicine/Infectious Disease physician maintains this database.
2. Prior to the exercise, a brief should be performed regarding the plan, proper administration/handling/storage of the vaccine, and potential side effects.
3. Continuous communication should be maintained with JDOG for organization of the vaccine program in terms of the day of the immunization exercise, other scheduled camp activities, movement within the camp, blocks to begin with, appropriate medical escorts, etc.
4. Early involvement with the linguists to announce two to three days in advance of the upcoming immunization; emphasizing the reasons for the vaccine and the benefits offered to each detainee.

5. Supplies include: syringes, alcohol swabs, appropriate vaccine storage containers (on ice if cold chain required), 2x2 dressings, bandages, sharps container, gloves, and an alpha roster of detainees requiring immunization.
6. Just prior to the exercise, preparation of syringes with vaccine maintaining appropriate cold chain storage if indicated.
7. Following completion of the exercise, the immunizations will be transcribed from the database to the medical record.
8. Personnel required for immunization exercises
 - a) A nurse coordinator to organize the corpsmen and vaccine supplies
 - b) Teams constructed consisting of four individuals (1-2 to administer vaccines, 1 for organization of supplies, and 1 for administrative purposes to log immunizations). Linguists should be available to assist as needed.
 - c) An adequate number of corpsmen and nurses (from Detention hospital, the Joint Aid Station, and NH-Prev Med) to administer the vaccines and to then record all the shots in both the medical records and the database.

F. Reporting Requirements: at the end of each month the NCO of the S1 Processing Line will be given an updated disk of the Infectious Disease database. The S1 is housed in (b)(2)

G. Vaccine Information:

1. CDC, National Immunization Program: www.cdc.gov/nip
2. Reference 1.
3. FDA, Vaccine Adverse Reactions: 1-800-822-7967 or www.fda.gov/cber/vaers/vaers.htm
4. National Network Immunization Information: 877-341-6644 or www.immunizationinfo.org

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<p style="text-align: center;">NH GTMO AND DETAINEE HOSPITAL GUANTANAMO BAY, CUBA</p> <p>Title: Severe Acute Respiratory Syndrome (SARS)</p>	<p>SOP NO: 042</p> <p>Page 1 of 6 Effective Date: 29 Apr 03</p>
<p>SCOPE: Naval Hospital GTMO and the Detention Hospital</p>	

- Encl:
- (1) <http://www.cdc.gov/ncidod/sars/infectioncontrol.htm>
 - (2) <http://www.cdc.gov/ncidod/sars/exposureguidance.htm>
 - (3) <http://www.cdc.gov/ncidod/sars/ic-closecontacts.htm>
 - (4) <http://www.cdc.gov/ncidod/sars/factsheetcc.htm>
 - (5) www.cdc.gov/ncidod/sars/
 - (6) <http://www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm>

I. BACKGROUND:

SARS or Severe Acute Respiratory Syndrome is an emerging respiratory infection that was first described in Asia. This is a novel infection among humans, which is caused by a previously unrecognized coronavirus. Infection may occur in all age groups and races; cases have occurred equally in males and females to date. Symptoms include high fevers (>100.4F), headache, malaise, and body aches; these symptoms cannot distinguish SARS from other viral infections. After 2-7 days, some patients may develop a dry cough and dyspnea and hypoxemia. The incubation period from infection to the development of symptoms is 2-10 days.

II. PURPOSE:

Although no cases have been isolated in Cuba to date, a high awareness of this infectious disease is necessary given its rapid global spread. This SOP serves to increase awareness of this infectious disease and to set forth a protocol for isolation and evaluation of a suspected case of SARS.

II. PROCEDURES:

A. General Information:

1. All suspected cases of SARS will be immediately isolated in his/her own room and the healthcare staff will take the appropriate precautions outlined below to prevent the spread of this viral infection.
2. The chain of command will be immediately briefed on any suspected case.
3. The internal medicine and infectious diseases specialist should be consulted on any suspected case of SARS.
4. Preventive Medicine should be contacted regarding suspected cases for public health management of contacts.

B. Case Definition:

1. The CDC case definition for a suspected case:
 - a. Temperature >100.4F or >38C
and
 - b. Respiratory illness (cough, SOB, hypoxia, and/or CXR findings)
and
 - c. Travel within 10 days of onset of symptoms to an area* with documented or suspected community transmission of SARS or close contact within 10 days of onset of symptoms with a SARS case. Note: Travel to an affected area includes transit in an airport

*SARS has occurred in the Peoples' Republic of China (China and Hong Kong); Hanoi, Vietnam; Singapore; and Toronto.

2. The CDC case definition for a probable case:
 - a. Radiographic evidence of pneumonia or respiratory distress syndrome
 - b. Autopsy findings consistent with respiratory distress syndrome without an identifiable cause.

C. Diagnosis:

1. Patients with respiratory symptoms and the above criteria should be evaluated for SARS.

2. Initial diagnostic testing should include pulse oximetry, chest radiograph (may show patchy interstitial infiltrates), blood cultures, sputum Gram's stain and culture. An ABG should be considered with a pulse oximetry of <95%.
3. Basic laboratory values should be obtained including a cbc with a differential, chem. 7, liver function tests and CK. Blood counts may reveal normal or decreased white blood count and platelet count. Some patients have developed elevated CK levels and transaminases.
4. Tests for viral respiratory pathogens such as influenza A and B and respiratory syncytial virus should be obtained. A specimen (urine) for Legionella and pneumococcal should also be considered.
5. The genome of this new coronavirus has recently been sequenced making diagnostic testing feasible. Clinicians should save any available clinical specimens (respiratory, serum, whole blood, and stool) for additional testing until a specific diagnosis is made.
6. Inpatients should have nasopharyngeal swab, lower respiratory sample (BAL, pleural fluid, tracheal aspirate), whole blood, serum, and stool sent for evaluation in suspected cases. Outpatients should have the same samples collected excluding the lower respiratory sample. Autopsy specimens may also be submitted.
7. Acute and convalescent (greater than 21 days after onset of symptoms) serum samples should be collected from each patient who meets the SARS case definition. Paired sera and other clinical specimens can be forwarded through State and local health departments for testing at CDC or directly to the Naval Health Research Center in San Diego [Contact information at NHRC: (b)(6)
(b)(6)]

D. Protection:

1. The exact route of transmission has not been confirmed; infection is likely spread by airborne droplets, however, contact transmission has not been excluded.
2. Suspected cases in the clinic or ED should be identified early and immediately provided with a surgical mask to cover the patient's mouth and nose. He/she should be separated from other patients into a negative pressure or private room.
3. Health care providers are advised to use standard precautions (hand hygiene) as well as airborne precautions using a N-95 respirator (all personnel must have a qualitative fit test) and contact precautions with gowns and gloves. Eye protection should also be worn for patient

contact. Patients should be isolated in a negative pressure room; if this is not possible, a private room is advisable.

4. Cases should avoid interactions outside their hospital room (inpatients) or home (outpatients) and not go to work, school, or other public areas until 10 days after symptom resolution. The duration of infectivity has not yet been defined; therefore, precautions are advised for 10 days after respiratory symptoms and fever have resolved.
5. Health care workers who have unprotected exposure to a SARS patient should watch for fevers/respiratory symptoms for 10 days after exposure. All exposures should be reported to Preventive Medicine.
6. Exposed and symptomatic healthcare workers with fever or respiratory symptoms should seek medical attention and should not go to work.
7. Exposed healthcare workers who remain asymptomatic can perform their normal work duties.
8. Recommendations may change with further data concerning the etiologic agent and its transmission; check the CDC website for the most up-to-date information.
9. Further guidelines are located on the CDC website.
 - a. "Interim domestic guidance for management of exposures to SARS for healthcare and other institutional settings" at: <http://www.cdc.gov/ncidod/sars/exposureguidance.htm>
 - b. "Interim guidance on infection control precautions for patients suspected SARS and close contacts in households" at: <http://www.cdc.gov/ncidod/sars/ic-closecontacts.htm>
 - c. "Updated interim domestic infection control guidance in the healthcare and community setting for patients with suspected SARS" at <http://www.cdc.gov/ncidod/sars/infectioncontrol.htm>
 - d. "Information for close contact of SARS patients" at: <http://www.cdc.gov/ncidod/sars/factsheetcc.htm>

E. Treatment:

1. No specific treatment is currently available. Some patients have been treated with antiviral agents and/or steroids, but the benefits of such therapies are currently unknown.
2. Until a bacterial cause of the infection is excluded, broad-spectrum antibiotics are recommended for those with pneumonia to cover community-acquired pneumonia as well as atypical organisms. Examples of antibiotics include Ceftriaxone 2 grams iv qd and levaquin 500 mg IV/po qd OR Ceftriaxone 2 grams iv qd and Azithromycin 500 mg po qd.
3. Internal Medicine and infectious diseases consultation is recommended.

F. Prognosis:

1. The severity of illness is variable ranging from a mild viral illness to death.
2. To date, the case fatality rate is 3-5% with most deaths attributed to respiratory failure.

G. Case Reporting:

1. All cases should be reported to the chain of command, Preventive Medicine and to the IM/ID specialist.
2. State or local health departments in the U.S., can be notified for U.S. cases (not applicable)
3. CDC at 770-488-7100

H. Additional Information/Contacts Regarding SARS:

1. BUMED: (b)(6)
(b)(6)
2. www.cdc.gov/ncidod/sars/

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<p>DETAINEE HOSPITAL GUANTANAMO BAY, CUBA</p> <p>Title: RESTERALIZING AND CLEANING STRAIGHT CATHETERS</p>	<p>SOP NO: 045</p> <p>Page 1 of 2 Effective Date: 18 JUN 03</p>
<p>SCOPE: Detention Hospital</p>	

I. PURPOSE:

This SOP outlines the technique of cleaning and reesterilizing straight catheters.

II. PROCEDURE:

A. Cleaning:

1. Place straight catheters in the ultra sonic for 20min.
2. When finished take out and squirt water through the end with a syringe.

B. Wrapping

1. Place the well moisten straight catheters in the basin.
 - a. Squirt four drops of water in basin.
 - b. Make sure the inside and outside of the catheter is well moistened.
2. Use blue muslin to wrap
 - c. You must immediately wrap the catheter after moisten it and place it immediately in sterilizer.
 - d. If catheter is not placed in sterilizer directly after moistened, remoisten and rewrap.

C. Checks before giving catheter to Detainee

1. Make sure catheter is not hot
2. Check catheter for cracks or holes, or any type of rubber breakdown.

STANDARD OPERATING PROCEDURES
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 050
Title: DETAINEE REFUSAL OF CARE	Page 1 of 3 Effective Date: 07 Aug 03
SCOPE: Detention Hospital	

- I. ENCL:** (1) DoD Policy on Medical Care for Enemy Persons Under US Control Detained in Conjunction with Operation ENDURING FREEDOM, 10 April 2002.
- (2) U.S. Southern Command Confidentiality Policy for Interactions Between Health Care Providers and Enemy Persons Under U.S. Control, Detained in Conjunction with Operation ENDURING FREEDOM, 6 August 2002.

II. BACKGROUND. The Detainees held at Joint Task Force (JTF) GTMO are not Prisoners of War, they are considered to be unlawful combatants. The Detainees do not qualify for the Geneva Convention Rules; however, they will be treated humanely, in a manner consistent with the principles of the Geneva Convention relative to the treatment of prisoners of war.

III. POLICY:

A. Detainees under U.S. control suffering from a serious disease, or whose condition necessitates special treatment, surgery, hospital care, or rehabilitation shall be provided, to the extent feasible, the medical attention required by their state of health per the policies delineated in enclosure (1).

B. JTF military medical personnel will provide medical care as applicable to military correctional facilities (SOUTHCOM Policy Memorandum 8-02) found in enclosure (2).

IV. PROCEDURES:

A. Detainees may refuse care that is not required to protect their lives, significant health interests (limbs/organs), the lives or health of others, or legitimate security interests of the United States.

B. Detainees will be treated humanely at all times.

C. Force should be avoided whenever reasonable.

D. Do not use force in situations where the risk of danger to the detainee exceeds the risk of not getting the treatment.

E. Do not use medical treatments as a discipline tool in order to modify detainee behavior. Joint Detainee Operations Group and the JTF Commander will handle the discipline of detainees.

F. Time out or a delay in most treatments by 1-2 hours is acceptable to diffuse the

situation, allow the detainee to reconsider, and/or adjust to the realities of his situation.

G. Refusals are usually an expression or an attempt to achieve control by the detainee. These control issues are usually related to a personal issue and not a larger group or philosophy issue.

H. Ramadan is a religious holiday that requires fasting all day for an entire month. Medication and clinic schedules will need to be adjusted during that time period.

I. The detainees come from a barter culture. Excessive discussion and permission seeking for a benign procedure that does not require informed consent is usually counter-productive. The detainees have a generally fatalistic view of life. Threatening the detainee with a shorter life span for not taking his blood pressure medication or lipid-lowering medication will usually not convince the detainee to take the medication.

J. The Bioethics Committee, Naval Hospital GTMO is another source to help resolve significant issues of bioethical conflict.

K. Informed consent with a native language interpreter as the witness will be obtained for all surgeries and use of anesthesia.

L. The Senior Medical Officer will review all requests for the use of force and provide final approval for the use of force in the case of medical treatment or management.

M. JTF Commander has final decision for all medical matters in regards to issues concerning national security.

STANDARD OPERATING PROCEDURES
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Copy to: Joint Task Force Surgeon's Office	

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 054
Title: KOH (POTASSIUM HYDROXIDE) PREPARATION	Page 1 of 3 Effective Date: 23 SEP 03
SCOPE: Detention Hospital	

I. BACKGROUND: The KOH prep is used to aid in the detection of fungal elements in thick mucoid material or in specimens containing keratinous material, such as skin scales, nails or hair. The KOH solution dissolves the background keratin, unmasking the fungus elements to make them apparent. Hyphae and yeast cells, that resist digestion by the KOH, can then be seen clearly against a homogenous background.

II. SPECIMEN: Skin scales, nail scrapings, hairs, or other materials that are thick in consistency or opaque are appropriate for KOH preps.

III. MATERIALS REQUIRED

- A. Spot test Potassium Hydroxide (KOH) – 10%, storage at room temperature.
- B. Glass slide
- C. Cover slip
- D. Microscope

IV. QUALITY CONTROL

- A. Ensure that quality control is within normal range prior to testing patient samples.
- B. Negative – Uninoculated KOH
- C. Positive – Candida albicans
- D. Record results, lot number and date in the quality control log each day of use.

V. SAFETY. Gloves and resistant lab coats must be worn at all times when working with blood and body fluids or body tissues. Protective face shields must be worn when working with biological specimens that may be aerosolized such as opening blood tubes.

VI. PROCEDURE

- A. On a clean glass slide, suspend fragments of skin scales, nails or hair in a drop of 10% KOH.
- B. Add a cover slip over the drop and let the slide sit for 10 to 15 minutes at room temperature.
- C. Examine the slide under the microscope at low and high power for the presence of fungal elements of hyphae.

VII. RESULTING RESULTS

- A. If no fungal elements are seen, report as follows, "No fungal elements present – KOH negative."
- B. If fungal elements are present on the slide, report as follows, "Fungal elements present – KOH positive."
- C. Ensure the result is entered accurately in CHCS.

VIII. REFERENCE RANGE. No fungal elements seen.

IX. LIMITATIONS. Care must be taken to differentiate fungal elements from other artifacts such as cotton, wool, or other fabrics as well as mosaic cholesterol crystals.

X. REFERENCES

A. Naval Hospital GTMO reference SOP.

B. Color atlas and Textbook of (b)(2)

(b)(2)

STANDARD OPERATING PROCEDURES

Detention Hospital
Guantanamo Bay, Cuba

PREPARED AND WRITTEN BY:

(b)(6) _____ Date _____

REVIEWED AND APPROVED BY:

Officer In Charge _____ Date _____

IMPLEMENTED BY:

Director for Administration _____ Date _____

Senior Enlisted Advisor _____ Date _____

ANNUAL REVIEW LOG:

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Title: _____
SOP NO: _____ Date: _____

**DETAINEE HOSPITAL
GUANTANAMO BAY, CUBA**

SOP NO: 055

Title: HIGH BLOOD PRESSURE MANAGEMENT

Page 1 of 5

Effective Date: 16 Oct 03

SCOPE: Detention Hospital

I. ENCL:

- (1) Chronic Disease Medical Flow Sheet

II. REFERENCES

- (1) Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. The Seventh Report of the JNC on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *JAMA*. 2003; 289(19):2560-72.
- (2) National Commission on Correctional Health Care Clinical Guideline for Correctional Facilities – Treatment of High Blood Pressure

II. BACKGROUND

High blood pressure is a disease that causes an increased risk for stroke, heart disease, and renal failure. While traditionally recognized as a problem in the United States, it is a significant cause of morbidity and mortality worldwide that can be reduced by early intervention. It is well established in Western populations, that the risk of stroke, CHD and other common cardiovascular diseases, have multiple determinants such as age, high blood pressure, hypercholesterol, obesity, and family history. How well these factors predict cardiovascular disease in non-Western populations is less certain, although recent evidence from Eastern Asian populations suggests that blood pressure may have a similar association. However, there is little evidence about these factors in other large populations such as in sub-Saharan Africa, India or South America. The evaluation and treatment of these determinants in a similar manner may be beneficial until future research dictates otherwise.

This guideline is adapted from the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.

III. POLICY

This is the first SOP on high blood pressure management and this program will be conducted by a medical provider on the JTF staff under the guidance of the Senior Medical Officer (SMO). Scheduled blood pressure monitoring will occur to screen detainees for hypertension and to offer further evaluation and treatment.

The Delta Medical Clinic is responsible for providing blood pressure monitoring and medical treatment as clinically indicated for detainees with high blood pressure. The SMO will ensure that the appropriate standards of care for the medical and administrative management of high blood pressure are adhered to.

Definition of Hypertension. The mean of two or more seated blood pressure (BP) readings on two or more occasions with a systolic BP greater than or equal to 140 or a diastolic BP greater than or equal to 90 will be considered hypertensive.

IV. PROCEDURES

A. Correct Measurement of Blood Pressure:

1. Detainee should be seated for at least five minutes with arm supported at heart level. The BP cuff bladder should encircle at least 80% of the arm. Systolic BP measurement should be noted at the point at which the first sound is heard and the diastolic measurement should be noted at the point just before the sound disappears.

B. In-processing

1. Initial history: Upon arrival, detainees will have a history and physical examination recorded on the report of medical examination (see SOP 037). History and symptoms of diabetes, heart disease, hypertension, hyperlipidemia, and renal disease will be obtained. Current/past medication use including illicit drugs, alcohol, and tobacco will be obtained.
2. Physical examination: At least two blood pressure measurements will be obtained using the above-described methods. Elevated measurements will be verified using the contralateral arm. The weight and height of each detainee will be determined with calculation of the body mass index (see SOP 014). Physical examination will include fundoscopic examination, auscultation for carotid bruits, thyroid examination, thorough cardiovascular and lung exam, abdominal examination for bruits, abnormal pulsations, and organomegaly, neurologic examination, and assessment of distal extremities for pulses and edema.
3. Diagnostic studies: As indicated by the historical or physical exam findings, additional laboratory studies may be obtained to assess for identifiable causes of hypertension or for the presence of end-organ damage. These may include, but are not limited to: complete blood count (CBC), blood chemistries, urinalysis, lipid panel, and 12-lead electrocardiogram.
4. All detainees will be reassessed for repeat blood pressure measurements within one month, which will be recorded in the medical record and a mean blood pressure measurement determined. Detainees with known hypertension or abnormal findings by examination will be managed per guidelines listed below.

C. Classification of Blood Pressure (from JNC VII)

1. Normal: systolic BP less than 120 and diastolic BP < 80
2. Prehypertension: systolic BP 120-139 or diastolic BP 80-89

3. Stage 1 hypertension: systolic BP 140-159 or diastolic BP 90-99
4. Stage 2 hypertension: systolic BP >159 or diastolic BP >99

V. MEDICAL EVALUATION AND MANAGEMENT

A. Management of Detainees with Hypertension

1. General Guidelines:

- i. All detainees will be educated regarding lifestyle modification. Please refer to SOP 014 for guidelines on the weight management program. Weight control and dietary sodium restriction have been shown to lower BP.
- ii. The blood pressure goal to reduce the risk of cardiovascular disease is a systolic and diastolic BP less than 140/90 mm Hg or less than 130/80 mm Hg for individuals with diabetes or renal disease.
- iii. Current clinical trials have demonstrated efficacy from several classes of antihypertensives including: angiotensin-converting enzyme inhibitors, beta-blockers, calcium channel blockers, and thiazide diuretics. 2 or more antihypertensive medications may be needed to reach the desired BP goal. While thiazide diuretics have been used in the most trials and have demonstrated efficacy both as single drug and in combination, providers should be cognizant of the hot weather climate and the potential risk for electrolyte abnormalities and dehydration.

2. Detainees with Prehypertension:

- i. Unless there is a medical indication for medical therapy such as: recurrent stroke, heart failure, diabetes, previous myocardial infarction, or high risk for coronary disease, no medical therapy is indicated. Management will include future assessment and lifestyle modification.

3. Detainees with Hypertension (stage 1)

- i. In addition to lifestyle modification, the use of medication will likely be required to meet the goals.

4. Detainees with Hypertension (stage 2)

- i. Detainees with stage 2 hypertension will require antihypertensive medical therapy in addition to lifestyle modification.

B. Detainees enrolled in the blood pressure management program will be categorized in the following manner based on the blood pressure classification and degree of control (using NCCHC guidelines):

1. **Poor Control**. Includes detainees with hypertension (systolic BP >159 or diastolic BP > 99) or those with significant cardiovascular comorbidities. These detainees will be monitored at least monthly or more frequent as necessary until BP goal is attained. Once BP goal is met and is stable, visits can be done every 3-6 months. Visits should include blood pressure determinations, assessment of medication tolerance, and education. Serum

creatinine and potassium should be obtained 1-2 times each year. Results will be recorded on the *Chronic Disease Medical Flow Sheet* (see enclosure 1).

2. **Fair Control**. Includes detainees with systolic BP 140-159 or diastolic BP of 90-99. These detainees will be monitored at least every 2-3 months for blood pressure determination, assessment of medication tolerance, and education. Results will be recorded on the *Chronic Disease Medical Flow Sheet* (see enclosure 1).

3. **Good Control**. Includes detainees with a blood pressure less than 140/90. These detainees should be seen initially every 3-4 months and if controlled and stable, this may decrease to twice yearly. Visits should include blood pressure determination, medication tolerance, and lifestyle education with the results recorded on the *Chronic Disease Medical Flow Sheet* (see enclosure 1).

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 56
Title: Medical Records	Page 1 of 3 Effective Date: 31 Mar 2004 Updated: 04 NOV 04
SCOPE: Detention Hospital	

I. REFERENCES:

- a) Manual of the Medical Department (P-17) Chapter 16, Health Records.

II. PURPOSE:

To establish standard operating procedures for the maintenance of detainee medical records.

III. RESPONSIBILITIES:

All JTF medical staff are responsible to ensure proper maintenance of the detainee medical record through creating new records, proper documentation and closing out of detainee medical records upon dismissal from Camp Delta, Guantanamo Bay Cuba.

IV. PROCEDURE:

1. The detainee will receive a pre-made medical record with the following forms: Report of Medical Examination (*see enclosure 1*), SF 88, SF 508, SF 600, SF 601, SF 603, DA 2664-R, NAVMED 6150/20, Detainee Behavioral Healthcare In processing Form and DA Form 4237-R. A CHCS medical record number will be assigned beginning with 888-0X-XXXX. The name will be recorded as D, JTFXXXXX.

2. All forms in the medical record will have proper detainee identification Numbers on them D (detainee) ISN (identification serial number) XXXX.

V. MEDICAL RECORD SECTION ORDER:

1. Outpatient Medical Record

Inside Part I:

The (left side) of the medical record will contain Medical Record Receipt (pink card #xxxx), NAVNMED 6150/20 (PSL), SF 508 (doctor's orders), Medical Record Standing Doctor's Orders for Routine Sickcall, Standing inprocessing orders for detainees, DA 2664-R (weight register), SF 601 (immunization record).

Inside Part II:

The (right side) will contain Progress notes, Surgery Reports, Request for Anesthesia, Report of Medical Examination (page 1&2), Dental exam (page 1&2), Psychological Screening/Notes.

Inside Part III:

Medication Administration Record (MAR)

Inside Part IV:

Radiology Reports
Electrocardiogram (EKG)
Laboratory results

2. Proper documentation on all forms is a joint responsibility. Medical providers making the diagnosis of a chronic disease is ultimately responsible to update the Problem Summary List NAVNMED 6150/20.

3. As medical records wear from continual use the jackets are to be replaced. Front covers should indicate any known allergies, ISN numbers and the language the detainee speaks. On the front right side of the medical record cover, in pencil, the current block and cell number should be listed.

4. As additional volumes of records are required volume number one shall be placed in a brown jacket and be prepared for closure. Closed shall be written on the front cover along with the date no further entries are to be made. Volume one records are to remain in the delta clinic until the detainee is to be processed out. A volume two record is to be opened and on the front cover state chart 2 of 2.

5. As detainees are processed out of Camp Delta the original records will be closed out, sealed and retained in permanent files at the Joint Task Force Staff Judge Advocate. No other copies will be distributed from the Detention Hospital or Camp Delta Medical Clinic.

6. *Inpatient Records*: When a detainee is discharged from the Detention Hospital, an Inpatient Record Jacket will be created for the patient. Reference (1) outlines the procedures for creating an inpatient record. Be sure to mark "Inpatient Record" on the Record Jacket. Mark the "Category" as "Other". On the blank line next to "Other" write: "D, JTF". Patient Admin will pick up all information found in the Nursing Charts and ensure that the Inpatient Record is placed in proper order. The record will be routed to the Attending and Admitting Physicians for signature. Once the record has been signed, it will be returned to Patient Admin for proper filing and maintenance. The front cover of the record will be marked with the dates of admission. A diagonal line will be drawn across the front of the Record Jacket and the word "CLOSED" will be written on the diagonal line. No further entries will be added to this record. Once the record is closed and filed, only personnel listed on the records access roster will have access.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
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Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
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DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 059
Title: DACU ORIENTATION	Page 1 of 9 Effective Date: Feb 2004
SCOPE: Detention Hospital	

I. JOB SUMMARY

Purpose: To provide Nursing and Corp staff with guidelines to assist with the Nursing care provided by the Detention Hospital in the Detainee Acute Care Unit.

Keep in mind that safety is first in the Detainee Acute Care Unit; medical care will always be secondary. When working with a detainee in the Detainee Acute Care Unit ensure to always have a guard alerted and present prior to your approach to the detainee. It is vital to your safety to have a guard aware of your plans to approach any detainee at all times. Teamwork and communication will always provide an effective and safe atmosphere. This document will serve as a turnover file and training template for incoming personnel tasked with opening and manning managing the Detainee Acute Care Unit. Whether it is responding to one or multiple casualties the principles of the medical response are the same.

II. RESPONSIBILITIES AND AUTHORITIES

The duties and responsibilities of the Nurse Corps Officer are as follows:

(b)(2)

Open the Detainee Acute Care Unit and ready it for the arrival of the detainee

Coordinate and administer patient care activities

Exercise a substantial degree of independence in the performance of their duties; they must function without direct supervision of a doctor of medicine or osteopathy when administering care.

Secure the DACU after use and report all usage of supplies to the appropriate people

Be available via pager 24 hours, when assigned, and frequently check for pages to ensure a timely response

The Nurse Corp Officers assigned to the DACU are qualified by orientation, training and experience to provide quality care.

Administer scheduled and PRN medication as ordered

Administer treatments such as dressing changes, etc.
Transcribe physician orders for all patients
Ensure all procedures and findings are documented on appropriate forms

III. PROCEDURE

DACU OPENING PROCEDURES

(b)(2)

4) Enter the DACU and prepare the unit as needed.

(b)(2)

6) Transfer patient to unit.

DACU EQUIPMENT ORIENTATION

1) (b)(2) Monitor

- Hands on demonstration
- HP Monitor reference book at nurse's station

2) (b)(2) Monitor

- Hands on demonstration
- Pro-Pac reference book at nurse's station

3) IVAC Intravenous Pump

- Hands on demonstration
- IV drug calculation
- IVAC reference book in DACU SOP

4) (b)(2) Pump (Enteral Feeding Pump)

- Hands on demonstration

5) Mechanical Ventilation and Ventilator Troubleshooting

Overview

- RELAX!!
- Ventilators are positive pressure devices that blow up the lungs like balloons and allow O₂ in and CO₂ out
- Ventilator settings are ordered by the physician and set by respiratory therapist

(RT)

- Nurse's role is to monitor the patient and inform the physician and/or RT that the patient is not tolerating the current settings and that the patient must be assessed and changes made as necessary.

Objectives of Mechanical Ventilation

- | | |
|------------------------|--|
| Physiologic objectives | <ul style="list-style-type: none">- to support or manipulate pulmonary gas exchange- alveolar ventilation (arterial PCO₂, pH)- arterial oxygenation (PO₂, SaO₂, CO₂)- increase lung volume<ol style="list-style-type: none">1) end-inspiratory lung inflation2) functional residual capacity- to reduce or otherwise manipulate the work of breathing |
| Clinical Objectives | <ul style="list-style-type: none">- reverse hypoxemia- reverse acute respiratory acidosis- relieve respiratory distress- prevent or reverse atelectasis- reverse ventilatory muscle fatigue- permit sedation and/or neuromuscular blockade- decrease systemic or myocardial O₂ consumption- to reduce intracranial pressure- stabilize the chest wall |

Ventilator Parameters

- Mode - main difference is spontaneous vs. ventilator-assisted ventilation
- types: CMV, IMV, SIMV, Assist Control, Pressure support, CPAP, Inverse Ratio, etc.
- Rate - number of breaths per minute
- Trigger - amount of negative pressure needed to "trigger" the machine to deliver a breath
- sensitivity can be set as low as -0.5 to -1.5 cm H₂O

Tidal Volume - amount of air going into the lungs with each ventilation
- average tidal volume is 8-10ml/kg

FiO₂ - fractional percentage of O₂ delivered to the patient (.30, .50, 1.0, etc.)

Pressure Support (PS) - amount of air pressure used to augment inspiration

PEEP/CPAP - amount of air pressure the patient breathes against during exhalation
- prevents atelectasis
- normally set at 5cm H₂O and increased as necessary

I:E ratio - ration of inhalation to exhalation
- normal is 1:2 to 1:3
-can be adjusted to optimize ventilation

Suctioning

- 1) Ventilate if possible using 100% O₂ for one minute
- 2) Measure position of tube at level of teeth or approximate trach length (if applicable)
- 3) Disconnect patient from ventilator circuit (not need if using in-line suction)
- 4) Introduce suction catheter and advance just beyond trach or ET tube length
- 5) Suction approximately 5-10 seconds or until airway clear
- 6) Place patient back on ventilator circuit or ventilate for one minute and continue suctioning
- 7) When in doubt, or if SpO₂ falls with s/s of hypoxia present, manually ventilate with BVM and call for assistance

Ventilator Troubleshooting

- RELAX!!!
- most problems are simple in nature and can be assessed and remedied by the nurse at the bedside
- most important rule is to ASSESS THE PATIENT, NOT THE MONITOR!
- use a systematic approach to assessing the patient
- work from the patient back to the ventilator
- when in doubt, ventilate using a bag-valve mask (BVM)

Pneumonic for assessing ventilator alarm or malfunction is to “check your DOPE”:

D - *Dislodgement* between ventilator circuit and patient
Tx: attach ventilator circuit to patient and reassess

- O - *Obstruction* of patient airway or ventilator circuit
Tx: suction patient or un-kink ventilator tubing reassess

- *Oxygenation failure.*
 - 1) Total loss of oxygen coming from the O2 source
 - 2) Too low a FiO2 setting to adequately oxygenate the patient

Tx:

 - 1) Manually ventilate patient with alternate O2 source (i.e., O2 tank)
 - 2) Increase FiO2 setting until adequate SpO2 achieved

- P - *Pneumothorax* caused by ventilator or organic process
Tx: remove patient from ventilator, manually bag, and contact MO ASAP

- E - *Equipment failure.* Either mechanical or electrical failure of ventilator.
Tx: manually bag patient and contact RT ASAP for ventilator change-out

DACU MEDICATION REVIEW

- 1) See attached sheets for over view of medications commonly used in the DACU
- 2) Medications not in ward stock can be obtained from the NH GTMO Pharmacy.

(b)(2)

- 4) IV drip medication preparation information is located on the attached sheets.

DACU SUPPLY PROCEDURES

(b)(2),(b)(6)

TITLE:

SOP: 059

Page 6 of 9

4) After working hours you may utilize the multi-service ward for supply needs with a one-for-one return policy on all supplies used the next working day.

5) Upon securing the DACU, leave a note for (b)(2) stating all supplies used, as well as any identified supplies needs for the future.

DACU SECURITY PROCEDURES

(b)(2)



DACU CLEAN UP AND SHUT DOWN PROCEDURES

- 1) After discharging all patients, the DACU crew is responsible for cleaning up and preparing the DACU to receive new patients.
- 2) All dirty linen is to be bagged and placed in the linen bag on the multi-service ward.
- 3) All beds are to be made with fresh linen.
- 4) All monitors, cables and accessory items are to be wiped down with a disinfecting, germicidal solution.
- 5) All cables are to be stowed in the receptacles at the bedside.
- 6) Extra equipment shall be stored in equipment room in the back of the DACU.
- 7) The nurse's station is to be cleaned prior to departure. This includes removing any left over food items from both the patient and staff refrigerators, de-icing the refrigerators as needed, emptying and cleaning the coffee pot and emptying the garbage can.
- 8) All leftover narcotics are to be returned to pharmacy or wasted and properly documented.
- 9) Red bag trash is to be bagged, twisted shut and taped closed with a "goose neck" at the top of the bag. Red bag trash containers are located
- 10) All lights are to be turned off.

(b)(2)

12. Return the keys to the multi-service ward.

(b)(2),(b)(6)

- 14) Drop off regular trash in the large dumpsters (b)(2)

Detention Hospital Guantanamo Bay Cuba

DACU ORIENTATION

Preceptor Initials / Orientee Initials

Review SOP _____

Open DACU _____

Orient to Equipment/

- HP Monitors _____
- ProPaks _____
- Kangaroo Pumps _____
- IV Pumps _____
- Ventilators _____

Medication Review

- Critical Drip Calculations _____

Common Procedures _____

Supply Replacement _____

Security _____

Clean up / Shut Down DACU _____

Preceptor's Signature _____
Signature _____

Orientee's

TITLE:

SOP: 059
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STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge

Date

IMPLEMENTED BY:

Director for Administration

Date

Senior Enlisted Advisor

Date

ANNUAL REVIEW LOG:

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SOP NO: _____ Date: _____

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 060
Title: CARDIAC ARREST PROCEDURE(S) AT CAMP DELTA	Page 1 of 9 Effective Date: January 2005
SCOPE: Detention Hospital, Delta Clinic, Block Area, Reservations	

I. REFERENCES:

- a) Detainee Acute Care Unit Standard Operating Procedure #059

II. PURPOSE:

To outline the standard operating procedure regarding emergency medical response to personnel and detainees at Camp Delta and to define the cardiac arrest (Code Blue) criteria for activating the Emergency Medical Response Team while identifying the personnel who will respond. This Standard Operating Procedure document is intended to deal with individual cases and not mass casualty situations although some of the same principles may apply.

III. POLICY:

The Detention Hospital and Delta Clinic are intended for providing care to detainees only. However, emergency medical care may be rendered to U.S. personnel pending arrival of Emergency Medical Services from the Naval Hospital, Guantanamo Bay (GTMO). Otherwise, Joint Task Force personnel are to receive care in the Joint Aid Stations (JAS) set up for that purpose or the U.S. Naval Hospital. Definitive emergency medical care for detainees will be rendered in the Detention Hospital or the Detainee Acute Care Unit (DACU) located in the U.S. Naval Hospital based on clinical acuity and availability of necessary resources.

IV. CAMP DELTA PROCEDURES:

1. In the event of an emergency involving a member of the Joint Task Force, the following will apply:

- A medical "Code Blue" will be announced on the radio. A lockdown of all the units will be done and an accounting of all detainees will quickly be performed by security staff. (b)(2)
- (b)(2)
- Medical personnel at Camp Delta will respond initially to the medical call to render immediate aid and assess the need for emergency transport. Emergency response teams (b)(2) will be dispatched for all possible code blues. The medical staff will initiate BLS on scene.
- If the member does not have a pulse, apply power to the AED and follow voice prompts. Press the shock button on the AED when a shock is indicated and directed to by the voice prompt. After three stacked shocks, reassess and resume CPR for one minute before attempting defibrillation with the AED.
- The medical staff will initiate ACLS protocols, if ACLS certified provider is on scene, and direction to give ACLS meds has been given by a medical doctor.
- U.S. Naval Hospital, Guantanamo Bay (b)(2) will dispatch an ambulance for transport to the hospital facility.
- Medical personnel at Camp Delta will secure the patient on backboard or litter with all necessary precautions to prevent further injury as may be indicated by the clinical condition and mode of injury. The EMS

crew/ambulance sent from Naval Hospital Guantanamo Bay will enter (b)(2) and drive the ambulance, as directed by Guard Force personnel, to a site closest to the patient for pickup.

- The ambulance will transport the patient to the U. S. Naval Hospital, Guantanamo Bay Emergency Room for further evaluation and treatment.

2. At Detention Hospital:

- The Registered Nurse (RN) or designee will call Delta Clinic (b)(2) to report cardiac arrest (Code Blue) and request activation of Emergency Medical Response teams.
- Page Duty Medical Officer (refer to on Call schedule for numbers). If no answer from Medical Officer, call GTMO Naval Hospital ER Medical Officer at (b)(2)
- Bring Crash Cart to scene to initiate CPR (ABCs, Airway, Breathing, Circulation).
- Initiate ACLS protocol if ACLS provider is on scene and direction to give ACLS meds is given by a medical doctor.

The following list of personnel is available 24 hours/day, 7 days/week, and will respond to all cardiac arrest(s) in Detention Hospital, Delta Clinic, Blocks, Reservations, and Tribunal Hearing areas:

- Duty Medical Officer, by pager. If no call returned, call GTMO Naval Hospital ER Medical Officer at (b)(2)
- Detainee Operations Center (D.O.C) (b)(2)
- Emergency Response Teams #1 (Delta Clinic) and #2 (Detention Hospital)
 - a) Red Resuscitative Jump Bag
 - b) Automated External Defibrillator (AED)
 - c) Respiratory Bag
 - d) ACLS Medication Box

At Delta Clinic:

- The Registered Nurse (RN) or designee will announce "Code Blue" over radio and request activation of Emergency Response Teams.
- Bring Crash Cart to scene to initiate CPR (ABCs, Airway, Breathing, Circulation).
- Page Duty Medical Officer. If no call returned, call GTMO Naval Hospital ER Medical Officer at (b)(2)
- Initiate ACLS protocol if ACLS provider is on scene and direction to give ACLS meds is given by a medical doctor.

In as specific Camp (1, 2, 3, 4) and/or in a specific Block area(s):

- The block will notify medical that there is a man down and describe if possible (b)(2). After receiving acknowledgment from Delta Clinic, medical will switch to (b)(2). All other communications in reference to medical emergency will be transmitted on (b)(2)
- Emergency Medical Response Team (b)(2) will be directed to respond to the medical emergency with:

- a) Red Resuscitative Jump Bag
- b) Automated External Defibrillator (AED)
- c) Respiratory Bag
- d) ACLS Medication Box (nurse will bring to scene if ACLS certified)

- Notify Duty Medical Officer, by pager. If no call returned, call GTMO Naval Hospital ER Medical Officer at (b)(2)

- (b)(2)
- (b)(2) to allow for quick transit to the site of the detainee or staff member.
- A security escort team will be dispatched to the location to secure the detainee per and will be available for transport as needed.
- Assess for unresponsiveness and ABCs (Airway, Breathing, Circulation). **ENSURE AREA SAFE FROM MP'S BEFORE ENTERING CELL.**
- If detainee is unresponsive without pulse, position on backboard and initiate CPR for 1 minute.
- Transport Detainee via backboard to the causeway STAT, apply AED and follow prompts, shock as advised. **(DO NOT APPLY AED TO DETAINEE IN CELL BLOCK).**
- Reassess pulse, if no pulse, continue CPR and follow ACLS algorithm(s) (obtain authorization for ACLS medications from MO prior to administration).
- If Detainee stabilized (b)(2)
- (b)(2)
IAW SOP 059.
- **Documentation of Cardiac Arrest shall be documented on the Advanced Cardiac Life Support Flow Sheet.**

BLS/ACLS DRILLS:

Cardiac Arrest (Code Blue) Drills will be performed at least twice a month at various locations by the Registered Nurse assigned to Delta Clinic, or Crash Cart Officer. Locations that drills can be performed:

Detention Hospital
Delta Clinic
Training Block

Code Blue Critiques of the Corps staff and other applicable staff will be completed by the RN and documented on the critique form(s). The RN will place the one copy of the completed critique in the Crash Cart book and one copy in the DNS folder.

SOP Issued: 2/2/04

Resubmitted: 12/30/04

CODE BLUE CRITIQUE

Area of Drill: Hospital Delta Clinic Camp ____ Block ____

Medical notified of Code Blue by: _____ @ _____ Radio Lan Line

Brief description of scene:

TIME	ACTIVITY	Comments	Met	Not Met
	a. Establish unresponsiveness			
	1. Absence of breathing			
	2. Absence of pulse			
	b. Call for help			
	c. Initiate Code Procedures			
	1. Pager systems activated			
	2. Personnel assigned			
	d. Begin Basic Life Support			
	1. Patient Positioned for CPR			
	2. Airway			
	3. Chest Compressions			
	e. Crash Cart Setup			
	1. Airway equipment			
	2. Oxygen			
	3. Medications			
	4. IV equipment			
	f. Defibrillator/Monitor setup			
	1. Rhythm established/recognized			
	g. IV established			
	h. Airway Maintenance			
	1. Adequate mask ventilation			
	i. Palpable pulse during compressions			
	j. Detection of pulse without compressions			
	k. Treatment modality			
	1. Follows algorithm for scenario			
	2. Used ACLS cards from Crash Cart			
	l. Post-resuscitation management			

Enclosure (6)

**CARDIAC ARREST PROCEDURE(S)
STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba**

SOP: 060

REVIEWED AND APPROVED BY:	
_____ Officer In Charge	_____ Date
IMPLEMENTED BY:	
_____ Director for Administration	_____ Date
_____ Senior Enlisted Advisor	_____ Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
SOP REVISION LOG:	
Revision to Page: _____	Date: _____
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Enclosure (7)

<p style="text-align: center;">DETAINEE HOSPITAL GUANTANAMO BAY, CUBA</p> <p>Title: BLOCK NURSE</p>	<p>SOP NO: 061</p>
<p>SCOPE: Detention Hospital</p>	

I. PURPOSE: The nurse assigned to this position provides nursing oversight to care provided outside the Delta Clinic, including Medication Administration and Block Sick Call. The nurse provides an indispensable liaison relationship with the Delta Clinic between the corpsmen and the medical providers. The nurse fulfills one of the main functions of Navy Nurses, that of training corpsmen. Additionally, the nurse serves as an intermediary for issues that arise between the corpsmen and detainees and MPs.

II. NURSING DUTIES AND RESPONSIBILITIES:

- Direct observation of first medication administrations by newly reporting corpsmen.
- Direct observation of the medical care administered during detainee incidents that require the intervention of the Emergency Response Team (ERT).
- Safety observer during evolutions requiring the intervention of the ERT.
- Spot monitoring of corpsmen encounters.
- Serve as resource for the corpsmen.
- Observation of patient encounters, including OpSec, customer service.
- Oversight of block sick call.
- Identification of just-in-time training needs. Provision of group and individual training as needed.
- Documentation of corpsmen performance in anecdotal or narrative format.
- Assist in clinic after completion of morning med pass and sick call. Priorities will be reviewing Medication Administration Records and SOAP notes.
- Early identification of problem areas on blocks, and provision of potential solutions.
- Potentially establish skilled nursing block for patients who require frequent observation, but not hospitalization.
- Establish a relationship with the MP's on the block to establish positive communications channels between medical and non-medical entities.
- Provide continuity of care in a challenging environment.

- Hours will generally be during the daytime (0800-2000), Monday through Saturday. When staffing permits, a block nurse can be assigned to the night shift.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____ Officer In Charge	_____ Date
IMPLEMENTED BY:	
_____ Director for Administration	_____ Date
_____ Senior Enlisted Advisor	_____ Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
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ENTIRE SOP SUPERSEDED BY:	
Title: _____	
SOP NO: _____	Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 066
Title: Multi-Dose Vials	Page 1 of 2 Effective Date: 1 April 2004
SCOPE: Detention Hospital, Delta Clinic, Delta Block	

I. POLICY:

Single dose vials will be utilized for patient medication administration across the Detainee Hospital and Delta Clinic. The only exceptions to this policy will be the use of multi-dose vials for:

- PRN medication administration
- Treatment of a single patient (i.e. use of a multi-dose vial for one specific patient only)
- Vaccines

II. PROCEDURE:

When using a multi-dose vial (MDV) the following procedures are followed to eliminate the risk of contamination:

1. Label the MDV with the date of entry (month, day and year), along with administrator's initials.
2. Use strict aseptic technique.
3. Thirty days after opening, discard any MDV that requires the addition of a diluent, unless the manufacture's stability data dictates otherwise.
4. Discard any opened MDV that does not require addition of a diluent on the expiration date specified by the manufacturer's label.
5. Discard contaminated vials immediately upon detection.
6. Do not store MDV in the refrigerator unless required to do so by the manufacturer.

III. ADDITIONAL INFORMATION

1. Detention Hospital Standard Operating Procedure 21- Infection Control

TITLE:

**SOP:
Page 2 of 2**

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge

Date

IMPLEMENTED BY:

Director for Administration

Date

Senior Enlisted Advisor

Date

ANNUAL REVIEW LOG:

By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 068
Title: EMERGENCY MEDICAL TREATMENT SOP	Page 1 of 25 Effective Date: May 2004
SCOPE: Detention Hospital, Delta Medical Clinic	

I. MISSION

To provide standardized emergent treatment to military and detainee personnel secondary to illness or injury.

II. OVERVIEW

Accident, injury or illness can occur at any time. By utilizing a standardized set of treatment principles and actions, the overall incidence of morbidity and mortality can be reduced. Also, by providing medical care utilizing protocols emergent treatment can be initiated in the absence of a medical officer and can be continued until a medical provider is contacted via phone or is present at the scene.

III. PROCEDURES

- 1) All nurses and corpsmen will receive training on protocol usage.
- 2) Once initial training is completed, shift nurses will be able approve corpsmen on protocol usage and medications specifically administered by hospital corps staff.
- 3) Newly arriving personnel must be approved on protocol usage prior to being assigned to an emergency response team (ERT).
- 4) Nurses and shift leaders will conduct ongoing protocol and medical refresher training.
- 5) Hospital corps staff will have this training annotated in their training record while at JTF GTMO.
- 6) Protocols are only in effect in the absence of a credentialed medical provider. Medical providers may modify, supercede or negate any protocol once the patient is under his or

her care.

ALTERED MENTAL STATUS

Common Causes:

- 1) Assure ABC's
- 2) Provide supplemental O2 to maintain SpO2 > 92%
- 3) Obtain vascular access
- 4) If dehydration or hypoperfusion evident, go to **REHYDRATION/SHOCK PROTOCOL**
- 5) Obtain FSBS:

- Alcohol
- Epilepsy
- Infection
- Overdose
- Uremia
- Trauma, Temperature
- Insulin (Hyper/Hypoglycemia)
- Psychogenic, Poison
- Shock, Stroke (CVA)

60-300 mg/dl: monitor

> 300 mg/dl: - give 250 ml NS fluid bolus(s) to maintain SBP > 90 mmHg

< 60 mg/dl: - give 1-2 tubes oral glucose if alert and able to maintain own airway (C)/(N)

If unresponsive or unable to maintain own airway:

- give *Thiamine* 100 mg IVP (N) if malnourished or pt is on hunger strike
- *D50W* 25 grams IVP (N) or *Glucagon* 1mg IM (C)/(N) if IV not established

- 6) *Naloxone* 0.4-2mg IVP (N) titrated to effect for suspected narcotic overdose
- 7) If seizures evident, go to **SEIZURE PROTOCOL**
- 8) Consider *Flumazenil* for barbiturate overdose **
- 8) Continue to monitor, transport to clinic, and contact MO for medical oversight.

** Contact MO for guidance regarding risk for seizures and dosing amounts

ALLERGIC/ANAPHYLACTIC REACTION

- 1) Assure ABC's
- 2) Provide supplemental O₂ to keep SpO₂ > 92%
- 3) Obtain vascular access
- 4) *Diphenhydramine* 50mg IM (C) or 25-50mg IVP (N)
- 5) If hypotensive or respiratory distress evident:
 - EKG monitor
 - *Epinephrine* 1:1000 0.3mg SC (C)/(N) **
 - *Albuterol* 2.5mg/5cc NS via HHN (C)/(N)
 - 250 cc NS bolus(s) to maintain SBP > 90 mmHg
 - *Solumedrol* 125mg IVP (N)
- 6) Continue to monitor, transport to clinic, and contact MO for medical oversight

HHN= hand held nebulizer

** Use Epinephrine with caution in persons with known cardiac history or > 40y old

BURNS

- 1) Extinguish flames and ensure scene safety.
- 2) Go to **ADVANCED AIRWAY PROTOCOL** if inhalation injury present
- 3) Give supplemental O₂ to keep SpO₂ > 92%
- 4) Remove smoldering clothing and constricting jewelry
- 5) Evaluate burn extent using “Rule of Nines”
- 6) Attempt to remove offending agent:
 - Dry chemical: Brush off. Irrigate for 20 min with H₂O
 - Liquid chemical: Irrigate for 20 min with H₂O
- 7) Cover with burn sheets or dry, sterile dressing
- 8) Obtain vascular access
- 9) 250 ml NS bolus(s) to maintain SBP > 90 mmHg (Keep I/O total for burn formula calculation)
- 10) *Morphine sulfate 2-4 mg IM (C) or IVP (N) q 5 min to a max of 10mg for pain control.*
- 11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

CHEST PAIN

- 1) Assure ABC's
- 2) If having difficulty breathing, go to **DIFFICULTY BREATHING PROTOCOL**
- 3) Give O₂ 2-4 lpm via NC or as needed to keep SpO₂ > 92%
- 4) 3-lead EKG monitor
- 5) Obtain IV access and draw "Rainbow" lab panel
- 6) *ASA* 324 mg PO (C)/(N) X (2) doses. (Chew first dose, swallow second dose)
- 7) NS 250 ml bolus(s) to maintain SBP > 90 mmHg **
- 8) *Nitroglycerin* 0.4 mg SL (C)/(N) q 5 min up to a max of three doses *
- 9) 12 Lead EKG
- 10) *Morphine sulphate* 2-4 mg IVP (N) q 5 min (max 10 mg) titrated for pain relief
- 11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* Check blood pressure in between nitroglycerin doses. Withhold nitroglycerin if SBP < 90mmHg

** If evidence of right ventricular failure (hypotension, JVD, pitting edema), withhold nitroglycerin and morphine. Contact MO ASAP for medical oversight.

DEHYDRATION

- 1) Assure ABC's
- 2) Vital signs with Tilts. (A decrease in 10 pts for B/P or increase of the HR of 20 points means pt is tilt positive) You may just follow HR and response vice complete set of tilts.
- 3) Draw CBC, and Chem 7 to be sent stat, if detainee does not respond to 2 liters of IV fluids. May D/C labs if detainee is tilt negative. There is no need for IVF.
- 4) Two liter bolus of NS or LR.
- 5) Finger stick. If blood glucose is less than 60 then start second IV line and infuse D5W @ 200cc / hr for total of 400cc and Thiamine 100mg IM/IVPB and call MO.
- 6) Pulse ox. If pulse ox is less than 95% administer O2 and call MO if hadn't done so already.
- 7) May D/C to block if re-tilt is negative. You may re-tilt after first IV bag.
- 8) If re-tilt positive, call MO if hadn't done so already.
- 9) Please call MO for any concerns or questions.

DIFFICULTY BREATHING

- 1) Assure ABC's
- 2) If respiratory failure is imminent, got to **ADVANCED AIRWAY PROTOCOL**
- 3) Provide supplemental O₂ to keep SpO₂ > 92%
- 4) If anaphylaxis is present, got to **ALLERGY/ANAPHYLAXIS PROTOCOL**
- 5) If rales present or history of cardiac/MI:

- EKG monitor
- Obtain vascular access with "Rainbow" blood draw
- *Nitroglycerin* 0.4 mg SL (C)/(N) q 5 min X 3 doses
- *Lasix* 0.5-1 mg/kg IVP (N)
- *Albuterol* 2.5 mg/ 5cc NS via HHN if active wheezing present

If history of COPD, asthma, wheezes or diminished breath sounds:

- *Albuterol* 2.5 mg/5 cc NS via HHN (C)/(N)

If no improvement:

- *Albuterol* 2.5 mg/5cc NS/ *Atrovent* 0.5mg/5cc NS via HHN (C)/(N)
- Obtain vascular access
- *Solumedrol* 125 mg IVP (N)
- Repeat *Albuterol* 2.5 mg/5cc NS via HHN (C)/(N)

- 6) Continue to monitor, transport to clinic, and contact MO for medical oversight

HHN= Hand Held Nebulizer

DIVING MEDICAL DISORDERS

Mild Sx's: Extremity pain, itching

Serious Sx: Visual disturbances

Ear pain, vertigo

Focal weakness

Vision difficulty

Speech difficulty

Numbness, tingling

Mental status changes

Seizure

Cardiac arrest

1) Assure ABC's

2) Obtain diving history:

- depth of dive
- total diving time (time leaving surface until time reaching surface= total dive time)
- time spent at bottom
- ascent time
- type of mixture (air, NITROX, helium/oxygen mixture, etc.)
- any complications during dive

3) NRB 10-15 lpm O2

4) Obtain IV access

5) Transport supine on spine board to NH GTMO for eval

Important Numbers:

Dive Locker: (b)(2)

Dive Supervisor: (b)(2)

ELECTRICAL/LIGHTNING INJURIES

- 1) Ensure scene safety
- 2) Assure ABC's
- 3) Consider spinal immobilization
- 4) If cardiac arrest or bradycardia present, refer to appropriate protocol
- 5) 3-lead EKG monitor
- 6) Obtain vascular access with "Rainbow" lab draw
- 7) 250 ml NS bolus(s) to maintain SBP > 90 mmHg
- 8) 12-Lead EKG
- 9) If burn injury present, go to **BURN PROTOCOL**
- 10) Continue to monitor, transport to clinic, and contact MO for medical oversight

HYPERTHERMIA

- 1) Assure ABC's
- 2) If respiratory failure is imminent, go to **ADVANCED AIRWAY PROTOCOL**
- 3) Remove from environment
- 4) Provide supplemental O₂ to maintain SpO₂ > 92%
- 5) If altered LOC or rectal temp > 104 F:
 - FSBS (if less than 60 mg/dl, got to **ALTERED MENTAL STATUS PROTOCOL**)
 - obtain vascular access with "Rainbow" blood draw
 - Infuse 2 L IV NS bolus (C)/(N)
 - Aggressive cooling measures (ice to arm pits and groin, water and direct wind from fan, etc.)
 - Discontinue aggressive cooling measures when core temp reaches 101 degrees F

Heat Exhaustion

- Place in air-conditioned environment
- Infuse 2L IV NS bolus (C)/(N)

Heat Cramps:

- Encourage PO intake
- Educate need for increase fluid requirements while operating in hot environment

- 6) 250ml NS bolus(s) to maintain SBP > 90 mmHg
- 7) Continue to monitor, transport to clinic, and contact MO for medical oversight

NAUSEA AND VOMITING

- 1) Assure ABC's
- 2) Provide supplemental O2 to keep SpO2 > 92%
- 3) If dehydration or hypoperfusion evident, go to **REHYDRATION/SHOCK PROTOCOL**
- 4) Obtain vascular access as needed
- 5) If active nausea and vomiting present:
 - *Phenergan* 25mg IM (C)/(N) or 12.5-25mg IVP (N)
 - or
 - *Zofran* 4mg IVP (N)
- 6) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

POISONING/OVERDOSE

- 1) Assure ABC's
- 2) Obtain history:
 - type and amount of poison
 - route (ingested, inhaled, injected or through skin surface contamination)
 - time poisoned
 - has patient vomited? When?
 - history of drug or ETOH usage?
 - PMH
- 3) In unresponsive or altered mental status, got to **ALTERED MENTAL STATUS PROTOCOL**
- 4) If seizing, got to **SEIZURE PROTOCOL**
- 5) If anaphylaxis or allergic reaction suspected, go to **ANAPHYLAXIS/ALLERGIC REACTION PROTOCOL**
- 6) If inhaled poison:
 - expose to fresh air/remove from environment
 - administer 100% O₂ via NRB
- 7) If skin surface contaminated:
 - Dry Chemical
 - brush off particles
 - irrigate with H₂O for 20 min
 - Liquid Chemical
 - irrigate area with H₂O for 20 min
- 8) Ingested poison (non acid, alkali, or other caustic substance):
 - if acid, alkali or other caustic substance, proceed to step 9
 - if < 30 min after poison ingestion, give 1 gram/kg Activated Charcoal PO (if tolerated)

- place NG tube if unable to tolerate PO
 - if > 30 min since ingestion, monitor and proceed to step 9
- 9) Contact Poison Control Center or obtain MSDS sheets as needed
- 10) Continue to monitor, transport to clinic, contact MO ASAP for medical oversight

SEIZURE

- 1) Assure ABC's
- 2) Protect patient from injury
- 3) If respiratory failure is imminent, proceed to **ADVANCED AIRWAY PROTOCOL**
- 4) Obtain FSBS. If less than 60 mg/dl, go to **ALTERED MENTAL STATUS PROTOCOL**
- 5) If patient is actively seizing > 10 min:
 - obtain vascular access
 - *Diazepam* 2-10mg IVP (N) ** or *Lorazepam* 2-5 mg IVP (N) **
- 6) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

** If unable to obtain IV access, may administer Diazepam via rectum

GENERAL TRAUMA PROTOCOL

1) Assure scene safety

2) Perform primary assessment:

A - ensure open airway with c-spine control
- if respiratory failure imminent, go to **ADVANCED AIRWAY PROTOCOL**

B - IAPP and ensure adequate respiratory function
- provide supplemental O₂ to keep SpO₂ > 92%
- if S/S of tension pneumothorax evident, perform needle thoracentesis

C - stop all life-threatening hemorrhage
- perform “blood sweep”

D - AVPU or GCS
- ongoing mental status checks

E - expose all suspected injury areas
- prevent hypothermia and shock from excessive exposure

F - full set of vital signs (including SpO₂ and pain assessment)
- EBL to determine blood loss

3) Secure airway using **ADVANCED AIRWAY PROTOCOL** if needed

4) Obtain venous access and infuse NS via bolus(s) to maintain SBP > 90 mmHg

- 5) Perform secondary assessment and treat all associated injuries
- 6) *Morphine sulfate* 2-5mg IM (C)/(N) or 2-5mg IV (N) PRN for pain (maximum 10mg) titrated to effect
- 7) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

CARDIAC ARREST PROTOCOL FOR NON-ACLS PROVIDERS

AUTOMATED EXTERNAL DEFIBRILLATION (AED) FOR NON-ACLS PERSONNEL

- 1) Establish pulselessness
- 2) Contact Delta Clinic or Detention Hospital and call “Code Blue”
- 3) Start CPR utilizing BVM and 100% O₂.
- 4) Turn AED on
- 5) Attach electrodes
- 6) Analyze rhythm

If shock indicated:

- give (3) “stacked shocks”
- continue CPR for (1) minute
- maintain airway control utilizing **ADVANCED AIRWAY PROTOCOL** and establish IV access
- **Epinephrine** 1:10,000 1mg IVP (N) or 2.5 mg ETT (N) q 3-5 min
- analyze rhythm
- give (3) “stacked shocks” if needed
- continue CPR for (1) minute
- **Lidocaine** 1-1.5 mg/kg IVP (N) or 2-3 mg ETT (N) to a maximum of 3 mg/kg
- analyze rhythm
- give (3) “stacked shocks” if needed
- continue CPR, monitoring and delivering drug, shock, drug, shock, etc.

If no shock indicated:

- continue CPR
- maintain airway control and establish IV access
- **Epinephrine** 1:10,000 1mg IVP (N) or 2.5mg ETT (N) q 3-5 min
- continue CPR
- **Atropine** 1mg IVP (N) or 2mg ETT (N) q 5min (max of 3mg)

- continue CPR, monitoring with AED and proceed to "If shock indicated" if shock

7) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

8) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight.

**EMERGENCY CARDIAC
CARE PROTOCOLS FOR
ACLS PROVIDERS**

ASYSTOLE

- 1) Establish unresponsiveness
- 2) Begin CPR with BVM and 100% O₂
- 3) 3-lead EKG monitor
- 4) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**
- 5) Obtain vascular access
- 6) *Epinephrine* 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min
- 7) Continue CPR
- 8) *Atropine* 1mg IVP or 2mg ETT (C)/(N) q 3-5 min (max 3 mg)
- 9) Continue CPR
- 10) If spontaneous return of pulse, go to **POST RESUSCITATION PROTOCOL**
- 11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

Possible Causes

- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hypothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

BRAYDCARDIA

- 1) Assure ABC's
- 2) Provide supplemental O₂ to keep SpO₂ > 92%
- 3) EKG monitor
- 4) If 2nd degree Type II or 3rd degree Heart Block present with signs of hypoperfusion, consider early transcutaneous pacing (TCP)
- 5) Obtain vascular access
- 6) *Atropine* 0.5-1mg IVP (N) titrated to effect (maximum 3mg)
- 7) If patient fails to respond to atropine, consider transcutaneous pacing (TCP)
- 8) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

PULSELESS ELECTRICAL ACTIVITY (PEA)

- 1) Establish pulselessness
- 2) Begin CPR with BVM and 100% O₂
- 3) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**
- 4) Obtain vascular access
- 5) *Epinephrine* 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5 min
- 6) Continue CPR
- 7) *Atropine* 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5 min (maximum 3mg) **
- 8) Continue CPR
- 9) Rule out causes of PEA and treat according to appropriate protocol
- 10) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**
- 11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

Possible Causes

- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hypothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

** Give atropine for electrical heart rate < 60 bpm

TACHYCARDIA- NARROW COMPLEX

- 1) Assure ABC's
 - 2) Provide supplemental O2 to keep SpO2 > 92%
 - 3) 3-lead EKG monitor
 - 4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
 - synchronized cardioversion (100J, 200J, 300J, 360J) *
 - if pulseless go to appropriate protocol
 - 5) Obtain vascular access
 - 6) 12 Lead EKG
 - 7) If pulse > 150 bpm and without signs of hypoperfusion, attempt vagal maneuver **
 - 8) If signs of deteriorating mental status or hypoperfusion present
 - synchronized cardioversion (100J, 200J, 300J, 360J) ***
 - if pulseless go to appropriate protocol
 - 9) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight
-

* May start at 50J for Atrial Flutter

** Vagal maneuvers should not be attempted on the following:

- history of transient ischemic attack (TIA)/ cerebral vascular accident (CVA)
- previous neck surgery
- neck cancer
- history of aortic stenosis
- known carotid artery blockage

*** If possible, provide sedation with analgesia:

- *Versed* 1-2mg IVP (N)
- *Morphine Sulfate* 2-4mg IVP (N)

TACHYCARDIA-WIDE COMPLEX

- 1) Assure ABC's
- 2) Provide supplemental O2 to keep SpO2 > 92%
- 3) 3-lead EKG monitor
- 4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
 - synchronized cardioversion (100J, 200J, 300J, 360J) *
- 5) Obtain vascular access
- 6) 12 Lead EKG
- 7) *Lidocaine* 1-1.5 mg/kg slow IVP (N) over 2 min **
- 8) If rhythm does not spontaneously convert to sinus within 10 min:
 - *Lidocaine* 0.5-0.75 mg/kg slow IVP (N) over 2 min **
- 9) If patient becomes pulseless, go to **VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA PROTOCOL**
- 10) If patient develops sign of altered mental status or hypoperfusion:
 - synchronized cardioversion (100J, 200J, 300J, 360J) *
- 11) If patient converts to sinus rhythm, start *Lidocaine* drip 2-4 mg/min
 - Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* If possible, provide sedation with analgesia:

- *Versed* 1-2mg IVP (N)
- *Morphine Sulfate* 2-4mg IVP (N)

** Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA

- 1) Establish pulselessness
- 2) Contact Delta Clinic or Detention Hospital and call "Code Blue"
- 3) EKG monitor
- 4) Defibrillate at 200J, 300J, 360J
- 5) CPR with BVM and 100% O₂
- 6) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**
- 7) Obtain venous access
- 8) *Epinephrine* 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min
- 9) Continue CPR
- 10) Defibrillate at 360J
- 11) *Lidocaine* 1-1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) *
- 12) Continue CPR
- 13) Defibrillate at 360J
- 14) *Lidocaine* 1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) * (maximum 3mg/kg)
- 15) Continue CPR
- 16) Defibrillate 360J
- 16) Continue "drug-shock" sequence with defibrillation every 30-60 seconds after drug administration
- 17) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**
- 18) Continue to monitor, transport to clinic, and call MO ASAP for medical oversight

* Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

POST RESUSCITATION

- 1) Assure ABC's
- 2) Assess heart rate:
 - if heart rate < 60 bpm, go to **BRADYCARDIA PROTOCOL**
 - if heart rate > 150, go to **NARROW or WIDE TACHYCARDIA PROTOCOL**
- 3) If patient is hypotensive and lung sounds are clear:
 - give 250ml NS bolus(s) to maintain SBP > 90 mmHg
 - consider *Dopamine* 5-10 mcg/kg/min to maintain SBP > 90 mmHg if unresponsive to fluid bolus(s)
- 4) If patient V-FIB or V-TACH during resuscitation:
 - give *Lidocaine* 1.5 mg/kg slow IVP (N) over 2 minutes (if not previously given) *
 - start *Lidocaine* drip at 2-4 mg/min
- 5) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

* Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge

Date

IMPLEMENTED BY:

Director for Administration

Date

Senior Enlisted Advisor

Date

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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA Title: MEDICAL CARE AT CAMP 5	SOP NO: 070 Page 1 of 3 Effective Date: 1 May 04
SCOPE: Detention Hospital	

I. Overview

The Detention Hospital provides medical officers and a pool of “special duty” corpsman to care for detainees at Camp 5. Detainees continue to receive quality health care. They are offered sick call every other day, issued medications, and provided appropriate preventive services.

Additionally, emergency coverage is provided twenty-four hours per day, seven days per week.

Delta Clinic serves as the Point of Contact for all medical issues. A qualified nurse and team of corpsmen staff the clinic seven days a week. Medical officers are either in camp or on call. The Detention Hospital or Detainee Acute Care Unit is available for detainees requiring in-patient care.

II. Definitions

A medical emergency is any injury or illness perceived to be a risk to the patient’s life, limb, or eyesight. (b)(2)

An urgent condition is one in which the patient demonstrates an altered mental status or has suffered significant trauma and could become unstable if care is not provided (within 24 hours). (b)(2)

(b)(2)

Routine cases include everything else, and will be seen within 48 hours. Blood on a tissue does not equate to hemorrhage, and will be seen routinely.

A Mass Casualty is any group of injuries or illnesses that exceeds the ability of the staff on hand. (b)(2)

(b)(2)

III. Sick Call

Sick call will be performed every other day, as it is done in Camp Delta. Corpsmen will check with the SOG for known complaints, and then walk the blocks scheduled for that day. Medications will be passed at the same time.

Corpsmen will conduct a thorough history and a focused examination. If a higher level of care is required, they will contact the duty Medical Officer to develop a plan of care. Labs may be drawn, and the MO will examine the patient as needed.

Medical records are kept in Delta Clinic. Medical files are numerical by ISN, but Camp 5 (b)(2) Camp Delta.

IV. Non-routine Medical Care

In the event the MP staff determines a detainee has an urgent or emergent problem requiring medical evaluation before the next scheduled visit, the Control Room will report this to DOC. DOC will call Delta Clinic at (b)(2). The shift nurse will dispatch a corpsman if appropriate, and/or consult with the medical officer.

V. Mass Casualties

Multiple casualties present serious problems for security as well as medical personnel. Security concerns take precedence. MPs will (b)(2) and notify DOC with the number of detainees involved and the extent of injuries, providing as much detail as possible. DOC will call Delta Clinic at (b)(2) and provide authorization to institute a recall.

The shift RN at Delta Clinic dispatches corpsmen, and may accompany the team if ACLS/ATLS care is indicated. The medical officer on duty is paged. Delta Clinic must pass along factual details to allow a determination of which other resources will be called in. Meanwhile, the responding medical team must triage patients (b)(2) (b)(2). Priority of care is then given to the immediate category of patients, then the delayed, minimal and expectant. Medical officers arrive on scene and provide care on-site, then arrange any needed transport to the Detention Hospital or Detainee Acute Care Unit.

VI. IMPORTANT NUMBERS

(b)(2)

PAGERS:

(b)(2), (b)(6)

NAVAL HOSPITAL

(b)(2)

TITLE: Medical Care at Camp 5

SOP:
Page 3 of 4

VII. References

JDOG SOP for Camp 5
Mass Casualty SOP, Detention Hospital 025

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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SOP NO: _____	Date: _____

DETENTION MEDICAL GUANTANAMO BAY, CUBA	SOP NO: 079
Title: DETAINEE SUICIDE ATTEMPT	Page 1 of 3 Effective Date: 12 Aug 03 Revised: Feb 2005
SCOPE: DETENTION MEDICAL	

ENCLOSURES

- (1) Self-Injurious Behavior Definitions
- (2) Sample slide

I. BACKGROUND:

- Suicide Attempts can be expected in any detained population. The longer the detention period, and more uncertain the future, the greater the likelihood of the attempts.

II. DEFINITION OF SUICIDE ATTEMPT

- Behavior that has potential for serious self-harm and is lethal, planned, and serious, e.g. jumping off building, use of firearms, and actually hanging. There is usually not a 'rescuer' available and patient is found/stopped by accident.

III. POLICY

- Joint Task Force (JTF) Guantanamo policy is to report Detainee Suicide Attempts within 3-hours of the attending physician's determination (confirmation) of a suicide attempt. Upon notification of the attempt, it is the responsibility of the Medical Planner to ensure an updated and accurate Suicide Attempt Slide is forwarded to the JTF Commanding General, US Southern Command Surgeon (SOUTHCOM/SG), JTF Joint Operations Center (JOC) Watch Officer, and the JTF SJA and PAO. Enclosure (2) is the format for the slide submission, which is sent via the JMG Commander.

IV. PROCEDURES:

- Upon notification of an actual suicide attempt, the Detention Hospital Medical Officer will provide the Detention Hospital OIC, JMG Commander and the Medical Planner the following information—detainee number, number of previous attempts, method of attempt, i.e. hanging, and detainee's current medical status.

- A narrative summary will be prepared by the attending physician, reviewed by the JTF Surgeon, and forwarded to the JTF Commanding General, Staff Judge Advocate, and SOUTHCOM/SG. (Depending on the time of the incident, the summary is normally available for review by the JTF Surgeon the following day.)

V. IMPLEMENTATION:

- In-place.

STANDING OPERATING PROCEDURES

Medical Plans and Operations

Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge

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IMPLEMENTED BY:

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Date

Senior Enlisted Advisor

Date

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Title: _____
SOP NO: _____ Date: _____

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 080
Title: HANDLING OF THE KORAN/QURAN	Page 1 of 2 Effective Date: 14 JUN 05
SCOPE: DETENTION HOSPITAL	

REFERENCE: (a) Camp Delta SOP
(b) United States Southern Command News Release dtd 03 Jun 05

I. BACKGROUND: The majority of detainees at Camp Delta practice the Muslim religion and therefore use the Koran/Quran as their guide for the Muslim faith. The Koran/Quran, or last revealed word of God, is the primary source of every Muslim's faith and practice. It deals with all subjects that concern the relationship between God and His creatures, wisdom, doctrine, worship, transactions, law, etc. The way Detention Hospital staff interacts with and handles the Koran/Quran is very sensitive, and must be taken seriously.

II. POLICY:

- a. Detention Hospital personnel will not touch or handle the Koran.
- b. In the event that the Koran must be moved, and the detainee is unable to accomplish that movement secondary to a medical condition, the Chaplain or Muslim interpreter will be contacted to assist following guidelines outlined in reference (a) and (b).
- c. Ensure that the Koran is not placed in offensive areas such as the floor, near the toilet or sink, near the feet, or dirty /wet areas.
- d. Do not disrespect the Koran. This could potentially lead to a lack of cooperation from the detainees and could provoke a violent reaction from the detainee.

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

Officer In Charge Date

IMPLEMENTED BY:

Director for Administration Date

Senior Enlisted Advisor Date

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ENTIRE SOP SUPERSEDED BY:

Title: _____
SOP NO: _____ Date: _____

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 081
Title: Restraint Policy for Non-Psychiatric Detainees	Page 1 of 11 Effective Date: 04 Oct 05
SCOPE: DETENTION HOSPITAL	

- Enclosure:** (1) Medical Restraints Summary
(2) Restraint Observation Sheet
(3) Continuation Nursing Note
(4) RN Initiation Note
(5) MO Initiation Note
(6) Restraint Orders

I. BACKGROUND:

It is the Detention Hospital policy to deliver proper and humane care to all detainees while observing their basic human rights. Use of restraints temporarily restricts those rights. Restraints are limited to emergencies in which there is an imminent risk of a detainee harming themselves or others. This may include situations where detainees refuse to eat or drink, and in the opinion of a Medical Officer, such refusal puts them at risk of death or serious physical harm. In that situation, if the detainee demonstrates that he will not allow placement of the appropriate devices for resuscitation or feeding, or removes those devices when not restrained, medical restraints may be utilized. Restraints are to be used only after other less restrictive interventions have been unsuccessful or not viable.

As per Detention Hospital SOP # 001, involuntary feeding of detainees who are refusing to take food or fluids can only be initiated after the JTF Commander has granted authorization.

II. DEFINITIONS:

A. Acute Medical and Surgical Restraint: refers to the intended use of a device (such as physical restriction), its involuntary application, and/or the identified detainee need.

1. **Restraint.** Direct application of physical force or devices to a detainee, with or without the detainee's permission, to restrict his or her freedom of movement.

TITLE:**SOP:****Page 2 of 11**

2. **Supportive Devices.** Mechanisms that temporarily restrain, restrict, or limit an individual's physical movement or activities as part of a planned regimen of medical treatment and care. Use of these devices includes medical immobilization, adaptive support mechanisms, and protective devices. For a supportive device to be applied, voluntary consent from a cognitively intact detainee must be obtained.

(a) **Medical Immobilization.** Mechanisms considered as usual and customary when employed during medical, diagnostic, or surgical procedure or tests. Examples: Mechanisms that support the body during surgery; arm boards used during intravenous administration; and supportive devices for postoperative and post-anesthesia care.

(b) **Adaptive Support.** Mechanisms intended to assist a detainee in achieving and maintaining optimum normative body functioning. Examples: Orthopedic appliances; braces; wheelchairs; and appliances or devices used for postural support of the detainee.

(c) **Protective Device.** Mechanisms intended to compensate for a specific physical deficit or to prevent safety incidents not related to cognitive dysfunction. Examples: Bed rails; tabletop chairs; protective helmets; and halter-type devices (i.e. to prevent a cognitively intact detainee from falling out of bed at night).

3. **Custodial Restraints.** While medical staff will ensure the safety and health of detainees in custodial restraints, restraints ordered by custodial staff are not covered under this standard.

B. Licensed Independent Practitioner (LIP). For the purposes of this directive, an attending physician or psychologist who is permitted by law and by the hospital to provide detainee care services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

III. PROCEDURES:

1. Restraints are indicated in the following situations:

(a) In an emergency situation when a detainee is in imminent risk of injuring self or others.

(b) To prevent significant harm to a detainee during the treatment of certain specific conditions (eg. post-traumatic brain injury) or during their use of certain specific clinical procedures (eg. intubation).

(c) Medical restraints to allow the placement of appropriate devices for resuscitation or feeding if the detainee has refused to voluntarily take food/fluids, and the Medical

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Officer determines such actions have put the detainee in danger of death or serious physical harm. In the case of Involuntary Feeding, this can only be initiated with JTF Commander Authorization.

2. Efforts must be made to determine and treat the cause of the detainee's behavior necessitating restraints. Restraints are not to be used as a substitute for direct care, observation, or medical intervention.
3. Prior to application of restraints, appropriate alternatives or less restrictive means must be considered or attempted. Less restrictive measures may include increasing detainee-to-nurse interaction, special watches, closer supervision, distraction, involvement in activities, medications, negotiation, limit setting, problem solving, redirection, decreasing environmental stimuli, removal from the area, detainee education, increased staff, and social conversation. At no time will less restrictive measures justify endangering other detainees, staff, visitors or delay timely medical treatment.
4. Removal of restraints is done in an orderly sequence that allows the detainee opportunity to regain and maintain internal control. Behavior to be evaluated for release from restraints may include:

(b)(2)



5. When restraint is terminated early and the same behavior re-emerges, restraints may be reapplied under the original order within the time limits of the order if alternative means are not effective in controlling the behavior.

6. **Practice Authority**. A licensed independent practitioner orders the use of medical restraints. When the LIP is not immediately available, a registered nurse may initiate the use of restraints before an order is obtained from the LIP. As soon as possible, but no longer (b)(2) after the initiation of restraints, a qualified registered nurse notifies and obtains an order (verbal or written) from the LIP and consults with the LIP about the detainee's physical and psychological condition.

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(a) **Attending Physician.** Primarily responsible for the detainee's overall care and ongoing assessment. Must assess any detainee put into restraints for behavioral reasons (b)(2) for any detainee put into restraints for medical reasons.

(b) **Registered Nurse.** Responsible for observation of a restrained detainee, assessment of the physical and emotional needs of the detainee, re-evaluation of the need for continuation of restraints, documentation, and supervision of hospital corps staff, licensed practical nurses, and students.

7. **Critical Elements.** Critical elements of assessment, application, monitoring and documentation must be addressed when developing departmental practice guidelines.

A. Assessment of the detainee before, during and after application of restraints must include the following:

(b)(2)



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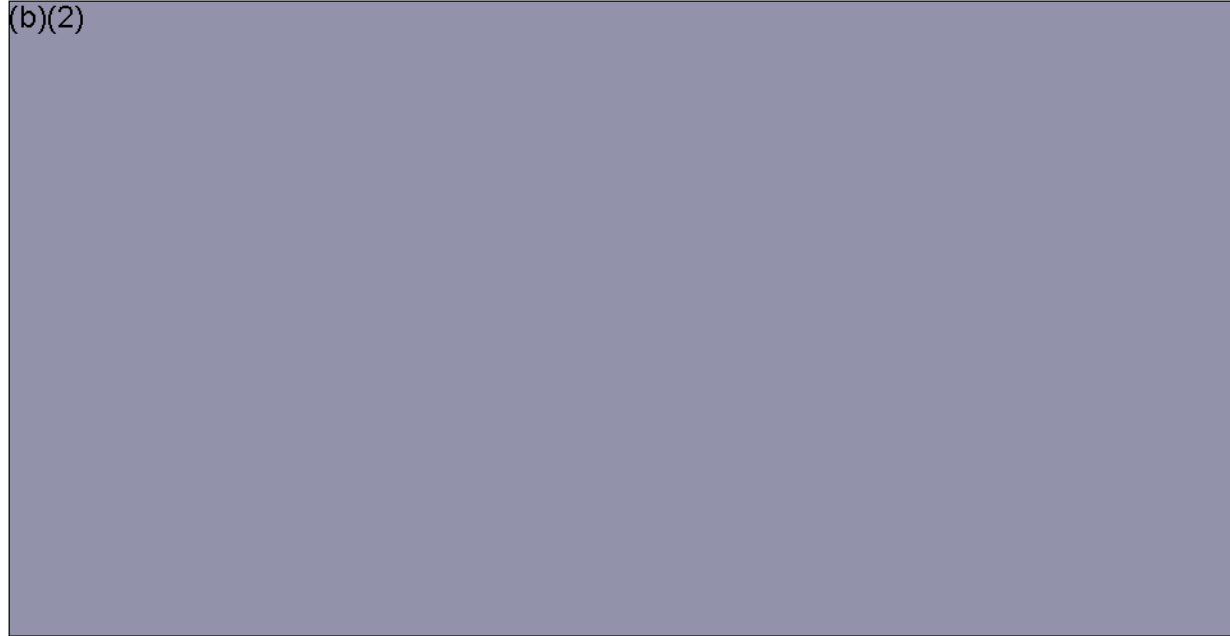
(b)(2)



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(b)(2)

**C. Monitoring and Detainee Care.**

(1) The monitoring process addresses physical and emotional needs of the detainee. This monitoring includes simple observation, vital signs, circulation checks, observation of the extremities, range of motion, emotional and physical response to restraints, food, hydration, and toileting needs. Other monitoring will be done as needed based on individual needs. Examples: Evaluation of IV site; cast checks; neurological exams; fetal heart rate; psychiatric; pediatric; geriatric; critical care detainees; etc. An observation sheet designed for documentation will be utilized, enclosure (2). An assigned staff member who is competent and trained in the following accomplishes monitoring through continuous in-person observation:

- (a) Understanding the underlying causes of threatening behaviors exhibited by the detainees they treat.
- (b) Aggressive behavior that is related to a detainee's underlying medical condition.
- (c) How their own behavior affects the behavior of their detainees.
- (d) The use of de-escalating techniques, mediation, self-protection, time out, etc.
- (e) How to recognize signs of physical distress in detainee who are being restrained, or secluded.
- (f) Taking vital signs and interpreting relevance.
- (g) Recognizing nutritional and hydration needs.

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- (h) Checking circulation and range of motion in the extremities.
- (i) Addressing hygiene and elimination.
- (j) Addressing physical and psychological status and comfort.
- (k) Assisting detainees in meeting behavioral criteria for discontinuation of restraints.
- (l) Recognizing readiness for discontinuation of restraints.
- (m) Recognizing signs of any incorrect applications of restraints.
- (n) Recognizing when to contact medically trained LIP or EMS in order to evaluate or treat the detainee's physical status.

(2) Detainee Care Minimum Intervals

(a) Continuously: The restrained detainee must be continuously observed. Unless contraindicated by the detainee's condition, such observation must include efforts to interact verbally with the detainee.

(c) (b)(2) Document detainee behavior.

(c) (b)(2) circulation checks

(d) (b)(2)

1 Fluids must be offered, or more frequently as requested.

2 Restroom use must be offered, or more frequently as indicated. If the detainee is combative or unpredictable, a plastic bedpan and/or urinal must be provided for use.

3 Detainees in restraints are to be turned, circulation and condition of the extremities checked. Restraints must be removed from each limb, one at a time, to perform range of motion exercises at least this frequently.

4 An RN will assess and document the detainee's condition (b)(2) while in restraints.

(e) (b)(2)

1 Vital signs

TITLE:**SOP:****Page 8 of 11**

2 Meals must be served at regular meal times using paper and plastic products.

(f) Daily.

1 Bathing and showering must be offered daily, or more often as needed, unless the detainee is hostile or unmanageable.

(g) Other Interventions.

1 Extra staff or security must be called to assist with detainee care, as needed to maintain detainee and staff safety.

2 An RN will assess the detainee's behavior for release from restraint as soon detainee demonstrates that internal control has been regained.

3 The OIC will be notified immediately when a detainee is put in restraints. The OIC will notify the JTF Surgeon. Thereafter, the JTF Surgeon will be notified (b)(2) if the restraints continue.

D. Documentation.

(1) The documentation requirement for a detainee requiring restraints must incorporate the critical elements of assessment, application and monitoring, and reflect concern for the detainee's humane needs, protection of rights and preservation of dignity.

(2) Each time a restraint is applied the following will be documented by a RN, see enclosures (3) and (4).

(a) Time and date restraint is applied.

(b) The detainee's behavior, verbalization or actions that lead to the need for external control.

(c) The types of less restrictive interventions that were attempted before restraint was applied, and the detainee's response to these less restrictive measures.

(d) That the detainee was told why restraint is being used.

(e) What the detainee was told the criteria for release from restraint.

(f) The detainee's response to restraint.

(b)(2)

(3) Each time a restraint is applied the LIP will document the following (encl. 5):

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(a) Any pre-existing medical condition or any physical disabilities that would place the detainee at greater risk during the restraint.

(b) Any history of sexual or physical abuse that would place the detainee at greater psychological risk during the restraint.

(c) Debriefing of detainee and staff. The debriefing will address behaviors or actions that led to detainee restraint and what could have been done differently, ascertain that the detainee's physical well being, psychological comfort and right to privacy were addressed, and counseling the detainee for any trauma that may have resulted and when indicated, modify the detainee's plan of care, treatment, and services.

8. Doctor's order

A. THE USE OF PRN ORDERS WHETHER INDIVIDUAL OR AS PART OF A PROTOCOL FOR DETAINEES WITH PRIMARY BEHAVIORAL HEALTH NEEDS IS PROHIBITED.

B. Doctor's orders, enclosure (6), for restraints must be written or verbally obtained from the LIP within (b)(2) of initiating the physical restraint. All orders for restraints are 'time limited'. The LIP who is primarily responsible for the detainee's ongoing care, or another LIP responsible for the detainee's ongoing care when the primary LIP is not available, conducts an in-person evaluation to the detainee within (b)(2) of the initiation of behavioral restraints and within (b)(2) of initiating medical restraint.

(1) Restraint orders for detainees with primary behavioral health needs are valid for (b)(2) and for medical restraints are valid for (b)(2). Time limited orders do not mean that the restraints must be applied for the entire length of time that the order is written. Discontinuation of restraints should occur soon as the detainee meets the behavior criteria for release.

(2) Reevaluation of the detainee in restraints. By the time the order for restraint expires the detainee will receive an in-person reevaluation conducted by the LIP primarily responsible for the detainee, another LIP when the primary LIP is not readily available or a Registered Nurse. In conjunction with reevaluation of the detainee the LIP gives a new written or verbal order which is time limited per paragraph 8b (1). The LIP conducts an in-person evaluation at least (b)(2) for behavioral restraints, and (b)(2) for medical restraints.

(3) The initial Doctor's note detailing the use of restraints must reflect:

(a) The behavior the detainee displayed necessitating restraints.

(b) All lower level interventions attempted prior to the detainee being restrained.

(c) The detainee's response to the restraints.

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(d) Plans for assisting the detainee to regain control.

(e) The explanations and instructions given to the detainee as well as the detainee's response to this information.

C. Acute Medical and surgical restraints:

(1) Initiated pursuant to either an individual order of a LIP or an approved protocol, the use of which is authorized by an individual LIP order.

(2) Continued use of restraint beyond (b)(2) is authorized by an LIP renewing the original order or issuing a new order if restraint use continues to be clinically justified. Such renewal or new order is issued no less often than once each calendar day and is based upon an examination of the detainee by the LIP.

9. **Interdisciplinary Resources**. For assistance in managing agitated, violent or confused behavior and using the least restrictive means possible, contact Behavioral Health Services.

10. **Staff Education and Training Department**. All JMG detention hospital personnel will be trained on restraints during their orientation week.

11. **Performance Improvement Processes**. Behavioral health services will review each episode of restraint, including reasons and documentation for adherence to these guidelines. The Executive Committee of the Medical Staff in conjunction with Performance Improvement will monitor the practice of restraint including detainee concerns, injuries that may have occurred during the process and peer review of the documented procedures. Use of restraints is a difficult, high-risk detainee care intervention and is continually monitored and reviewed.

V. **IMPORTANT NUMBERS:** (b)(2)

VI. REFERENCES

(a) 2003 Comprehensive Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(b) BUMEDINST 6010.17A

(c) Prison Health Standards: National Commission on Correctional Health Care

TITLE:

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STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

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MEDICAL RESTRAINTS SUMMARY
02 OCT 2005

Please refer to Detention Hospital SOP #15 regarding restraints, and the Restraint Letter regarding involuntary feeding. Below is a summary of the monitoring required for medical restraints.

Monitoring (Document on Standard Flowsheet):

1. Line of sight at all times.
2. Every (b)(2)
 - a. Circulation checks for (b)(2)
 - b. Visual observation
3. Every (b)(2)
 - a. Circulation checks after (b)(2)
4. Every (b)(2)
 - a. RN assessment must be conducted (b)(2) and a note written
 - b. Offer Restroom/bedside urinal
 - c. Range of Motion with full control one limb at a time.
 - d. Fluids offered (b)(2)
5. Every (b)(2)
 - a. Vital signs

Orders:

1. A Licensed Independent Practitioner (LIP) orders for restraints must be written or verbally obtained within (b)(2) of initiating restraints.
2. A LIP must evaluate the detainee (b)(2) of initiating restraints and if a verbal order was given for the restraints, sign that order.
3. A nursing note and LIP note must be completed. See standard forms.
4. Utilize standard order form for initiating restraints.
5. The initial order for medical restraints is valid (b)(2). An order for Behavioral Restraints is valid (b)(2). By the time the order for restraints expires, the patient will receive an in-person reevaluation conducted a LIP or a Registered Nurse.
6. For Medical Restraints, a LIP must do an in person evaluation at least (b)(2). For Behavioral Restraints, this evaluation must be done every (b)(2).

Enclosure (1)

(b)(2)

RESTRAINT OBSERVATION SHEET

(b)(2)

Date: _____ Limb Restrained: _____ Time In: _____ Time Out: _____ Limb Restrained: _____ Time In: _____ Time Out: _____
 Left arm _____ Left leg _____
 Right arm _____ Right leg _____

Observation: (every 15 minutes)*. Select the appropriate codes and initial each entry.

- | | | | |
|----------------------------|--------------------------|------------------------|-----------------------------------|
| 1. Line of sight | 7. Talking | 13. Quiet | 19. Crawling |
| 2. Beating or kicking door | 8. Mumbling incoherently | 14. Sleeping | 20. Noncommunicative |
| 3. Yelling or screaming | 9. Standing | 15. Requesting release | 21. Destructive Behavior |
| 4. Cursing | 10. Walking or pacing | 16. Harmful to self | 22. Disrobing |
| 5. Crying | 11. Lying down | 17. Threatening staff | 23. Urinating/defecating on floor |
| 6. Laughing | 12. Sitting | 18. Assaultive | 24. Other: See Notes (SF 509) |

Monitoring/Care Provided: Select the appropriate codes and initial each entry.

- | | | | |
|-----------------------------|-----------------------------|---------------------------------|------------------------------|
| A. Meal offered | E. Toilet offered (q 2 hr)* | I. Circulation checks (q 2 hr)* | M. Bath/shower (q1)* |
| B. Meal refused | F. Toilet refused | J. ROM (q 2 hr)* | N. Bath/shower refused |
| C. Fluids offered (q 2 hr)* | G. Medication accepted | K. RN observation (q 2 hr)* | O. Pt/staff interaction |
| D. Fluids refused | H. Medication refused | L. Physician Visit | P. VS (q 4 hr)* |
| *Minimal Time Requirements | | | Q. Other: See Notes (SF 509) |

Time	Code	Initials	Time	Code	Initials	Time	Code	Initials	Time	Code	Initials
0000			0600			1200			1800		
0015			0615			1215			1815		
0030			0630			1230			1830		
0045			0645			1245			1845		
0100			0700			1300			1900		
0115			0715			1315			1915		
0130			0730			1330			1930		
0145			0745			1345			1945		
0200			0800			1400			2000		
0215			0815			1415			2015		
0230			0830			1430			2030		
0245			0845			1445			2045		
0300			0900			1500			2100		
0315			0915			1515			2115		
0330			0930			1530			2130		
0345			0945			1545			2145		
0400			1000			1600			2200		
0415			1015			1615			2215		
0430			1030			1630			2230		
0445			1045			1645			2245		
0500			1100			1700			2300		
0515			1115			1715			2315		
0530			1130			1730			2330		
0545			1145			1745			2345		
Signature		Initials	Signature		Initials	Signature		Initials	Signature		Initials

Address: _____

(b)(2)

MEDICAL RECORD	PROGRESS NOTES (Sign all orders)
DATE AND TIME	
	(CHOOSE 1, either discontinue or continue restraints)
	CONTINUATION/ DISCONTINUATION OF RESTRAINTS NOTE
	Reason For Restraint: Harm to Self Harm to Others Medical Necessity
	Detainee is currently: sleeping agitated calm and cooperative
	If there is a continued need for restraints, please explain:
	Detainee will be observed continuously and encouraged to find ways to control his
	behavior so that restraints can be removed.
	Detainee was offered medications that may help him to regain control sooner
	Detainee was reminded of the requirements to get out of restraints: Demonstrate
	controlled behavior. No profanity or threatening language. Listen to and follow directions
	No attempts to loosen or pull at restraints. No attempt to remove medical devices
	Detainee was released from restraints at:
	Following release, staff reviewed the events leading up to restraints with the detainee
	Detainee provided/did not provide input to staff about how incident could have been
	avoided.
	Detainee had/did not have physical injury from the restraint episode.
	Detainee reported the following problems related to the restraint episode.
	Enclosure (3)

(continue on reverse side)

PATIENT'S IDENTIFICATION (FOR TYPED OR WRITTEN ENTRIES GIVE NAME--last, first, middle; grade; rank; rate; hospital or medical facility)

PROGRESS NOTES
Medical Record

MEDICAL RECORD	<p align="center">PROGRESS NOTES (Sign all orders)</p>
DATE AND TIME	
	<p>INITIATION OF RESTRAINTS -- NURSING NOTE</p>
	<p>Detainee placed in: 3-pt 4-pt 5-pt 6-pt restraints</p>
	<p>Reason For Restraint: Harm to Self Harm to Others Medical Necessity</p>
	<p>His behavior is significantly different from his baseline</p>
	<p>His behavior is in response to a perceived problem</p>
	<p>Staff/Guards attempted to work out the problem with him.</p>
	<p>Detainee was encouraged to distract himself (read Koran, talk)</p>
	<p>Detainee was offered medications for anxiety/agitation <u>refused</u> <u>accepted</u></p>
	<p>Nursing staff spent <u> </u> min trying to calm him. (in emergencies this may be Zero)</p>
	<p>Staff considered moving detainee to a more secluded area.</p>
	<p>Brief Narrative</p>
	<p>Prior to applying restraints (or soon after in emergency) the reasons for restraints were explained to the detainee.</p>
	<p>Detainee will be observed continuously and encouraged to express his frustration. He will be reminded of how his behavior must change if he is to be allowed out of restraints.</p>
	<p>Detainee was told that he will remain in restraints until he:</p>
	<p>(b)(2)</p>
	<p align="center">Enclosure (4) <small>(continue on reverse side)</small></p>

PATIENT'S IDENTIFICATION (FOR TYPED OR WRITTEN ENTRIES GIVE: NAME--last, first, middle; grade; rank; rate; hospital or medical facility)

PROGRESS NOTES
Medical Record

MEDICAL RECORD	<p align="center">PROGRESS NOTES (Sign all orders)</p>
DATE AND TIME	
	<p>INITIATION OF RESTRAINTS -- MEDICAL OFFICER NOTE</p>
	Reason For Restraint: Harm to Self Harm to Others Medical Necessity
	Prior to using restraints detainee was:
	verbally encouraged to calm himself
	offered medications to reduce his anxiety/agitation
	had increased staffing nearby to calm him
	staff attempted to work out the problem with him.
	emergency situation, detainee was restrained and then situation was discussed
	There is/is not evidence that medications or a medical process are contributing to this
	detainee's behavioral problems. Detainee has/does not have any medical condition or
	disability that would place him at greater risk during restraint.
	Brief Narrative
	Detainee will be observed continuously and encouraged to express his frustration. He
	will be reminded of how his behavior must change if he is to be allowed out of restraints.
	Detainee was told that he will remain in restraints until he:
	(b)(2)
	Enclosure (5)

(contin. on reverse side)

PATIENT'S IDENTIFICATION (FOR TYPED OR WRITTEN ENTRIES GIVE: NAME--last, first, middle; grade; rank; rate; hospital or medical facility)

PROGRESS NOTES
Medical Record

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME		RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
START	STOP				
			RESTRAINT INITIATION ORDERS		
			Place Detainee in: 3-pt 4-pt 5-pt 6-pt restraints		
			Reason For Restraint: Harm to Self Harm to Others		
			Medical Necessity		
			Behavioral Restraints: order expires after (b)(2)		
			Medical Restraints: order expires after (b)(2)		
			Restraints may be removed early if detainee meets behavioral standards		
			Line of Sight observation while in restraints.		
			Record (b)(2) checks while in restraints.		
			Circulation checks (b)(2)		
			Vital sign checks immediately after restraint (b)(2)		
			Offer restroom and fluids (b)(2) (sooner if detainee requests)		
			Range of motion one limb at a time (b)(2)		
			Initiate Restraint Observation Checklist.		
			Orders must be signed by Licensed Independent Practitioner (LIP) within (b)(2) of restraints.		
			Continuation orders may be given telephonically at (b)(2) for behavioral restraints and every (b)(2) for medical restraints if RN eval indicates		
			Licensed Independent Practitioner MUST REEVALUATE if restraints continue (b)(2) hrs for behavioral restraints and every (b)(2) for medical restraints		
			Enclosure (6)		

(continue on reverse side)

PATIENT'S IDENTIFICATION (FOR TYPED OR WRITTEN ENTRIES GIVE: NAME—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. WARD NO.

DOCTOR'S ORDERS
MEDICAL RECORD

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 083
Title: EXERCISE STRESS TESTING	Page 1 of 5 Effective Date: 19 Oct 2005
SCOPE: DETENTION HOSPITAL	

Enclosure: (1) Consent for Stress Test

I. BACKGROUND: Exercise stress testing is frequently used to ascertain whether a given patient has obstructive (>70% stenosis) coronary artery disease (CAD). In patients who are able to exercise and achieve more than 85% of their age-related maximal predicted heart rate, a graded exercise stress test is a reasonable screening test for CAD.

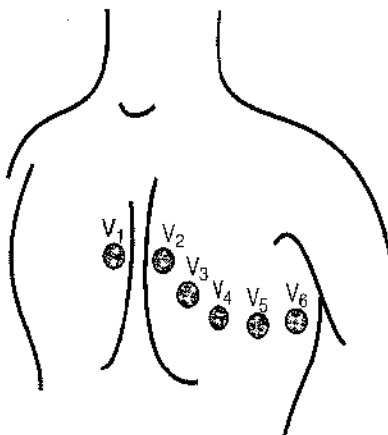
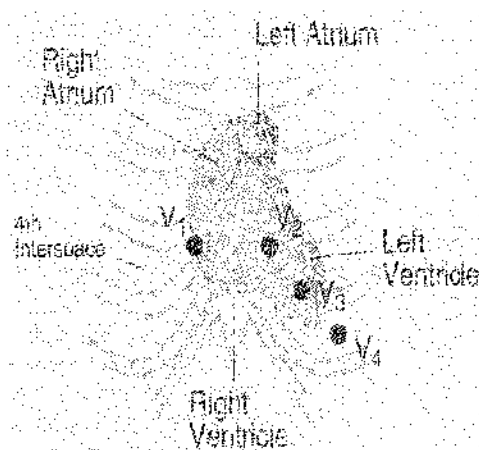
II. POLICY: Exercise stress testing will be performed as a screening test for coronary artery disease on detainees deemed at risk because of prior medical history or who present with clinical symptoms concerning for angina or CAD. This procedure will be performed and supervised by a physician who has hospital privileges to perform exercise stress testing.

III. PROCEDURE:

- Before the procedure, depending on the indication for the stress test, the physician may request that the patient withhold taking certain medications for a period of time before the test. Common medications that may be held the morning of the procedure include:
 - Beta-blockers (Lopressor, atenolol, inderal): depress the squeeze of the heart as well as impede normal heart rate and blood pressure response during exercise.
 - Calcium-channel blockers (verapamil, diltiazem): depress the squeeze of the heart as well as impede normal blood pressure response during exercise.
 - Nitrates (nitroglycerin, isordil): cause venous relaxation and can falsely mask underlying coronary heart disease by inhibiting normal changes in exercise physiology.
- Patient shall be told nothing to eat or drink for 3 hours prior to procedure.
- The following guidelines will ensure the exercise stress test is performed efficiently and safely.
 - Ensure crash cart readily available and is fully stocked, to include a full oxygen cylinder with regulator.
 - Ensure defibrillator is functioning properly.

TITLE: EXERCISE STRESS TESTING**SOP: 083**
Page 2 of 5

- Ensure that there is an adequate supply of ECG paper in the recorder.
 - Maintain sublingual nitroglycerin and aspirin on the monitoring station.
 - Ensure intravenous fluids and phlebotomy supplies and oxygen delivery equipment readily available.
 - Keep extra lead preparation supplies, linens, and table paper in the room.
 - Maintain extra consent forms in the room.
 - Ensure crash cart is readily available and adequately stocked.
 - Ensure patient straddles the treadmill belt with both hands on the bars prior to starting the treadmill.
 - Stand by to be ready in case the patient falls stepping onto the moving belt.
 - Monitor BP, ECG, and patient's appearance throughout the test and for a 6 to 10 minute recovery period.
 - Ensure patient cable is secured away from the patient's legs.
 - Be alert and ready to terminate the treadmill if an indication arises (See "Factors Leading To Termination").
- Have patient complete the "Consent for Exercise Test" in presence of interpreter prior to procedure. See Enclosure (1).
 - Have patient disrobe from the waist up.
 - Leads will be placed on the anterior chest in the following locations (see Figures A & B below):
 - LA- Left deltopectoral groove at the medial clavicular head.
 - RA- Right deltopectoral groove at the medial clavicular head.
 - LL- Left lower rib cage (try to avoid placing over the lower abdomen due to increased muscle and adipose artifact generation in these spots).
 - RL- right lower rib cage. (See LL comment).
 - V₁- Fourth intercostal space along right sternal border.
 - V₂- Fourth intercostal space along left sternal border.
 - V₃- Between V₂ and V₄.
 - V₄- Fifth intercostal space along mid-clavicular line.
 - V₅- Between V₄ and V₆.
 - V₆- Fifth intercostal space along mid-axillary line.

Figure A:**Figure B:**

TITLE: EXERCISE STRESS TESTING**SOP: 083**
Page 3 of 5

- Using a new prep razor, shave hair in areas just large enough to accommodate the electrodes (approximately 3 inches in diameter).
- Use either 4x4 gauze pads or a buffing pad to lightly abrade the skin at the lead sites.
- Rubbing alcohol is then used on the site to remove some of the skin oils as well as the abraded epithelium.
- Apply a small dab of electrode gel to the electrode paste surface and firmly apply to the site. The use of a liquid adhesive, such as Mastisol®, facilitates stronger lead-to-skin contact and minimizes the risk of lead loss due to perspiration.
- Secure the lead package to the patient's waist snugly and connect the leads.
- Apply appropriate size blood pressure cuff to the patient's left arm. Secure it in place by running a strip of tape from the shoulder to the underside of the manometer and back to the shoulder.
- Have the patient lie supine on the gurney and obtain a blood pressure and supine ECG tracing.
- When the physician is present, have the patient stand on the treadmill straddling the belt with an upright posture. During the test, emphasize to keep the hands relaxed on the bars with eyes focused straight ahead during test.
- Start treadmill belt and have patient start walking with normal length strides on the belt. Be alert for the patient falling as he/she steps onto the moving belt.
- Obtain manual blood pressure and ECG tracing every three minutes. Record BP using the entry method required for the treadmill computer program.
- Continually assess the patient's appearance and symptoms during the test.
- Warn patient of expected stage progression (typically with Bruce protocol, every 3 minutes the treadmill will increase in speed and incline).
- The following factors should lead to consideration for test termination:
 - General signs and symptoms
 - Severe chest pain or pressure suggestive on angina
 - Severe dyspnea
 - Dizziness or faintness
 - Sudden onset of pallor and sweating
 - Onset of cyanosis
 - Patient inability to continue on with exercise due to such factors as leg or hip pain, cramping, etc.
 - ECG signs
 - Frequent PVC's, R-on-T PVC's, short runs of VT
 - Atrial fibrillation, when absent at rest
 - High degree atrioventricular (AV) block
 - Ischemic changes
 - Marked ST depression > 3 mm and/or elevation > 1 mm.
 - T wave inversion or hyperacute T wave
 - Q waves appear
 - Appearance of bundle branch block pattern
 - Decreasing heart rate during exercise
 - Blood pressure signs

TITLE: EXERCISE STRESS TESTING

SOP: 083
Page 4 of 5

- Fall of systolic BP below resting level or fall of more than 20 mmHg in SBP
- Exercise-induced rise SBP > 230 mmHg, DBP > 110 mmHg

VII. REFERENCES

1. Exercise Testing: ACC/AHA 2002 Guideline Update for (Circulation 2002; 106:1883-92)

TITLE: EXERCISE STRESS TESTING**SOP: 083**
Page 5 of 5**STANDING OPERATING PROCEDURES**
Detention Hospital
Guantanamo Bay, Cuba**REVIEWED AND APPROVED BY:**

SIGNED 19 OCT 05 _____

Officer In Charge_____
Date**IMPLEMENTED BY:**_____
Director for Administration_____
Date_____
Senior Enlisted Advisor_____
Date**ANNUAL REVIEW LOG:**

By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
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SOP REVISION LOG:

Revision to Page: _____	Date: _____
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ENTIRE SOP SUPERSEDED BY:

Title: _____
 SOP NO: _____ Date: _____

Circle positives Line through negative No mark indicates not evaluated

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
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CONSENT FOR EXERCISE STRESS TESTING	
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	1. I voluntarily consent to engage in an exercise stress test to determine the state of my lungs, heart, and circulation. The information obtained will help my physician advise me as to the activities in which I may safely engage and guide appropriate medical therapy if needed.
	2. I am aware that I will have an interview and an examination by a physician to determine if I have any condition that would make it unsafe to undergo this test before actually starting the test.
	3. I understand that the test will be performed on a treadmill with the amount of required effort gradually increasing. The test will continue until I have symptoms such as fatigue, shortness of breath, or chest discomfort, or my heart rate has reached an appropriate level at which point my physician will stop the test. During the test, my pulse, blood pressure, and electrocardiogram will be monitored closely.
	4. I understand that risks and side effects during the test include: abnormally high or low blood pressure, fainting, leg cramps or pain, chest pain, joint pain, disorders or irregularities of the heart beat (too rapid/slow or ineffective), and very rare instances of a heart attack (1 in 2500-10,000). Every effort will be made to minimize any of these from occurring by close monitoring of my vital signs and electrocardiogram, and conversation with me while exercising and emergency equipment and trained personnel are readily available.
	<u>PHYSICIAN</u> : I have counseled and fully advised the undersigned patient as to the nature and extent of the proposed procedure(s) and attendant risks, the possible complications involved, and the expected results as described above.

	_____ SIGNATURE OF PHYSICIAN, DATE
--	---------------------------------------

	<u>PATIENT</u> : I have been fully advised as to the nature and extent of the proposed procedure(s), the risks involved, the possible complications and the expected results of the exercise testing as described above. I fully understand the advice and instructions and do hereby give my voluntary consent that the procedure be conducted and acknowledge that all of my questions have been answered to my full satisfaction.
--	--

	_____ SIGNATURE OF INTERPRETER, DATE	_____ SIGNATURE OF PATIENT, DATE
--	---	-------------------------------------

	RECORDS MAINTAINED AT:
--	------------------------

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)	PATIENT'S NAME (Last, First, Middle)	
	RELATIONSHIP TO SPONSOR:	SEX M
	SPONSOR'S NAME	STATUS RANK/GRADE
	DEPART./SERVICE	ORGANIZATION

Detention Hospital Guantanamo Bay, Cuba Title: VENIPUNCTURE TECHNIQUE	SOP# 086 Written Date: 12 Jun 98 Revised Date: 23 Sep 05 Page 1 of 7
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1.0 PRINCIPLE

1.1 Phlebotomy procedures can be a traumatic experience for our patients. When a patient enters the drawing room they expect to be greeted by a competent and sincere Laboratory Technician. This technician needs to be friendly and understanding. They also need to ask certain questions to assess the patient's condition and expected reaction from the procedure.

1.2 Most phlebotomy procedures are performed from the arm veins. However, if arm veins are not accessible an experienced phlebotomist can obtain blood from other sites such as the back of the hands.

2.0 SPECIMEN

2.1 Per the College of American Pathologists (CAP) Checklist, all specimens collected via venipuncture must have the patient's full name, Social Security Number, date and time of draw, and phlebotomist's initials on each tube (for further label requirements, as in the case of certain reference testing, refer to the Mailout SOP.

2.2 Refer to the Mailout SOP, (b)(2) (b)(2) for information on what type of venipuncture tube to draw with each test.

3.0 MATERIALS REQUIRED

- 3.1 2 x 2 Gauze sponges
- 3.2 Isopropyl alcohol, Povidone-iodine, or green-tincture soap pads
- 3.3 Tourniquet or blood pressure cuff
- 3.4 Vacutainer or butterfly type needle
- 3.5 Vacutainer holder.
- 3.6 Vacutainer tubes for the appropriate tests
- 3.7 Test tube rack
- 3.8 Gloves
- 3.9 Bandage material
- 3.10 Appropriate specimen labels

(b)(2)

4.0 QUALITY CONTROL

Not applicable.

5.0 SAFETY

Gloves and liquid resistant lab coats must be worn at all times when working with blood and body fluids or body tissues. Protective face shields must be worn when working with biological specimens that may be aerosolized such as when opening blood tubes.

6.0 PROCEDURE

6.1 Confirm the patient's identification. Log the patient (b)(2) and print labels for all blood samples.

6.2 If the test requires fasting ask the patient when they last ate or drank to determine if the results will be valid for the tests ordered.

6.3 Ask the patient if they have ever experienced any difficulties while having blood drawn. If they answer, "yes" discuss in detail what problems they've had. Assess the severity of past problems and determine whether or not it may be safer to perform venipuncture in another location.

6.4 Ask the patient if they are currently taking any blood thinners such as heparin, coumadin, or aspirin. If they answer "yes," pressure should be applied to the puncture site for a longer period of time after phlebotomy. A small gauge needle should be used.

6.5 Ask the patient if there is any reason blood cannot be drawn from either arm (e.g., mastectomy, vein grafts, burns, heplocks).

6.6 Ask the patient if they are allergic to latex or rubber. If so, **a blood pressure cuff is the only tourniquet that may be used.** Furthermore, ensure that gloves used during venipuncture are hypoallergenic and contain no rubber proteins.

6.7 Inspect the antecubital area of the patient's arms for a prominent vein. A tourniquet may be used to aid in vein selection.

6.8 Ask the patient if they are allergic or sensitive to alcohol. If "yes," ask the patient if they are allergic to iodine and/or shellfish (shellfish have a high iodine content). If "no," use povidone-iodine. If not, use green-tincture soap, obtained from the (b)(2)

Note: The germicide/antiseptic of choice for most routine phlebotomy is 70% isopropyl alcohol. When performing a phlebotomy to determine blood alcohol (ethanol) level, however, it is necessary to use a germicide/antiseptic that does not contain alcohol, as alcohol arm preparations can contribute to falsely elevated results.

6.9 Site selection procedure.

- a. Locate the prominent vein by palpation.
- b. It should feel like a rope cord.
- c. Differentiate veins from tendons by flexing the arm.
- d. Differentiate veins from arteries by feeling for a pulse.

6.10 If you are uncomfortable after searching both arms for an alternative site ask another phlebotomist for assistance.

6.11 Place the tourniquet above the elbow, as high up as possible.

6.12 Scrub the site with an isopropyl alcohol pad (or povidone-iodine in a circular motion progressing outward) and allow to air dry for 30 seconds.

Note: Do not re-palpate after cleaning the site.

6.13 Place your thumb below the puncture site and pull downward holding the skin taut to keep the vein from rolling.

6.14 Insert the needle at a 15° angle to the skin with the needle bevel side up, in one continuous motion.

6.15 Vacutainer method:

a. Securely hold the vacutainer barrel and insert the vacutainer tubes in the following order:

- (1) Red top tubes (see notes).
- (3) Lavender top tubes (EDTA).
- (4) Green top tubes (Lithium heparin).
- (5) Blue top tubes (Sodium citrate).
- (6) All other tubes.

Notes: Sodium citrate (light blue top) tubes must be filled until the vacuum stops. Do not over or under fill the tubes. EDTA (lavender top) tubes must be filled at least 1/3 full. Blood cultures will not be collected in the Laboratory. **Do not cross-contaminate anticoagulants/preservatives. Ensure a red top tube is drawn separating tubes with anticoagulants and preservatives. In cases where only a coag tube is needed, a waste tube is not required.**

b. Tubes contain a vacuum and will stop filling as the vacuum decreases (approximately $\frac{3}{4}$ full).

c. Invert the tubes 4 to 5 times before placing them in the test-tube rack. Do not shake the tubes, as this will cause hemolysis.

d. Release the tourniquet when collection is done.

e. Place a 2 x 2 gauze on the puncture site.

f. Remove the needle with one quick motion.

g. Apply pressure to the 2 x 2 gauze.

h. Instruct the patient to keep the arm straight and apply pressure.

6.16 **Syringe Method:** This method will not be performed in the Laboratory.

6.17 **Butterfly method:**

a. Ideal for pediatric patients, hard/difficult draws, and drawing from wrist or back of the hand.

Note: Arm preparation and post venipuncture care is the same as with the Vacutainer method above.

b. Gently and quickly enter the vein. Hold the "butterfly" tabs to ensure that the needle is in the vein while obtaining the blood.

c. Have an assistant gently push the Vacutainer tube all the way into the holder, and allow the vacuum to fill the tube.

d. After the flow of blood has ceased, remove the tube and insert another as needed.

6.18 Discard the complete needle assembly using sharps container needle remover. Do not recap or remove the needle by hand.

6.19 Label the tubes with the appropriate (b)(2) labels. Initial and indicate the date and time drawn on each tube. All tubes must be labeled before the patient leaves area.

6.20 Re-inspect the site and apply a bandage.

6.21 Ensure the patient is not feeling faint or other adverse affects.

6.22 Release the patient.

7.0 REPORTING RESULTS

Not applicable.

8.0 REFERENCE RANGE

Not applicable

9.0 LIMITATIONS

While most of the population has no sensitivity to topical alcohol preparations, certain individuals may be alcohol-

sensitive, or alcohol-allergic. Prior to arm preparation for venipuncture, every patient must be screened to determine if they are allergic to alcohol, iodine, or shellfish (shellfish contains a high concentration of iodine). If a patient is allergic to both alcohol **and** iodine, a green-tincture soap preparation can be obtained from the (b)(2) (b)(2)

10.0 NOTES

10.1 Sodium citrate (light blue top) tubes must be filled until the vacuum stops. Do not over or under fill the tubes.

10.2 EDTA (lavender top) tubes must be filled at least 1/3 full.

10.3 Blood cultures will not be collected in the Laboratory.

10.4 The germicide/antiseptic of choice for most routine phlebotomy is 70% isopropyl alcohol. When performing a phlebotomy to determine blood alcohol (ethanol) level, however, it is necessary to use a germicide/antiseptic that does not contain alcohol, as alcohol arm preparations can contribute to falsely elevated results.

11.0 REFERENCES

(b)(2)

DETENTION HOSPITAL
GUANTANAMO BAY CUBA

WRITTEN BY:

(b)(6) _____ Date _____

REVIEWED BY:

SIGNED 6 NOV 05 _____ Date _____

Officer In Charge - Detention Hospital _____ Date _____

APPROVED BY:

Head, Laboratory Department _____ Date _____

Laboratory Medical Director _____ Date _____

ANNUAL SOP REVIEW LOG:

By: _____ Date: _____

By: _____ Date: _____

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ENTIRE SOP SUPERSEDED BY:

Title: _____

SOP NO: _____ Date: _____

DETAINEE HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: #087
Title: Discharging Detainees from the BHS Non-Acute Psychiatric Ward.	Page 1 of 3 Effective Date: 07 Nov 05
SCOPE: BEHAVIORAL HEALTH SERVICES TO DETAINEES	

Enclosure: BHS Detainee Discharge Checklist

I. PURPOSE:

To specify the proper procedures to discharge detainees from the Non-Acute ward to the (b)(2)

II. BACKGROUND:

Overview

When Detainees become psychiatrically stabilized and are deemed safe and appropriate to return to (b)(2) certain steps must be completed to have them removed from (b)(2)

III. PROCEDURES: Discharging a Detainee

1. When the Psychiatrist or Psychologist deems the detainee appropriate for discharge.
2. The psychologist begins by coordinating the detainee's movement via the (b)(2)
3. (b)(2)
4. The message should be brief and should NOT include any protected medical information due to detainee confidentiality (e.g., "ISN XXXX is currently psychiatrically stable and ready for transfer (b)(2) (b)(2) Please advise once a transfer date has been determined.>").
5. The discharging officer then (b)(2) provides a brief summary of any pertinent information (keeping in mind detainee confidentiality) to the consideration of cell/block placement for a Detainee that you have requested transfer (b)(2) For example, if a Detainee engaged in SIB or a suicide gesture as a result of significant interpersonal conflict with his block mates, this information might be helpful when the (b)(2) components consider where

the Detainee should be transferred to in the (b)(2) [redacted] If there is no pertinent information, then this is what is stated (b)(2) [redacted] The (b)(2) [redacted]

6. To expedite the discharge process, this information regarding the detainee's suitability for discharge should also be (b)(2) [redacted] (b)(2) [redacted]
7. (b)(2) [redacted] (b)(2) [redacted] the Charge Nurse or BHS DIVO should contact a LIP to obtain orders for the detainee's discharge.
8. Orders for discharge should include dietary orders and medications as appropriate.
9. (b)(2) [redacted]
10. The Treatment Plan should be updated at the next treatment team meeting to include any changes in medications or visit frequency.
11. Nursing staff should review the medical record to ensure that it is complete according to the discharge checklist (attached). The medical record, detainee profile and the MAR should be returned to a Nurse at the Delta Clinic so that there is no break in medications.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____	_____
Officer In Charge	Date
IMPLEMENTED BY:	
_____	_____
Director for Administration	Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
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Title: _____	
SOP NO: _____	Date: _____

BHS Detainee Discharge Checklist

ISN

Nurses Duties:

1. Ensure detainee has a Doctor's Order for discharge. _____ ()
 - a. Note the orders _____ ()
2. Ensure that detainee has a follow-up appointment. _____ ()
3. Complete a Nursing Discharge Note. _____ ()
4. Place Medical and Psychiatric profile sheet in the chart
in Section 1 _____ ()
5. Place MAR in detainee's chart in Section 3 _____ ()
6. Place all flow sheets in detainee's chart in Section 4 _____ ()
7. Ensure all the chart sections are in chronological order
with the most recent on top _____ ()
8. Place the Discharge Checklist in Section 4 of the chart _____ ()

Technician's Duties:

1. View Doctor's Order for discharge order. _____ ()
2. Instruct detainee to strip the bed and gather
all his belongings _____ ()
3. (b)(2) _____ ()
 - b. Allow detainee to carry his Quran or call for a
Muslim interpreter to carry it for him. _____ ()
4. (b)(2) _____ ()
5. Erase the detainee's ISN from the ward census _____ ()
 - a. Correct the ward census number _____ ()

After Detainee Leaves

1. Take the chart and all medications to the Delta Clinic Nurse _____ ()
2. Inform the clinic nurse that the detainee
 - a. has been discharged from BHS _____ ()
 - b. that there are doctor's orders _____ ()

Technician's Signature _____

Psychiatrist's Signature _____

<p style="text-align: center;">MEDICAL/PLANS OPERATIONS GUANTANAMO BAY, CUBA</p> <p style="text-align: center;">Title: REQUEST FOR MEDICAL/DENTAL INFORMATION</p>	<p>SOP NO: JMG 001</p> <p>Page 1 of 2 Effective Date: 1 Mar 2005</p>
<p>SCOPE: JOINT MEDICAL GROUP (JMG)</p>	

I. PURPOSE:

To outline the Standard Operating Procedure (SOP) regarding requests for detainee medical/dental information. This SOP document is intended to describe the process the Joint Medical Group will use to correctly task and track outside agencies (governmental and non-governmental) requests for detainee medical information.

II. POLICY:

The Joint Task Force Surgeon (SG) will serve as the approving authority for requests for detainee medical/dental information. The Officer in Charge (OIC), Medical Plans/Operations (MPO) will serve as the entry point for all outside agency requests for detainee medical/dental information as well as track, using a spreadsheet, the JMG response. The Senior Medical Officer (SMO)/Detention Hospital will be the primary point of contact for medical information requests. The Senior Dental Officer (SDO)/Detention Hospital will be the primary point of contact for dental information requests. The JTF Staff Judge Advocate (SJA) will act as legal consultant as needed to assist the SG to determine if/when medical/dental information can be released and the correct format for the release. Original medical records will remain in the custody of the JMG. If records are cleared for release, certified copies will be provided. Documentation of the appropriate authorization will be kept on file by the MPO office.

III. PROCEDURES:

1. Requests for medical/dental information:

- a. Requests for medical/dental information are common from the J-1, in the form of a Freedom of Information Act (FOIA); Behavioral Science Consultation Team (BSCT); Public Affairs Office (PAO); Federal Bureau of Investigation (FBI); Detainee Assessment Branch (DAB); the Office for the Administrative Review of Detainee Enemy Combatants (OARDEC) and detainee counsel.

- b. Medical/dental information requests will be sent through the SG, as identified below, or to the OIC MPO via the JMG organizational e-mail (SIPR). The OIC or NCOIC will enter the request into an excel spreadsheet. The MPO office will task the request for information to the SMO or SDO.
- c. Requests from the FBI, OARDEC, and the DAB will come through the JMG organizational email (SIPR) on official letterhead and be signed by the respective director with an explanation of what information is required, how the information will be used, and date information needed. An accurate and current letter from these agencies/sections on file with the SG and MPO may be used to satisfy the above requirement (i.e. a letter is not required to be submitted for each request).
- d. Requests from the J-1 regarding a FOIA will be accompanied by the complete FOIA package and be suspended to the JMG organizational e-mail box.
- e. Requests from the PAO and BSCT will be sent to the JMG organizational e-mail box.
- f. Requests from detainee counsel, if received by the JMG, will be forwarded to the SJA office. The JMG will not provide any medical/dental information until the SJA has reviewed the request and determined the legal nature of the request and what, if any, information can be provided.
- g. Requests for medical/dental information made directly to the Detention Hospital (DH) will be returned to the sender with an explanation of how to correctly request medical/dental information as described in this SOP.
- h. The SDO/DH or SMO/DH will complete a medical/dental summary or complete the Medical RFI e-form submitted by the MPO, as appropriate, and respond directly to the MPO via SIPR e-mail, while courtesy copying the SG and Deputy SG. The SG will approve or deny the release of medical information and forward to the MPO. The MPO will track responses to ensure task completion. The MPO will forward the information, with the SG's approval noted, to the requestor.

2. Release of medical/dental information:

- a. When detainee medical/dental information is released using names or ISNs, the information is considered SECRET. When the medical/dental information does not reveal names or ISNs, the information is considered For Official Use Only (FOUO).
- b. No medical/dental information is to be used for the purposes of furthering intelligence gathering.
- c. All release of medical/dental information must have written approval (email or hard-copy memo) of the SG or Deputy SG.

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: JMG 006
Title: MORTUARY AFFAIRS	Page 1 of 4 Effective Date: 1 Jun 2005
SCOPE: JOINT MEDICAL GROUP (JMG)	

- Ref:** (a) Geneva Convention on Prisoners of War
(b) JTF GTMO/JDOG SOP for Mortuary Affairs
(c) NAVMEDCOMINST 5360.1

I. BACKGROUND:

As a consequence of disease, battle injury and non-battle injury it is assumed that some loss of life may occur among detainees.

II. POLICY:

JTF GTMO conducts mortuary affairs services in support of detainee operations. Mortuary services include the supervision and execution of matters pertaining to:

- A. Search, recovery, identification, and evacuation of deceased U. S. Military, civilians, and detainees.
- B. Recovery and disposition, including collection, receipt, recording, and storage of personal effects of deceased personnel.
- C. The maintenance of pertinent records and reports in connection with graves registration services. A graves registration program will only be implemented at the direction of USSOUTHCOM.

III. PROCEDURE:

- A. Mortuary services (current/concurrent death program) will remain in effect as long as the operational and logistical situation permits. Mortuary affairs will not be performed per reference (a), but "consistent with" the Geneva Convention.
- B. JTF GTMO J4 Mortuary Affairs Officer serves as coordinating activity for all aspects of mortuary affairs at GTMO and coordinates directly with USSOUTHCOM Joint Mortuary Affairs Office (JMAO).
- C. Limited mortuary services are available at Naval Hospital Guantanamo Bay.

D. All U. S. remains will be handled per reference (b) and (c).

E. Detainee remains.

1. If a detainee dies while in the Detention Hospital or Delta Medical Clinic the JDOG Watch Officer, Detention Hospital Officer in Charge, Duty Medical Officer, Senior Medical Officer and JTF SG/JMG Commander will be notified immediately.

(a) Once a detainee's body is cleared for release (by NCIS), JDOG personnel will bag the body and place it in an ambulance. Care will be given to not remove any life sustaining, tubes or lines, these must be clipped and remain intact. Detention Hospital will provide the ambulance and driver to transport the body to the morgue.

2. Detainee remains will be cared for per reference (a) and as amplified by the following procedures:

(a) To the extent possible, detainee remains will be cared for in a matter consistent with their religious tradition.

(b) JTF GTMO JOC Watch Officer will notify USSOUTHCOM CAC and provide detainee personal data.

(c) JTF Surgeon will coordinate a post mortem medical evaluation.

(d) JTF GTMO Surgeon's Office will request a pathologist from the Armed Forces Institute of Pathology (AFIP). The AFIP/Armed Forces Medical Examiner (AFME) takes the request for action and a pathology team will be ready to fly within four (4) hours of notification. Military Air will need to be coordinated with the J4 Strategic Mobility Officer.

(1) As of May 2005, the point of contact is (b)(6) at the Office of Armed Forces Medical Examiner, Armed Forces Institute of Pathology, (b)(2),(b)(6)

(e) JTF GTMO Surgeon's Office will coordinate with the JTF Chaplain, and if necessary, request an Imam from Navy Mortuary Affairs (Great Lakes).

(1) As of May 2005, the Military Medical Support Office Mortuary (b)(2),(b)(6) (b)(2),(b)(6) Normal office hours are 0700 to 1600 Central time. After hours, the duty mortician can be paged. Mortuary Affairs can be contacted at

(b)(2)

and follow

the prompts provided.

(f) An autopsy will be conducted in every case to document the cause of death for all detainees. The autopsy will be conducted at the Naval Hospital morgue. Once complete and AFME has released the body, burial will occur as soon as practical.

(g) JTF GTMO Surgeon will send a copy of detainee death certificate to USSOUTHCOM CAC (surgeon).

(h) JTF GTMO J-4 Mortuary Affairs Officer will notify the Department of State, who will contact the embassy of the decedent's home of record and advise them of the death and for a determination of the detainee remains disposition as well as disposition of detainee personal effects.

(b)(2)

(j) Naval Hospital Patient Administration (mortuary services) will coordinate with the JTF GTMO J-4 Mortuary Affairs Officer to obtain cemetery access and purchase services from base contractor for burial ground preparation.

(k) Detainee personal effects will be handled by the J-4 in the same manner as those of U.S. decedents.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____ Officer In Charge	_____ Date
IMPLEMENTED BY:	
_____ Director for Administration	_____ Date
_____ Senior Enlisted Advisor	_____ Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
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Title: _____	
SOP NO: _____	Date: _____

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 007
Title: MEDICAL DOCUMENTATION AND REPORTING PROCEDURES FOR SUSPECTED DETAINEE ABUSE	Page 1 of 3 Effective Date: FEB 05 Reviewed: 16 JUN 05
SCOPE: JOINT MEDICAL GROUP (JMG)	

I. BACKGROUND:

Detainees will be treated humanely. Verbal harassment, physical abuse, or any form of corporal punishment is prohibited.

II. DEFINITIONS

For the purpose of this instruction, the term provider refers to a licensed independent provider who is credentialed at U.S. Naval Hospital Guantanamo Bay, Cuba to practice as a Physician, Physician's Assistant, Psychologist or Nurse Practitioner.

III. POLICY:

Detention Hospital will intervene in and report any observed detainee abuse. Detention Hospital will report any incident of suspected detainee abuse uncovered during routine medical examinations.

IV. PROCEDURES:

Procedure for evidence of abuse, reports of abuse or detainee reports that they have been abused.

- A. The Hospital Corpsman or Nurse does an initial history and examination. Findings will be objectively documented in the detainee's medical record.
- B. The initial documentation in the detainee's health record will contain a detailed account of the events surrounding the incident and will, at a minimum, include the following elements:
 1. The location of the incident.
 2. The mechanism of injury.
 3. The time of the incident.
 4. A timed/dated detailed description of findings on the initial examination.

- C. The Nurse on duty will notify the on-call provider of the complaint, allegation, or suspicion within one hour.
- D. The on-call provider will examine the detainee within 4 hours. Appropriate studies will be ordered and processed within that time.
- E. The provider will forward a summarized account of the incident to the Senior Medical Officer and the Detention Hospital Officer in Charge.
- F. This information will subsequently be provided to the Joint Task Force (JTF) Surgeon and Commander, Joint Detention Operation's Group.
- G. The JTF Surgeon will be responsible for notifying the Staff Judge Advocate as appropriate.
- H. Photography for Documentation of Suspected Detainee Abuse.
 - 1. Visual documentation will be obtained as determined by the Senior Medical Officer and will be made part of the medical record.
 - 2. Any photographs will be made part of the medical record.

STANDING OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
(b)(6) _____ Officer In Charge	<u>16 JUN 05</u> Date
IMPLEMENTED BY:	
(b)(6) _____ Director for Administration	<u>16 JUN 05</u> Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
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SOP NO: _____	Date: _____

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 008
Title: DETENTION MEDICAL INTERFACE WITH BEHAVIORAL SCIENCE CONSULTATION TEAM	Page 1 of 3 Effective Date: 15 Feb 05
SCOPE: JOINT MEDICAL GROUP (JMG)	

I. REFERENCE

- (a) Director, Joint Intelligence Group Operational Policy Memorandum
dtd 10 Dec 04

II. ENCLOSURE – N/A

III. BACKGROUND:

The Behavioral Science Consultation Team (BSCT) is NOT part of the Joint Task Force Guantanamo (JTF-GTMO), Joint Medical Group (JMG). They are a component of the Joint Interrogation Group (JIG) that supports the Interrogation Control Element (ICE) and Joint Detention Operations Group (JDOG). The mission of BSCT includes providing psychological consultation in support of safe, legal, ethical, and effective interrogation and detention operations at JTF-GTMO. Reference (a) outlines the specific objectives and mission essential tasks for the BSCT.

IV. POLICY

- JMG staff members do NOT participate in any interrogation activities nor are they present during any interrogation activities.
- The BSCT should redirect medical concerns raised by Detainees during the interrogation or intelligence gathering process to Detention Medical personnel if they are beyond the scope of the normal sick-call opportunities made available to all Detainees.
- Concerns about health status or medical condition of detainees will NOT be conveyed directly to Detention Medical personnel by interrogators. Any attempt to do so, will be redirected to the BSCT.
- BSCT staff may check directly with Detention Medical clinical staff to confirm whether or not a detainee is medically fit for interrogation activities.

V. PROCEDURES

- Requests from the BSCT for medical information related to a detainee will be forwarded to the JMG Medical Planner group email. The requests will be assigned individual tracking numbers as appropriate and forwarded to the Detention Medical Senior Medical Officer for response.
- Recognize that there may be time sensitive issues, such as possible detainee abuse, where BSCT staff may contact the Detention Medical Officer in Charge or Senior Medical Officer and request medical evaluation of a detainee.
- Meetings between BSCT staff and JMG staff will be held on an as needed basis, but not less than quarterly, to facilitate resolution of procedural issues and discuss common problems. Specific detainee medical information will not be solicited or discussed in this forum.

REVIEWED AND APPROVED BY:

Officer In Charge

Date

IMPLEMENTED BY:

Director for Administration

Date

Senior Enlisted Advisor

Date

ANNUAL REVIEW LOG:

By: _____ Date: _____
By: _____ Date: _____
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Title: _____
SOP NO: _____ Date: _____

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 009
Title: CUSTODY AND CONTROL OF MEDICAL/DENTAL RECORDS	Page 1 of 7 Effective Date: 01 JUN 05
SCOPE: JOINT MEDICAL GROUP (JMG)	

I. ENCLOSURE:

- (1) NAVMED FORM 6150/7
- (2) Sample, Record Closure Insert
- (3) Sample, Chain of Custody

II. BACKGROUND:

On arrival to Guantanamo (GTMO), all Detainees have a medical and dental record established to document their healthcare while in custody. Joint Medical Group (JMG) and Detention Hospital personnel will exercise control, custody and management of all inpatient and outpatient medical/dental records with guidance from applicable service instructions. This Standard Operating Procedure provides guidance on the storage, handling and accountability of all healthcare records in JMG custody.

III. POLICY:

A secure, climate-controlled environment is required for the storage of all active and retired Detainee medical records. All Detainee healthcare information will be treated as sensitive material. All medical/dental records will be maintained in a secure storage device if the space is not continuously manned.

At no time will active Detainee medical/dental records leave the custody of Detention Medical staff. Whenever a Detainee is admitted to the Detainee Acute Care Unit (DACU) at the U.S. Naval Hospital, the custody of the medical record will reside with Detention Medical staff working in that location. Any exception to this policy will be cleared by the Senior Medical Officer (SMO), Officer in Charge (OIC) or the JMG Commander.

IV. PROCEDURES:

A. Active Outpatient Records

1. The Detainee's Internment Serial Number (ISN) will be used as the primary filing number for all Medical and Dental records.
2. All active outpatient medical records will be kept in the Delta Detention Clinic at all times. Enclosure (1), commonly known as the "Pink Card", will be completed for any record transported out of Delta Clinic.
3. All dental records will be kept in the Detention Hospital Dental Clinic. These records will not be removed from this space without the express approval of the Dental Officer, the Senior Medical Officer (SMO) or the Detention Medical Officer in Charge (OIC). The dental record will accompany all Detainees undergoing oral surgery procedures at U. S. Naval Hospital GTMO.
4. The outpatient medical record will accompany all Detainees admitted to the Detention Hospital or the DACU. The record will be stored in a cabinet or file drawer at the detention hospital (b)(2) or at the DACU (b)(2)
5. Delta Clinic will charge out all outpatient medical records for Detainees admitted to Delta Block. These medical records will remain stored at the Delta Block (b)(2)
6. The Director for Clinical Services will maintain a listing of all outpatient medical/dental records in Delta Clinic's possession sorted by ISN number and the number of volumes for each. The list will be compared to the Detainee camp roster maintained by J3. This list will be updated quarterly and a report submitted to the JMG Commander via the SMO and the OIC no later than 10 days after the end of each quarter.
7. The Dental Officer will maintain a listing of all dental records in Dental's possession. This list will be updated quarterly and a report submitted to the JMG Commander via the SMO and the OIC no later than 10 days after the end of each quarter.

B. Active Inpatient Records

Inpatient records for Detainees still in custody will be considered active inpatient records.

1. Active inpatient records are maintained in a locked cabinet in the (b)(2) (b)(2) or at the Detention Hospital (b)(2) if currently an inpatient.
2. They will be catalogued by ISN number.

3. Each admission will have a separate health record jacket and filed separately.
4. The Director for Administration (DFA) is responsible for the maintenance and storage of these records.
5. The DFA will maintain a listing of all active inpatient medical records sorted by ISN number and the number of volumes for each. The list will be updated quarterly and a report submitted to the JMG Commander via the SMO and the OIC no later than 10 days after the end of each quarter.
6. Once a detainee is discharged from the Detention Hospital or the U.S. Naval Hospital DACU, a final administrative review of the record will be conducted prior to filing it in the (b)(2) [REDACTED]

C. Inactive Records

Medical/Dental records for detainees who have been permanently released from custody will be placed in an inactive status.

1. Inactive Detainee medical/dental records, both inpatient and outpatient, are maintained in a secure storage device.
2. Inactive records will be catalogued by ISN number.
3. All records (inpatient, outpatient or dental) will be grouped together by ISN.
4. Detainees who are permanently transferred from GTMO will have their outpatient medical record and their dental record closed. To close a medical record, enclosure (2) will become the topmost form of Part 2 in the outpatient medical records, inpatient medical records, and dental records. Enclosure (2) will be signed by the SMO for all medical records and by the Dental Officer for all dental records.
5. All permanently transferred Detainees will have the inactive records (all volumes) bundled and forwarded to the JMG Commander. Enclosure (3) will accompany all transferred records, and the DFA and the JMG Medical Planner will keep a copy on file of each signed enclosure (3).
6. The JMG Medical Planner will maintain a listing of all medical/dental records in their possession sorted by ISN number, record type, number of volumes for each and the date accepted into custody. This list will be updated quarterly and a report submitted to the JMG Commander no later than 10 days after the end of each quarter.

D. Missing Records

1. When a Detainee medical/dental record is unaccounted for, the record custodian will submit a memorandum to the JMG Commander via the OIC documenting the record as missing. The DFA or the JMG Medical Planner, as appropriate, will maintain a copy of this memorandum on file.

E. Record Inventory

1. A complete inventory of all medical/dental records will be conducted when the OIC or the JMG Medical Planner turn over.

F. Medical Evacuations

At no time will the original medical or dental record leave Guantanamo Bay, Cuba.

1. If a Detainee requires medical evacuation from the island, a photocopy of the Detainee Medical and Dental record will be made.
2. The copies will be clearly marked as duplicate across the cover sheet.
3. The copies will remain in the possession of a JMG representative or designated medical authority at all times while undergoing medical care.
4. When the final medical disposition is made on the detainee, the copies will accompany the detainee back to Guantanamo Bay, Cuba.
5. The copies will then be destroyed by the JMG Medical Planner.

ISN: XXX-XX-XXXX

**RECORD
INACTIVATED**

(DATE) _____

SIGNED: _____

SMO DENTAL OFFICER

**DEPARTMENT OF THE NAVY
DETENTION HOSPITAL
JTF- GTMO-JMG,
APO-AE, 09360**

5000
DD Sep YY

From: Officer in Charge, Detention Hospital, Joint Task Force, Guantanamo Bay, Cuba
To: Commander, Joint Medical Group, Joint Task Force, Guantanamo Bay, Cuba

Subj: RECEIPT OF DETAINEE RECORDS

Encl: (1) Diskette With Detainee ISN's
(2) List of Enclosed Medical Records

1. The enclosed Detainee records are forwarded along with enclosures (1) and (2) acknowledging transfer of custody to and receipt by the Joint Medical Group Commander. These records are no longer in the custody of the Detention Medical Administrative Department.
2. If there are any questions in this matter please feel free to contact _____ at ext. 3025.

OIC
Detention Hospital
JTF GTMO

Enclosure (3)

STANDING OPERATING PROCEDURES
Medical Plans and Operations
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
(b)(6) _____ Officer In Charge	1 JUN 05 Date
IMPLEMENTED BY:	
(b)(6) _____ Director for Administration	31 MAY 05 Date
_____	_____
Senior Enlisted Advisor	Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
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Title: _____	
SOP NO: _____	Date: _____

HEALTH RECORD RECEIPT FILE CHARGE-OUT AND DISPOSITION RECORD NAVMED 0150/7 (2-74)	
NAME (LAST)	(FIRST)
GRADE/RATE	SSN
DISPOSITION	
RECEIVED FROM	DATE
TRANSFERRED BY	DATE
REMARKS:	
INSTRUCTIONS	
<p><i>This form is designed for use as a permanent record of receipt and disposition of the HEALTH RECORD.</i></p> <p>(A) For each HEALTH RECORD received, complete lines 1 through 4 and file in the HEALTH RECORD.</p> <p>(B) Upon transfer complete line 5 and retain form in permanent files.</p> <p>(C) Whenever HEALTH RECORD is temporarily removed from files enter information provided for below and retain form in HEALTH RECORD files.</p>	
FILE CHARGE-OUT	
DATE	RECEIVED BY AND/OR LOCATION
<p>S/N 0105-LF-209-5071 U.S. Government Printing Office: 1969 - 704-002/42121</p>	

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: 010
Title: DETENTION MEDICAL INTERACTION WITH INTELLIGENCE GATHERING OPERATIONS	Page 1 of 3 Effective Date: FEB 05 Reviewed: 15JUN05
SCOPE: JOINT MEDICAL GROUP (JMG)	

I. BACKGROUND:

Compliance with widely held standards of medical ethics demands that medical staff follow set procedures when interacting with intelligence gathering operations. It is important that medical staff focuses on the provision of medical care to the detainees and not become involved in intelligence gathering objectives.

II. POLICY:

Detention Medical staff will not participate or assist in Intelligence gathering. Detention Medical staff will not provide intelligence gathering operations access to Medical Records. Any request for medical information will be routed through the JMG Medical Planner and the Senior Medical Officer.

III. PROCEDURES:

Medical Information

- All requests for limited medical information will be made through the JMG Medical Planner and the Senior Medical Officer.
- Authorization for any limited information sharing will be via the Joint Task Force Surgeon in accordance with the Joint Medical Group Standard Operating Procedures.

Medical Response at Interrogations

- Detention Medical Emergency Response Teams (ERT) will respond to Urgent/Emergent situations anywhere in the camp including interrogations.
- The Delta Clinic Nurse will triage all calls and send the ERT as necessary.

- The ERT will respond to, stabilize and transport the detainee to Delta Clinic for further evaluation.
- If the situation is not Emergent/Urgent, the Clinic Nurse will recommend that the Detainee be returned to the block where the Corpsman will evaluate the detainee's routine medical issues.
- Under no circumstances will a Detainee receive Emergent/Urgent medical care and be allowed to continue interrogations.

STANDING OPERATING PROCEDURES

Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

(b)(6) _____ 15 JUN 05
Officer In Charge Date

IMPLEMENTED BY:

(b)(6) _____ 15 JUN 05
Director for Administration Date

Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By: _____ Date: _____
By: _____ Date: _____
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SOP NO: _____ Date: _____

DETENTION HOSPITAL GUANTANAMO BAY, CUBA	SOP NO: JMG 011
Title: ADVANCE DIRECTIVES	Page 1 of 3 Effective Date: 1 Apr 2005
SCOPE: JOINT MEDICAL GROUP	

I. BACKGROUND:

As a consequence of disease, battle injury and non-battle injury it is assumed that some loss of life may occur among detainees.

II. ADVANCED DIRECTIVES

A. Detainees have the right to self-determination and the opportunity to request advance directives or living wills.

B. Given the inherent difficulty in next of kin notification, no health care surrogates will be chosen. The JTF Commander will act as the health care surrogate for all detainees under advisement of the JTF Surgeon and JTF GTMO Staff Judge Advocate.

C. To the degree possible, cultural sensitivity will be maintained in executing these requests. For detainees wishing to execute an advance directive/living will, form NHGTMO 6320/24 will be completed and placed in the record. The medical officer will ensure the detainee understands this process and its implications prior to accepting the directive.

III. DO NOT RESUSCITATE

A. Detainees have the right to end-of-life medical care. They also have the right to refuse resuscitation in the event of cardiopulmonary arrest. Detainees requesting such orders will discuss them with a medical officer.

B. Only the medical officer can write a DNR order; it must be reviewed and approved by the Detention Hospital CO, the JTF Surgeon and Staff Judge Advocate. Documentation within the medical record must be clear and include the following at a minimum:

- Diagnosis and prognosis
- Description of the detainee's mental state

- Express wishes of the detainee and evidence of informed consent
- Reference to an advanced directive/living will if one exists

IV. SUICIDE

A. The medical staff is trained to recognize signs of suicidal thinking and behavior. Detainees will be screened during in-processing and if identified as “at risk” referred for psychiatric evaluation.

B. Duty medical staff and security personnel will be informed of any detainees on a “suicide watch” and follow the instructions of the consulting psychiatrist. The JTF Surgeon via the Detention Hospital CO will be apprised of any such determinations.

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:	
_____ Officer In Charge	_____ Date
IMPLEMENTED BY:	
_____ Director for Administration	_____ Date
_____ Senior Enlisted Advisor	_____ Date
ANNUAL REVIEW LOG:	
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
By: _____	Date: _____
SOP REVISION LOG:	
Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
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Revision to Page: _____	Date: _____
Revision to Page: _____	Date: _____
ENTIRE SOP SUPERSEDED BY:	
Title: _____	
SOP NO: _____	Date: _____

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**Behavioral Science Consultation Team
Joint Intelligence Group, Joint Task Force-GTMO
Standard Operating Procedures (U)**

28 March 2005

1. (U) **Purpose.** The purpose of this document is to establish Standard Operating Procedures (SOP) for the daily operation and administration of the Behavioral Science Consultation Team (BSCT), Joint Interrogation Group (JIG), Joint Task Force-Guantanamo Bay, Cuba (JTF-GTMO).

2. (U) **Scope.** This SOP applies to all personnel assigned to the BSCT and supersedes the previous BSCT SOP.

3. (U) **BSCT Personnel.**

a. (U) **BSCT Chief (BSCT1).** Clinical Psychologist, USA, 73B. Chief, responsible for all issues relating to BSCT operations. Develops detailed BSCT policies and operating procedures. Reports to the Director, JIG; coordinates with the Commander, Joint Detention Operations Group (JDOG); and, as directed, provides special staff officer functions to the Commander, JTF-GTMO. In the event that the USAF 42P3 is senior in rank to the USA 73B, JIG Director will designate team chief based on experience and training in interrogation support.

b. (U) **Assistant BSCT Chief (BSCT2).** Clinical Psychologist, USAF, 42P3. Assumes duties of BSCT1 in his/ her absence. Provides consultation and interrogation support to the Interrogation Control Element (ICE). Works with JDOG-S2 (Counter-Intelligence) to identify trends in detainee behavior

(2) [REDACTED] may support Deployment Cycle Support program by providing training on Posttraumatic Stress and Anger Management for personnel departing JTF-GTMO.

c. (U) **BSCT NCOIC (BSCT3).** Mental Health Specialist, USA, 91X. Provides consultation and interrogation support to the ICE. Assesses camp climate and provides feedback to BSCT1 on issues and trends. May provide training in behavioral principles/ management to ICE and JDOG personnel; may support Deployment Cycle Support program by providing training on Posttraumatic Stress and Anger Management for personnel departing JTF-GTMO.

4. (U) **Mission.** Provide psychological consultation in order to support safe, legal, ethical, and effective detention and interrogation operations at JTF-GTMO.

5. (U) **Objectives.**

a. (U) Provide psychological expertise to assess the individual detainee and his environment; provide recommendations to enhance the effectiveness of interrogation operations.

b. (U) Use psychological expertise to provide monitoring, consultation, and feedback regarding the entire detainee environment in order to assist the command in ensuring humane treatment of detainees, the prevention of abuse, and the safety of U.S. personnel.

CLASSIFIED BY: JTF-GTMO Classification Guide dated 10 June 2004
REASON: 1.4(C) or Intelligence Activity, Source, or Methods
DECL ON: 28 March 2030

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JTF-GTMO-JIG-BSCT
SUBJECT: BSCT SOP (U)

6. (U) Mission Essential Tasks.

a. (U) Provides consultation to interrogation staff in support of the intelligence collection mission.

(1) (S)

[REDACTED]

(b)(1)

(2) (S)

[REDACTED]

(b)(1)

(a) (U//FOUO)

[REDACTED]

(b)(2)

(b) (S)

[REDACTED]

(b)(1)

(3) (S)

[REDACTED]

(b)(1)

b. (U) Monitors interrogations and other staff-detainee interactions; provides consultation on policies and strategies for ensuring the safety of detainees and JTF-GTMO personnel; provides direct feedback to command on issues involving psychological risk factors affecting detainee operations.

(1) (U) Provide psychological oversight to ensure that staff-detainee interactions are safe for both detainees and U.S. personnel. Immediately call attention to and appropriately report any interactions that are considered unsafe, unethical, illegal or in violation of applicable policies and procedures.

(2) (U) Provide feedback to command in verbal or written form to JIG Director, JDOG Commander, or JTF Commander, as appropriate, regarding potential risks to detainees and U.S. personnel at JTF-GTMO.

(3) (U//FOUO)

[REDACTED]

(b)(2)

JTF-GTMO-JIG-BSCT
SUBJECT: BSCT SOP (U)

c. (U) Monitors behavioral trends in the detainee population and integrates findings into consultation in support of interrogation and detention operations.

(b)(1)(1) (S) [Redacted]

(b)(1) (2) (S) [Redacted]

(b)(1)(3) (S) [Redacted]

d. (U) Provides selected JIG and JDOG personnel with training on behavioral, psychological, and cultural issues pertaining to the detainee population.

(b)(2)(1) (U//FOUO) [Redacted]

(b)(2)(2) (U//FOUO) [Redacted]

(3) (U//FOUO) Provides training to facilitate the maintenance of a stable and secure detention environment, such as appropriate ways to respond to detainee misbehavior, recognition and reporting of behavior patterns, minimizing transfer of information from guard staff to detainees, and strategies for increasing pro-American sentiment.

(4) (U) Provides training to increase awareness of religious and cultural issues unique to the detainee population, such as proper handling of Qur'ans, ways to demonstrate respect for religious practices, and special practices during religious holidays (e.g., Ramadan).

e. (U) Advises JIG and JDOG on use of materials for the Detainee Library and sits on the Library Advisory Board.

(1) (U) Participates on Library Advisory Board to review library materials and advise JIG and JDOG on future acquisitions.

(2) (U) As a member of the Board, reviews library operations and forwards recommendations to the JIG Director and JDOG commander

f. (S) [Redacted] (b)(1)

(1) (S) [Redacted] (b)(1)

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JTF-GTMO-JIG-BSCT
SUBJECT: BSCT SOP (U)

(2) (S)
(b)(1)
(3) (S)

g. (U) Assists in the development of detention facility behavior management plans.

(1) (U) Consults with JDOG S-3, JDOG S-2, Medical, Behavioral Health, and ICE personnel to develop camp-wide strategies for improving behavioral levels of detainees.

(a) (U) Provides input into the development of strategies for reducing unwanted behavior, such as re-location or movement of detainees, disciplinary actions, structural or procedural changes within the camp.

(b) (U) Provides input into the development of strategies for increasing positive behavior, such as implementation of incentive programs, reinforcement programs for positive behavior, and increasing access to recreational and social activities.

b(1) (2) (S)

h. (U) Consults with JTF Commander on detainee issues, staff issues, and camp dynamics, and provides recommendations on ways to improve camp operations. BSCT personnel have full and direct access to JTF Commander to consult on all aspects of JTF mission.

i. (U) Other duties as assigned.

7. (U) Mental Health and Medical Services.

a. (U) BSCT personnel shall not conduct mental health evaluations or provide mental health treatment to detainees or JTF-GTMO personnel. BSCT personnel will take all reasonable steps to ensure that they are not perceived as healthcare providers for detainees or JTF-GTMO personnel.

(1) (U) The Joint Medical Group (JMG) provides all medical treatment, including mental health evaluation and treatment, for detainees and JTF-GTMO personnel. Services for detainees are provided through the Detention Hospital, Detention Clinic, and Detainee Behavioral Health Service. Services for JTF-GTMO personnel are provided through the Combat Stress Control, Joint Aid Station, and U.S. Naval Hospital, GTMO.

(2) (U) The JMG is responsible for advising JIG personnel (i.e., BSCT and ICE Operations) if there are any known physical, psychological, or medical conditions; limitations to functioning; or restrictions to usual activities that one is required to consider in order to ensure the safety of the detainee and U.S. personnel, e.g., diabetes, heart condition, special diet, psychological instability, contagious conditions.

b. (U) BSCT personnel will function as Medical Liaison Officers for the intelligence unit based on procedures established in conjunction with Joint Medical Group. When concerns about health status or medical condition of detainees are raised through observation by BSCT personnel, inquiries

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JTF-GTMO-JIG-BSCT
SUBJECT: BSCT SOP (U)

raised by interrogators or other reporting mechanisms, BSCT will convey these concerns to appropriate medical personnel for evaluation, treatment, and disposition.

(1) (U) Neither BSCT personnel nor interrogation teams have access to medical records of detainees. The BSCT acts as medical liaison between interrogation teams and medical personnel in order to maintain the separation between medical care and intelligence-collection.

(2) (U) The BSCT will direct requests for information and issues of medical concerns brought up by interrogation teams to the JTF-GTMO-JMG organizational box. From there it will be routed to the appropriate medical/ dental personnel for response to BSCT personnel who will forward to originator of the inquiry.

(3) (U) The kind of information shared will generally fall into two categories. The first is that of physical or medical conditions, or functional limitations, that one is required to consider in order to ensure the safety of the detainee and U.S. personnel, e.g., diabetes, heart condition, special diet, or contagious conditions. The other category of information shared is whether medical personnel were aware of the condition, if it had been evaluated and treated, or if an appointment is pending to address the concern.

(4) (U) The BSCT will meet on a regular basis with the Director, Joint Medical Group; Director, Medical Plans and Operations; OIC, SMO, and other staff from the Detention Hospital and Detainee Behavioral Health Service in order to discuss any issues related to policies and procedures.

8. (U) Intelligence Collection with Juveniles. JTF-GTMO does not normally detain Juvenile Enemy Combatants, however, in order to deal with this possibility, special procedures must be established. Juveniles are defined as any person below the age of 16. Gathering intelligence from juveniles will require special precautions and extra care because juveniles are often more vulnerable with less developed coping skills than adults. In order to ensure proper care for the juvenile detainee, the following procedures will be followed:

a. (U) For any person under the age of 16, a BSCT personnel will be present for the entire time of interrogation. A medical provider will evaluate the juvenile prior to and after the interrogation. The interrogation plan must be reviewed by the BSCT psychologist, ICE Regional Team Chief, ICE Chief, and the JIG Director.

b. (S)

[REDACTED] (b)(1)

c. (S)

[REDACTED] (b)(1)

(1)(S)

[REDACTED] (b)(1)

(2) (U) Since many juvenile detainees have come from deprived environments, special effort will be made to ensure their protection, to provide necessary emotional support, and to provide education as available.

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JTF-GTMO-JIG-BSCT
SUBJECT: BSCT SOP (U)

(3) (U) Transportation and the security of the detainees will be organized and implemented by the JDOG personnel. [REDACTED]

(b)(2)

9. (U) **Other Operational Procedures.** The following procedures apply to the daily BSCT operations.

a. (U) **OPSEC.** All operations of the BSCT must conform to guidance set forth in JTF-GTMO General Order Number 2. Specific considerations for BSCT personnel are as follows.

(1) (U) Ensure that classified material (files, papers, photos, disks) are properly secured in the safe designated for BSCT use; at no time shall classified materials be left unattended in BSCT offices.

(2) (U) Do not discuss detainee operations or other classified information over unclassified phone lines.

(3) (U//FOUO) Sanitize uniforms by placing tape over the name when working in or visiting areas where contact with detainees is possible, including detainee blocks, interrogation buildings, and medical facilities.

(4) (U//FOUO) Use a courier bag when transporting classified or sensitive documents. Do not use courier bags for transportation of unclassified or prohibited materials.

(5) (U) Do not discuss detainee operations in areas where individuals without appropriate clearance or need to know could overhear information.

(6) (U) Do not discuss operations, current events, or personal information in the presence of detainees.

(7) (U) Ensure BSCT offices are locked at the end of the day and that the security checklist is completed. The last person leaving the building must also complete the security checklist for the building and ensure the front door is secured using the combination lock.

b. (U) **Vehicle Operations.** Ensure the BSCT vehicle is taken to motor pool for reassignment and routine maintenance NLT the end of each month.

c. (U) **Supplies.** Required office/administrative supplies can be obtained through the ICE Admin office. Other supplies and equipment can be ordered through ICE Admin office by completing the appropriate purchase order request.

10. (U) **Battle Rhythm.** Successful execution of day-to-day mission requirements requires flexibility, self-discipline, and ability to multi-task and prioritize in all BSCT personnel. There are often competing urgencies. Many tasks are self-directed; many demands are made with little or no notice while others are scheduled in advance. Assessments typically require a series of observations in different settings and hours of research. Many day-to-day activities are determined by response to requests for consultation and observation; often, rapid response is required. Some committee meetings and working groups follow established schedules while others are generated by the BSCT for specific purposes.

a. (U) **Ethical and legal responsibilities.** In addition to the other duties and qualifications noted in this document, it is the responsibility of all BSCT personnel to familiarize themselves with and adhere to

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BSCT SOP 6

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JTF-GTMO-JIG-BSCT
SUBJECT: BSCT SOP (U)

the UCMJ, Geneva Conventions, applicable rules of engagement, local policies, as well as professional ethics and standards of psychological practice. All BSCT personnel will be expected to:

(1) (U) Read and adhere to JTF-GTMO policy memoranda, regulations, and SOPs.

(2) (U) Immediately report any suspicions of abuse of detainees or misconduct by U.S. personnel to JIG Director who is responsible for further reporting to JTF Commander.

(3) (U) Consult with colleagues and their chain of command regarding any conflicts that may arise between professional requirements and performance of their duties.

b. (U) **Referral process for consultations.** Interrogators may request consultation to support interrogations or other requirements by contacting any member of the BSCT. This will most typically occur in person at BSCT offices, by telephone, or by email.

c. (U) **Committee Membership.** BSCT personnel participate in the following committees, working groups, and meetings.

(1) (U) Interrogation Strategy Meeting (ISM, BSCT1): weekly in the JIG conference room.

(2) (U) JIG Command and Staff Meeting (BSCT1): weekly in the JIG conference room.

(3) (U) JIG pre-ISM (BSCT1/2): weekly in the JIG conference room.

(4) (U) ICE Coordination Meeting (BSCT1/2): weekly in the ICE Conference Room.

(5) (U) JDOG Coordination Meeting (BSCT1/2): weekly in the ICE Conference Room.

(6) (U) JDOG Company Training (BSCT1/2/3): Camp America Chapel as convened by JDOG.

(7) (U) ICEbox Review Committee (BSCT1/2/3): ICE Conference Room; convened by BSCT as needed.

(8) (U) Library Advisory Board (BSCT1/2): Meetings as convened by chair.

(9) (U) Other committees/ roundtables/ working groups, as appropriate.

11. (U) **Point of Contact.** The point of contact for this SOP is BSCT Chief at [REDACTED]

Attachments:

Annex A – BSCT Assessment: Guidelines & Format (U)

Annex B – BSCT Observation Report: Guidelines & Format (U)

Annex C – BSCT Risk Assessment: Guidelines & Format (U)

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28 March 2005 Final Draft

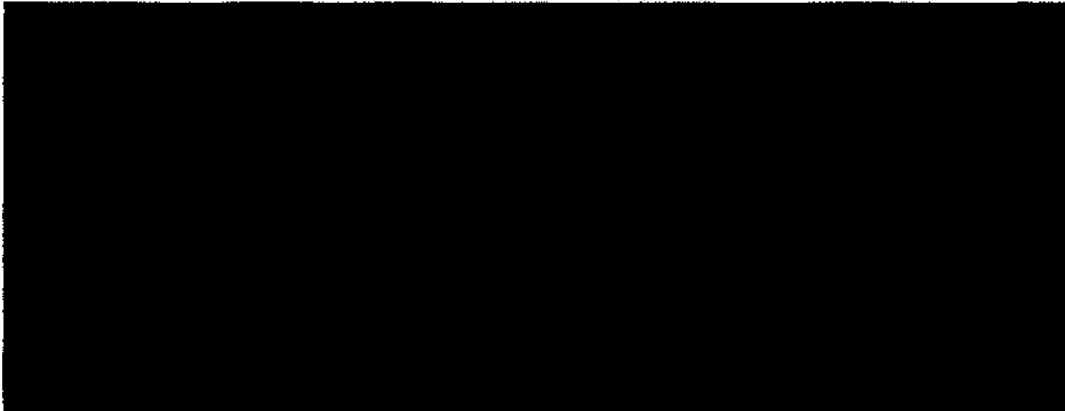
SUBJECT: BSCT SOP - Annex A
BSCT Assessment: Guidelines & Format (U)

JTF-GTMO- [REDACTED]

Date

MEMORANDUM FOR RECORD

SUBJECT: Behavioral Science Consultation Team Assessment; ISN XXX



4. (U//FOUO) Physical/ medical limitations: Include here a statement of any known physical or medical conditions, or limitations to functioning, that one is required to consider in order to ensure the safety of the detainee and U.S. personnel, e.g., diabetes, heart condition, special diet, or contagious conditions.

5. (U) Social history: [REDACTED]

a. (e) [REDACTED]

b. (e) [REDACTED]

c. (e) [REDACTED]

d. (e) [REDACTED]

CLASSIFIED BY: JTF-GTMO Classification Guide dated (date of current guide)

REASON: 1.4(C) or Intelligence Activities, Sources, or Methods

DECL ON: (Future date - dependent on report content and Classification Guide noted)

BSCT SOP, Annex A 1

WARNING NOTE: Paragraph classification markings in this document are specific to the information contained in the template. Classification markings in future generated reports must be determined by the originator (i.e., BSCT personnel writing the report) and may vary based on content and information provided in each section.

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28 March 2005 Final Draft

SUBJECT: BSCT SOP - Annex A
BSCT Assessment: Guidelines & Format (U)



BSCT2
X-####

Note: Sample reports may be found in electronic files.

BSCT SOP, Annex A 2

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FDMApress Annotation

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28 March 2005 Final Draft

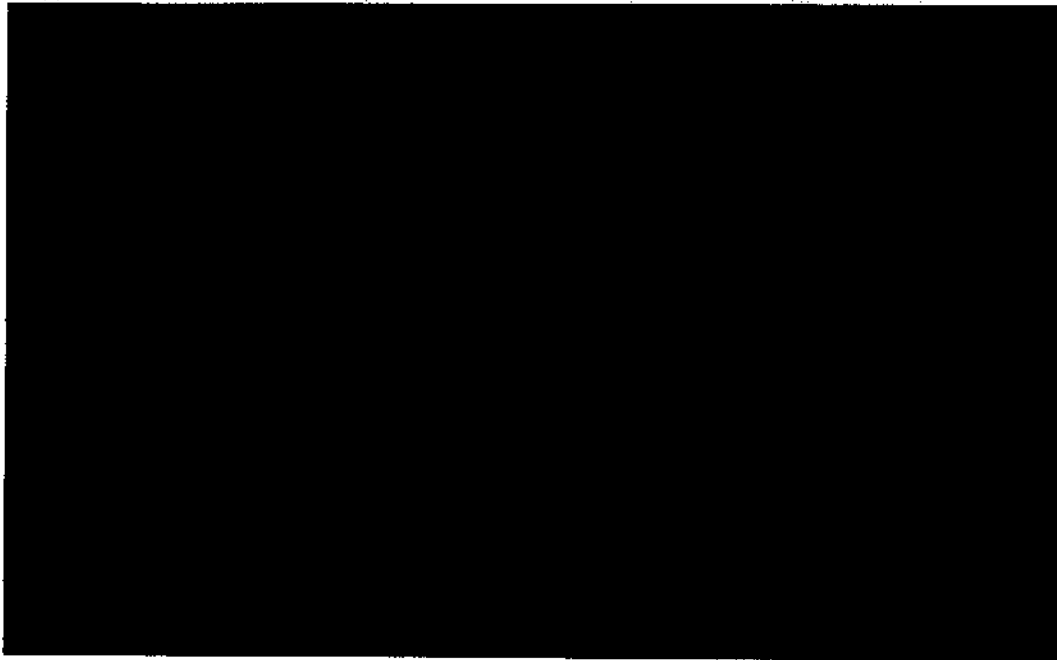
SUBJECT: BSCT SOP - Annex B
BSCT Observation Report: Guidelines & Format (U)

JTF-GTMO-██████████

Date

MEMORANDUM FOR RECORD

SUBJECT: Behavioral Science Observation Report - ISN XXXXX



BSCT3
X-####

CLASSIFIED BY: JTF-GTMO Classification Guide dated (date of current guide)
REASON: 1.4(C) or Intelligence Activities, Sources, or Methods
DECL ON: (Future date - dependent on report content and Classification Guide noted)

BSCT SOP, Annex B 1

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28 March 2005 Final Draft

SUBJECT: BSCT SOP - Annex C
BSCT Risk Assessment: Guidelines & Format (U)

JTF-GTMO- [REDACTED]

Date

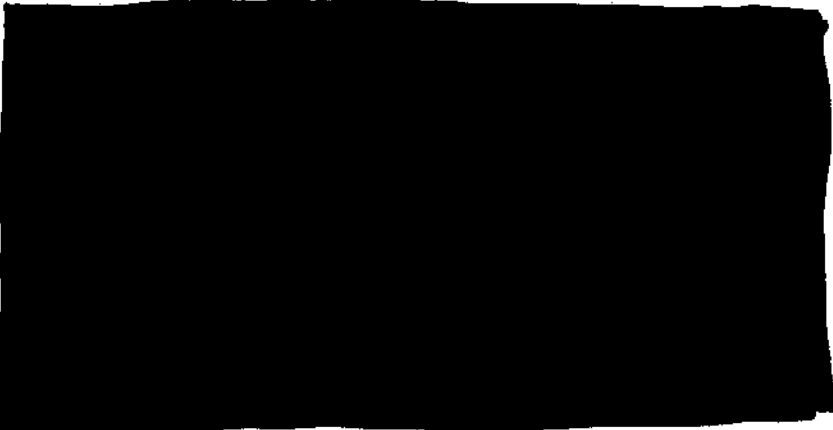
MEMORANDUM FOR RECORD

SUBJECT: Behavioral Science Consultation Team Risk Assessment; ISN XXXXXXXXXX



2. (U) Sources of Information: It is useful to identify in the risk assessment the sources used. There are many potential sources of information for these assessments including:

- a. (U)
- b. (U)
- c. (U)
- d. (U)
- e. (U)
- f. (U)
- g. (U)
- h. (U)



b(2)

CLASSIFIED BY: JTF-GTMO Classification Guide dated (date of current guide)
REASON: 1.4(C) or Intelligence Activities, Sources, or Methods
DECL ON: (Future date - dependent on report content and Classification Guide noted)
BSCT SOP, Annex C 1

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28 March 2005 Final Draft

SUBJECT: BSCT SOP - Annex C
BSCT Risk Assessment: Guidelines & Format (U)

3. (U//FOUO) **Psychosocial History:** Provide a brief history based on information from database and hard copy files available at the time of review. Include age, place of birth, family of origin, motivations for violent jihad-travels, training/ education, capture, custody; language(s) spoken and fluency.

4. (U//FOUO) **Health Status:** Provide a brief summative statement based on medical and other reports, interviews with medical personnel, and possibly direct observation. A general statement will have been provided to DAB by medical personnel and will be used to develop the assessment as noted below. BSCT will need to use medical summary to identify the three elements of function – physical, cognitive and behavioral.

a. (U//FOUO) **History:** a brief statement of overall medical condition, provided by medical personnel.

b. (U//FOUO) **Treatment:** primary focus of this section will be on treatment provided while in custody but may include prior history if significant. This may include both medical and behavioral health treatment. Medical personnel will provide information necessary for the purposes of the DAB assessment.

c. (U//FOUO) **Function:** section is comprised of a series of three statements regarding detainee's current level of functioning – physical, cognitive, and behavioral.

(1) (U//FOUO) **Physical:** a statement of overall physical functioning, including any significant limitations.

(2) (U//FOUO) **Cognitive:** a statement of general cognitive functioning including any significant limitations or deficits, and demonstrated intellectual abilities.

(4) (U//FOUO) **Behavioral:** an observationally-based statement of behavioral functioning while in detention.

d. (U//FOUO) **Prognosis:** a statement of prognosis based on current health status.



BSCT SOP, Annex C 2

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28 March 2005 Final Draft

SUBJECT: BSCT SOP - Annex C
BSCT Risk Assessment: Guidelines & Format (U)



BSCTI
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Note: Sample reports may be found in electronic files.

BSCT SOP, Annex C 3

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FCIA/Press Annotation



~~UNCLASSIFIED//FOUO~~

DEPARTMENT OF DEFENSE
HEADQUARTERS, JOINT TASK FORCE GUANTANAMO
U.S. NAVAL BASE, GUANTANAMO BAY, CUBA
APO AE 09360

JTF-GTMO-JIG-BSCT

10 December 2004

MEMORANDUM FOR Joint Intelligence Group, Joint Task Force - Guantanamo, APO AE 09360

SUBJECT: Operational Policy Memorandum # 14, Behavioral Science Consultation Team (BSCT)

1. **Purpose:** The purpose of this instruction is to establish policy for the operations of the Behavioral Science Consultation Team (BSCT), Joint Interrogation Group (JIG), Joint Task Force-Guantanamo Bay, Cuba (JTF-GTMO).

2. **Scope:** This policy document applies to all personnel assigned to the BSCT.

3. **BSCT Personnel:**

a. BSCT Chief (BSCT1): Clinical Psychologist, USA, 73B. Chief, responsible for all issues relating to BSCT operations. Develops detailed BSCT policies and operating procedures. Reports to the Director, JIG; coordinates with the Commander, Joint Detention Operations Group (JDOG); and, as directed, provides special staff officer functions to the Commander, JTF-GTMO.

b. Assistant BSCT Chief (BSCT2): Clinical Psychologist, USAF, 42P3. Assumes duties of BSCT1 in his/her absence. Provides consultation and interrogation support to the Interrogation Control Element (ICE). Works with JDOG-S2 (Counter-Intelligence) to identify trends in detainee behavior (b)(2)

(b)(2) Supports Deployment Cycle Support program by providing training on Posttraumatic Stress and Anger Management for personnel departing JTF-GTMO.

c. BSCT NCOIC (BSCT3): Mental Health Specialist, USA, 91X. Provides consultation and interrogation support to the ICE. Assesses camp climate and provides feedback to BSCT1 on issues and trends.

4. **Mission:** Provide psychological consultation in order to support safe, legal, ethical, and effective interrogation and detention operations at JTF-GTMO.

~~UNCLASSIFIED//FOUO~~

JTF-GTMO-JIG-BSCT

SUBJECT: Operational Policy Memorandum # 14, Behavioral Science Consultation Team (BSCT)

5. Objectives:

a. Provide psychological expertise to assess the individual detainee and his environment, and to provide recommendations to enhance the effectiveness of interrogation operations.

b. Use psychological expertise to provide monitoring, consultation, and feedback regarding the entire detainee environment in order to assist the command in ensuring humane treatment of detainees, the prevention of abuse, and the safety of U.S. personnel.

6. Mission Essential Tasks:

a. Provides consultation to interrogation staff in support of the intelligence collection mission.

b. Monitors interrogations and other staff-detainee interactions; provides consultation on policies and strategies for ensuring the safety of detainees and JTF-GTMO personnel; provides direct feedback to command on issues involving psychological risk factors affecting detainee operations.

c. Monitors behavioral trends in the detainee population and integrate findings into consultation in support of interrogation and detention operations.

d. Provides selected JIG and JDOG personnel with training on behavioral, psychological, cultural, and religious issues pertaining to the detainee population.

e. Advises JIG and JDOG on use of materials for the library and sits on the advisory board.

f. Provides assistance in the development of psychological operations plans and consultation on the utilization of products developed by Psychological Operations team.

g. Assists in the development of detention facility behavior management plans.

h. Consults with JTF Commander on detainee issues, staff issues, and camp dynamics, and provides recommendations on ways to improve camp operations.

JTF-GTMO-JIG-BSCT

SUBJECT: Operational Policy Memorandum # 14, Behavioral Science Consultation Team (BSCT)

7. Mental Health and Medical Services:

a. BSCT personnel do not conduct mental health evaluations or provide mental health treatment to detainees or JTF-GTMO personnel. The Joint Medical Group provides all medical treatment, including mental health evaluation and treatment, for detainees and JTF-GTMO personnel. Services for detainees are provided through the Detention Hospital, Detention Clinic, and Detainee Behavioral Health Service. Services for JTF-GTMO personnel are provided through the Combat Stress Control, Joint Aid Station, and U.S. Naval Hospital, GTMO. BSCT Personnel will take all reasonable steps to ensure that they are not perceived as health care providers for detainees or JTF-GTMO personnel.

b. When concerns about health status or medical condition of detainees are raised through observation by BSCT personnel, through inquiries raised by interrogators or other reporting mechanisms, these concerns will be conveyed to medical personnel for evaluation, treatment, and disposition.

8. Point of Contact: The point of contact for this Operational Policy Memorandum is the (b)(6)

(b)(6)

SECRET



DEPARTMENT OF DEFENSE
JTF GTMO
GUANTANAMO BAY, CUBA
APO AE 09360

JTF GTMO-BSCT

11 November 2002

MEMORANDUM FOR Record

SUBJECT: BSCT Standard Operating Procedures

1. Purpose. The purpose of this memorandum is to establish procedures for the daily operation and administration of the BSCT working under the Joint Interrogation Group (JIG) of JTF GTMO.

2. Personnel. The BSCT is comprised of the following U.S. Army occupational specialties.

- a. 1 Clinical Psychologist, 73B.
- b. 1 Psychiatrist, 60W.
- c. 1 Mental Health Specialist, 91X.

3. Mission. Provide behavioral science consultation in support of JTF GTMO's interrogation mission.

4. Mission Essential Tasks.

a. Consult on interrogation approach techniques.

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

b. [REDACTED]

c. [REDACTED]

d. Assist in the development of detention facility behavior management plans.

e. Act as a liaison between the JIG and the JTF GTMO medical assets. Describe the implications of medical diagnoses and treatment for the interrogation process.

f. Support good stress management, morale, cohesion and organizational functioning in the JIG.

b(1)

JTF GTMO-BSCT
SUBJECT: BSCT SOP

5. Referral Process for Consultations to Support Interrogation. Interrogators may request consultation by contacting any member of the BSCT at [REDACTED] (b)(2)
6. Detainee Mental Health Evaluations and Medical Care.
 - a. Interrogators should contact the JTF GTMO camp medical clinic at [REDACTED] to request a mental health evaluation for a detainee. (b)(2)
 - b. The BSCT does not conduct medical evaluation or treatment of detainees and does not participate in determining medical treatment protocols for detainees.
 - c. The health status of detainees is solely the responsibility of the JTF GTMO medical staff.
 - d. The BSCT is available on request to observe a detainee to provide input on the appropriateness of a mental health referral for that individual.
7. Security Clearance. All members of the BSCT will have a clearance of Secret or higher.
8. Point of contact for these SOP is [REDACTED] (b)(2), (b)(6)

[REDACTED] (b)(6)

[REDACTED] (b)(6)



REPLY TO
ATTENTION OF

DEPARTMENT OF DEFENSE
UNITED STATES SOUTHERN COMMAND
3811 NW 81ST AVENUE
MIAMI, FL 33172-1277

SCCS

09 AUG 2004

MEMORANDUM FOR

Commander, Joint Task Force Guantanamo, US Naval Base Guantanamo Bay, Cuba, APO AE 09360
JTF Surgeon, Joint Task Force Guantanamo, US Naval Base Guantanamo Bay, Cuba, APO AE 09360

SUBJECT: USSOUTHCOM Policy on Health Care Delivery to Enemy Persons Under U.S. Control at US Naval Base Guantanamo Bay, Cuba

1. References:

- a. DoD Directive 2310.1, "DoD Program for Enemy Prisoners of War (EPOW) and Other Detainees," August 18, 1994
- b. Third Geneva Convention Relative to the Treatment of Prisoners of War of August 12, 1949
- c. AR 190-8, OPNAVINST 3461.6, AFJI 31-304, MCO 3461.1, "Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees," 1 October 1997
- d. HA Policy 02-005, "DoD Policy on Medical Care for Enemy Persons Under U.S. Control Detained in Conjunction with Operation ENDURING FREEDOM," April 10, 2002
- e. USSOUTHCOM Confidentiality Policy for Interactions Between Health Care Providers and Enemy Persons Under U.S. Control Detained in Conjunction with Operation ENDURING FREEDOM, August 6, 2002

2. This policy memorandum, issued under the authority of reference (d), provides guidance, consistent with references (a) through (e), for medical care for enemy detainees under U.S. control at US Naval Base Guantanamo Bay, Cuba.

3. **Background.** Enemy persons have been detained at US Naval Base Guantanamo Bay, Cuba, since January 2002. Joint Task Force-Guantanamo (JTF-Guantanamo) was established in November 2002. Since January 2002 the U.S. SOUTHCOM Surgeon's Office has been providing guidance regarding the healthcare being provided to the "detainees" at JTF-Guantanamo and its predecessor, JTF-160. This policy encapsulates guidance that has been provided.

4. All health care is delivered at the U.S. Naval Base Guantanamo Bay, Cuba.

5. HQUSSOUTHCOM does not have approval authority for evacuation to the United States for health care.

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6. Level I and II medical care is provided at the detainee hospital.
7. Level III medical care is provided by the U.S. Naval Hospital Guantanamo Bay as needed.
8. Detention Hospital:
 - a. The detention hospital at JTF-Guantanamo is a fixed facility.
 - b. Manpower: Basic requirements are for internal medicine, family practice, General Surgery, psychiatry, psychology, dental, nursing staff (to include ICU nurses) and hospital corpsman staff. The Naval Hospital provides some medical and surgical support along with administrative, computer and supply support.
9. Mental Health Care:
 - a. Mental health care to detainees is provided as part of Detainee Hospital care.
 - b. One block of the detention camp is designated as an inpatient psychiatric facility. It is staffed full time with a team of providers devoted exclusively to detainee mental health care. This includes a psychiatrist, psychologist, psychiatric nurses and psychiatric technicians. The Social Worker assigned to USNH Guantanamo also serves as a consultant to the facility.
 - c. Mental health support to JTF personnel is provided separately.
10. Health and Medical Care:
 - a. All detainees are provided a safe environment with adequate nutrition. Medical personnel who gain knowledge of physical or mental ill-treatment of detainees will report this ill-treatment to the appropriate military authority.
 - b. All detainees undergo a complete physical exam upon arrival. Particular attention is given to potential infectious diseases. Detainees found to have a possible history or clinical evidence of infectious diseases are treated and kept in isolation until the treatment is completed before entry into the general population.
 - c. Medical care and treatment shall be provided whenever necessary. Detainees are offered routine general medicine, dental, optometry, infectious disease, internal medicine, general surgery, orthopedics, physical therapy and limb-prosthetics. Required specialty care not available at the Detention Hospital or U.S Naval Hospital, Guantanamo Bay is requested via proper channels.
 - d. Extraordinary situations that require special diagnostic and/or specialized medical care beyond the capability of the Department of Defense to provide or import to U.S. Naval Base, Guantanamo Bay are considered on a "case by case" basis. Such cases are reviewed by all applicable parties and possible options for care are submitted to CDR USSOUTHCOM for review and concurrence then forwarded to Office of the Secretary of Defense (OSD) via Joint Staff J-4-HSSD for final disposition.

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- e. No experimental drugs are used on any detainee. All medications utilized are U.S. Food and Drug Administration approved.
 - f. No human research is to be conducted.
 - g. U.S. accepted standards of medical care (current practice guidelines) are used.
11. Detainees are not allowed to stop oral intake to the point where it adversely affects their health.
12. Communications between detainees and military medical, dental and mental health care providers are not confidential and are not subject to the assertion of privileges by or on behalf of detainees.
- a. Medical information can be made available to appropriate military authority as required and released by the JTF-Guantanamo Surgeon or the Command Surgeon, USSOUTHCOM.
 - b. Health care providers who directly care for detainees and JTF members may not become active participants in the collection of information for purposes other than medical treatment.
13. Any health care issues beyond the scope of usual clinical practice causing an ethical dilemma are reviewed and addressed as follows:
- a. The detainee hospital physician in-charge submits a clinical summary and recommendations to the JTF Surgeon who in turn forwards the information to USSOUTHCOM Surgeon.
 - b. The USSOUTHCOM Surgeon in consultation with the Joint Staff J4-HSSD/SG convenes a panel to include a detainee hospital physician, JTF Surgeon, SCDCOS, SCCH, SCSJA, JS J4-HSSD/SG-2 and others as required to consider the case and make recommendations to the SCCOS, CDR JTF-Guantanamo and CDR USSOUTHCOM. In certain situations (reference 10d above) case recommendations may require submission to OSD via Joint Staff J4-HSSD for final disposition.
14. The JTF Surgeon develops SOPs for daily operations.
15. My point of contact for detainee medical issues is the Command Surgeon, DSN (b)(2)

FOR THE COMMANDER:


MICHAEL R. LEHNERT
Brigadier General, U.S. Marine Corps
Chief of Staff, U.S. Southern Command



REPLY TO
ATTENTION OF

DEPARTMENT OF DEFENSE
UNITED STATES SOUTHERN COMMAND
3811 NW 91ST AVENUE
MIAMI, FL 33172-1217

SCCS

6 August 2002

POLICY MEMORANDUM 8-02

From: Chief of Staff
To: See Distribution

SUBJECT: U.S. Southern Command Confidentiality Policy for Interactions Between Health Care Providers and Enemy Persons Under U.S. Control, Detained in Conjunction with Operation ENDURING FREEDOM

1. References:

- a. DoD Directive 5136.1, "Assistant Secretary of Defense for Health Affairs (ASD (HA)),
May 27, 1994
- b. DoD Directive 2310.1, "DoD Program for Enemy Prisoners of War (EPOW) and
Other Detainees," August 18, 1994
- c. Third Geneva Convention Relative to the Treatment of Prisoners of War of August
12, 1949
- d. AR 190-8, OPNAVINST 3461.6, AFJI 31-304, MCO 3461.1, Enemy Prisoners of War,
Retained Personnel, Civilian Internees and Other Detainees," 1 October 1997

2. Purpose. This policy memorandum provides guidance, consistent with references 1.b. through 1.d. for medical care of enemy detainees under U.S. control.

3. Background. Foreign national persons captured and detained during combat operations in Afghanistan and elsewhere as part of Operation ENDURING FREEDOM ("detainees") have, in some cases, been transported to the Guantanamo Bay Naval Base in Cuba for detention pending interrogation and disposition. Detainees are not "prisoners of war," but instead are "unlawful combatants" who will be treated humanely and, to the extent appropriate and consistent with military necessity, in a manner consistent with the principles of the Geneva Convention Relative to the Treatment of Prisoners of War. Medical, dental, and mental health care is provided to the detainees by military medical personnel under conditions and for purposes similar to those applicable to military correctional facilities. Communications from detainee to provider are generally for the purpose of treatment, but may also contain information about harm to others or information of intelligence, tactical, or strategic value.

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SUBJECT: U.S. Southern Command Confidentiality Policy for Interactions Between Health Care Providers and Enemy Persons Under U.S. Control Detained in Conjunction with Operation ENDURING FREEDOM

4. Policy. It shall be the policy of the United States Southern Command that:

a. The purpose of medical, dental, and mental health care provided to detainees held at Guantanamo Bay Naval Base is to treat injuries and maintain health; to safeguard the public health as an exclusive Federal responsibility; and to assist in preserving the detention environment and the safety of cadre, staff, other detainees, and the surrounding population.

b. Detainees shall be treated humanely, without adverse distinction based on sex, race, nationality, religion, political opinions, or other similar criteria.

c. Communications between detainees and military medical, dental, and mental health care providers, including but not limited to doctors, dentists, psychiatrists, psychologists, psychotherapists, and persons directed or assigned to assist such persons, are not confidential and are not subject to the assertion of privileges by or on behalf of detainees. Detainees shall not be given cause to have expectations of privacy regarding their communications.

d. Medical personnel shall convey any information concerning the safety and security of military or civilian personnel, military or civilian property, classified information, or the accomplishment of a military or national security mission including homeland defense obtained from detainees in the course of treatment to non-medical military or other United States personnel who have an apparent need to know the information. Such information shall be communicated to other United States personnel with an apparent need to know, whether the exchange of information with the non-medical person is initiated by the provider or by the non-medical person. Medical personnel may not, however, become active participants in the collection of information, and may not be tasked in any way for collection of such information. Medical personnel may seek medical history to include by whom and where previous treatment was rendered.

e. Medical, dental, and mental health care providers, who in the course of treatment receive from a detainee information that constitutes a threat of bodily harm to a specific individual, must take immediate steps to make the target of the threat, the authorities responsible for the security of the threatened individual, and the authorities responsible for counteracting the threat (if different from those responsible for the individual's security), aware of the nature and source of the threat.

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SUBJECT: U.S. Southern Command Confidentiality Policy for Interactions Between Health Care Providers and Enemy Persons Under U.S. Control, Detained in Conjunction with Operation ENDURING FREEDOM

5. Point of Contact. The U.S. Southern Command Surgeon's Office is the point of contact for this policy at commercial [REDACTED] and DSN [REDACTED]

FOR THE COMMANDER IN CHIEF:



R.A. HUCK
Brigadier General, U.S. Marine Corps
Chief of Staff, U.S. Southern Command

DISTRIBUTION

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DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
WASHINGTON, DC 20301-1010

JAN 12 2005

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARY OF DEFENSE FOR POLICY
COMMANDER, U.S. CENTRAL COMMAND
COMMANDER, U.S. EUROPEAN COMMAND
COMMANDER, U.S. PACIFIC COMMAND
COMMANDER, U.S. SOUTHERN COMMAND
COMMANDER, U.S. SPECIAL OPERATIONS COMMAND
ASSISTANT SECRETARY OF DEFENSE FOR SPECIAL
OPERATIONS AND LOW INTENSITY CONFLICT
ASSISTANT SECRETARY OF DEFENSE FOR
HEALTH AFFAIRS
GENERAL COUNSEL OF THE DEPARTMENT OF
DEFENSE

**SUBJECT: Policy Statement and Guidelines on Body Cavity Searches and
Exams for Detainees Under DoD Control**

Body cavity exams for detainees under DoD control shall be conducted in accordance with the attached policy guidance. Please ensure that this guidance is distributed within your organization. The Joint Staff is responsible for implementing this policy.

A handwritten signature in black ink, appearing to read "Paul Wolfowitz".

Attachment:
As stated

OSD 18742-04



**Policy Statement and Guidelines on Body Cavity Searches and Exams
of Detainees in DoD Control.**

The United States has a significant and legitimate interest in performing appropriate security searches and medical exams that address the safety, health, and security concerns of DoD personnel and detainees under DoD control. However, the use of body cavity exams and searches may conflict with the customs of some detainees. Therefore, effective immediately, the following guidelines are in effect:

- Do not perform routine detainee body cavity exams or searches (to include hernia exams).
- Body cavity exams may be performed for valid medical reasons with the verbal consent of the patient. However, these exams should not be performed as part of a routine medical intake exam.
- Body cavity searches are to be conducted only when there is a reasonable belief that the detainee is concealing an item that presents a security risk.
- To the extent possible and consistent with military necessity, a body cavity exam or search, whether conducted for medical or security reasons, should be conducted by personnel of the same gender as that of the detainee being searched.
- All body cavity exams and searches will be conducted in a manner that respects the person.
- The first general officer in the chain of command shall be the approval authority for body cavity searches (other than those performed for valid medical reasons).
- For the purposes of this policy, a detainee is a person under the control of the Department of Defense as a result of armed conflict, including the global war on terrorism, and includes enemy combatants, enemy prisoners of war, and civilian internees.