I. PURPOSE:

The purpose of this health services bulletin is to provide guidelines:

A. For a 24 hour institutional health services emergency plan.

B. For the immediate response and care of inmates with medical emergencies.

C. For training health care staff on emergency guidelines, equipment and medication.

These standards and responsibilities apply to both Department staff and Comprehensive Health Care Contractor (CHCC) staff.

II. DEFINITIONS:

A. **Comprehensive Health Care Contractor (CHCC)** - refers to contracted staff that has been designated by the Department to provide medical, dental and mental health services at designated institutions within a particular region.

B. **Medical emergency**- an acute injury or illness which poses an immediate risk to a person's life or long term health.

C. **First responder**- the first person who discovers the emergency who is trained to perform basic first aid and CPR.

D. **Cardio Pulmonary Resuscitation (CPR)** - an emergency procedure for people in cardiac and or respiratory arrest

E. **Automatic External Defibrillator (AED)** - a portable electronic device that automatically diagnoses the potentially life threatening cardiac arrhythmias of ventricular fibrillation and ventricular tachycardia in a patient, and is able to treat them through defibrillation.

F. **Jump Bag**- a bag containing a specific set of equipment/medication that is used in a medical emergency.

G. **Health Care Provider**- Clinicians and nursing staff trained in first aid, CPR and the use of an AED.

H. **Auxiliary Aids and Services:** refers to devices and/or services that provide assistance to allow otherwise eligible individuals with documented impairments and/or disabilities equal access to the Department's programs, services and/or activities.

III. EMERGENCY PLAN:

Note: When carrying out emergency planning, preparedness and response, health care staff shall consider the needs of inmates with hearing, mobility and vision impairments/disabilities, to ensure they are able to understand

and follow instructions, and receive any assistance they may need to participate in the emergency activities. Planning and response should include a process to secure auxiliary aids and services once the emergency has been addressed and the patient is considered stable.

A. The institution's HSA (Health Services Administrator)/ DON (Director of Nursing), working with the Warden or his/her designee, will ensure that a written emergency services plan that includes the following is in place:

1. On-site emergency first aid
2. Emergency evacuation of the inmate from the facility
3. Use of an emergency vehicle
4. Use of one or more designated hospital emergency rooms or other appropriate health care facilities
5. Emergency on-call physician, psychiatrist, pharmacist and dental services
6. Security procedures providing for the immediate transfer of inmates, when appropriate
7. Control and access for keys to secured Jump Bag, medications and emergency treatment area
8. For health care emergencies in institutions where medical staff are not available seven (7) days a week and/or 24 hours a day, security staff will initiate a call to local EMS (Emergency Medical Services).
9. Access to auxiliary aids and services as needed for inmates with disabilities once the emergency has stabilized.

IV. RESPONSIBILITY:

A. Any first responder who discovers a suspected medical emergency will immediately initiate the procedures listed in this health services bulletin.

B. The Chief Health Officer/Institutional Medical Director (or designee) is ultimately responsible for assuring optimal medical treatment is delivered to inmates.

C. The Chief Health Officer or designee is the team leader during regular working hours. After hours, the most senior health care provider will act as such until EMS arrives.

D. All health care providers must be certified in basic CPR and the use of an AED.

E. Health care staff must perform Mock Code exercises on a quarterly basis as part of an efficient institutional training program.

F. In-service training for health care providers will be documented on the form DC2-901, Training Attendance Report. A copy of this form will be maintained in the medical unit of each institution.

V. GUIDELINES FOR TREATMENT OF MEDICAL EMERGENCIES:

A. First responders will initiate appropriate emergency intervention as quickly as possible after identifying a medical emergency (unless security constraints prevent intervention).

B. Health Services staff must be notified of the type of emergency and the location.

C. The health care provider will:

1. Either respond to the site of the emergency or have the patient transported to the clinic.

2. Assess the medical emergency and ask for additional help if necessary.

3. Continue appropriate first aid and/or CPR.

4. Monitor and document vital signs.

5. After the assessment of a legitimate medical emergency, staff will report the patient's condition and status to the chief health officer or designee, as soon as possible. All communications with the clinician must be documented on the appropriate DC4-683 series form (or DC4-701, Chronological Health Record of Health Care, if there's no applicable Nursing Protocol) and the DC4-760B, Health Information Summary for Emergency Transfer to Outside Hospital. Document the date and time.

7. Notify the control room of any pending transfer and request provision of security staff.

8. Activate local EMS if the inmate's condition is unstable. Record the date and time of activation.

9. Obtain a current health history on inmate (the medical record should be obtained, if time permits, before clinician is notified).

10. Notify local emergency room of pending transfer.

11. Record the date and time of EMS arrival.

12. Complete documentation of the medical event, findings and treatment and inmate response to treatment on the appropriate DC4-683 series form (or DC4-701 if there's no applicable Nursing Protocol) and the DC4-760B.

13. Send copies of documentation to receiving facility.

DO NOT SEND ORIGINAL INMATE HEALTH RECORD!

14. Inform Health Services Administrator/Nurse Manager and Utilization Management of the transfer as soon as possible (by next working day, if after hours).

15. Document the condition of the patient and time of transfer.

VI. GUIDELINES FOR EMERGENCY PROCEDURES FOR CARDIOPULMONARY RESUSCITATION (MED CODE 99):

A. Any person who discovers a suspected cardiopulmonary arrest must initiate cardiopulmonary resuscitation protocol (Med Code 99 protocol).

B. If a suspected cardiac arrest occurs outside the medical unit, health care provider/s will respond with the Jump Bag and AED. If indicated, health care provider/s will transfer the patient to the medical unit for further treatment, continuing CPR en route.

C. If transfer to the medical unit is unrealistic due to physical barriers or the condition of the inmate, the use of the AED and/or CPR shall be continued until EMS arrives and takes over the delivery of care.

D. Notification and Staff Utilization:

1. The control room or medical staff (determined by individual institutional policy) can activate the EMS system for transfer/assistance of inmates while Med Code 99 protocol is in progress. First responders and designated health care provider/s will respond to cardiopulmonary emergencies.

2. Additional personnel can be utilized for:

   a. Assisting the team as needed.
   b. Making phone calls.
   c. Ensuring organization and maintaining as calm an atmosphere as possible.
   d. Monitoring traffic.
   e. Performing CPR.

3. During regular working hours, the HSA / DON can arrange for transport of inmate.

4. Notify Warden, officer in charge (OIC), and Chaplain. If the inmate is admitted to the hospital notify Utilization Management (by next day if after hours).

E. Guidelines for Cardiac Emergency:

1. Initiate CPR as needed. Activate the EMS system as soon as possible.

2. When AED arrives, hook patient up to AED on scene and follow AED instructions. If no order is given for shock, continue CPR.

3. Transfer patient, if appropriate, with CPR in progress to medical unit for continuation of Med Code 99.

4. Place backboard under patient to administer CPR.

5. Prepare suction and set up oxygen if in the medical unit.

6. A peripheral IV with a large-bore catheter and 0.9% NS IV solution will be started by appropriately trained staff; e.g. registered nurse, IV certified licensed practice nurse, or certified paramedic in medical unit.

7. Use Ambu Bag or one way mask.

8. Assess respiratory status frequently.

9. Document patient's condition, Code treatments, and patient's responses on the DC4-679 Med Code 99 Emergency Resuscitation Flowsheet. When Code is over, make a copy of the Flowsheet for the institutional DON. File the original DC4-679 in the patient's medical record.

10. Transfer patient to the appropriate medical facility locally via EMS. Send copies of DC4-679, appropriate DC4-683 Series Form, and DC4-760B that were completed during the code.

DO NOT SEND ORIGINAL INMATE HEALTH RECORD!

11. Complete notification to key administrative personnel.

12. Following the Code, Form DC4-677, MED CODE 99 CRITIQUE is to be completed by a nursing staff member who was present during the code and observed team members in action. The completed form is to be submitted to the institutional DON.

13. The DON is responsible for stapling the copy of the completed DC4-679 code report to the completed DC4-677 code critique report. These forms are to be kept in a folder in a locked, secure room and be available for medical review at any time.

14. Document patient encounter and outcome on the DC4-781M, Emergency Nursing Log.

F. Equipment:

1. Automated External Defibrillator
2. Suction
3. Respiratory: One way mask or Ambu bag
4. EKG
5. IV supplies (solutions, tubing, and start kits)
6. Oxygen, tubing and mask
7. Jump Bag (see attachment 1)

VII. GUIDELINES FOR TREATMENT OF POSSIBLE DRUG OPIOID OVERDOSE

A. Narcan (Naloxone) Nasal Spray should be administered immediately on scene when a suspected or known opioid overdose has occurred.

1. Ascertain if Security staff have already administered 2 doses (sprays) of Narcan to the inmate.

a. If only 1 dose has been administered, and there's been no response by the patient, administer a 2nd dose 2-3 minutes after initial dose. Initiate 911 EMS system.

b. If 2 doses have been given by Security, with no response by patient, place patient in recovery position, initiate 911 EMS system, and closely observe patient for respiratory and/or cardiac arrest while awaiting EMS. Additional doses of NARCAN Nasal Spray may be required until emergency medical assistance becomes available.

B. Administration of Narcan Nasal Spray

NOTE:

*This medicine is for use only in the nose. Do not get any of it in the eyes or on the skin. If it does get on these areas, rinse it off right away.

*Abrupt reversal of opioid depression may result in nausea, vomiting, sweating, tachycardia, increased blood pressure, tremulousness, seizures, ventricular tachycardia and fibrillation, pulmonary edema, and cardiac arrest.

1. Remove the nasal spray from the box. Peel back the tab with the circle to open it.

2. DO NOT prime or "test" the nasal spray. It contains a SINGLE dose of naloxone

and cannot be reused. (I.e., priming or "testing" will use the single dose of Narcan in the container!)

3. Place your thumb on the bottom of the container and your first and middle fingers on either side of the nozzle.

4. Lay patient on their back with your hand supporting the patient's neck, allowing the head to tilt back before giving this medicine.

5. Gently insert the tip of the nozzle into one nostril of the patient, until your fingers on either side of the nozzle are against the bottom of the patient's nose.

6. Press the plunger firmly to give the dose. Remove the nozzle from the nostril after giving the dose. The usual patient response time is within 1- 2 minutes.

7. Move the patient on their side in the recovery position after giving the medicine and while awaiting EMS arrival.

8. Watch the patient closely for respiratory or cardiac arrest as well as for vomiting.

9. Re-administer NARCAN Nasal Spray, using a new nasal spray, every 2 to 3 minutes if the patient does not respond or responds and then relapses into respiratory depression.

C. While awaiting EMS arrival

1. Following the administration of Narcan Spray and while awaiting EMS arrival, obtain initial set of vital signs, if none have been obtained at this time. Initiate a thorough physical assessment of the entire body, to determine if the patient has injuries (hematomas, puncture wounds, etc.) contributing to (or causing) their current condition. This is especially important if there was no response to the Narcan.

2. Complete Nursing Protocol DC4-683JJ *Poisoning/Overdose Protocol.* If wounds are noted on the patient, complete the applicable protocol. If patient went into cardiac arrest, see Section VI.

VIII. STAFF EXPOSURE (skin or airborne) TO UNKNOWN, POSSIBLE OPIOID, SUBSTANCE

A. General Information

1. First responders (Security staff and medical personnel) may encounter drugs or drug

paraphernalia on or near an unresponsive inmate.

2. The most common and concerning routes of exposure include inhalation of aerosols and powders; direct mucous membrane contact in the eyes, nose, or mouth; ingestion (swallowing); and accidental needle stick.

3. Opioids must be absorbed into the body before the exposed person will suffer any harmful effects. Opioid poisoning will be apparent by the triad of:

    a. Slowed breathing,
    b. Decreased consciousness, and
    c. Pinpoint pupils

    Symptoms of passive exposure to opioids may include: respiratory distress/ depression, nervous system depression, drowsiness, reduced level of consciousness, dizziness, lethargy, and disorientation.

4. Toxicity cannot occur from simply being in proximity to an opioid.

5. First responders can mitigate the chance of an opioid exposure by suspecting any substance near or on the inmate is or contains an opioid.

6. Staff should be aware of medical care tasks that may aerosolize an illicit substance that is present on the patient or in the environment.

B. Personal Protective Equipment (PPE)

The following PPE is recommended by the CDC for staff at a scene where the use or presence of an opioid (e.g., Fentanyl) is suspected.

1. **Minimal Exposure**: No amount of the suspected illicit drug products are visible.

    ***Nitrile gloves** – double gloving is advisable using nitrile gloves. Any time the **g**loves become contaminated with the suspected substance, they should be removed, properly discarded (red bag), and changed.

2. **Moderate Exposure**: Small amounts of suspected illicit drug products are visible.

    ***Nitrile gloves**
    ***Safety goggles/glasses –** to prevent inadvertent eye exposures by touching with potentially contaminated hands or eyes

    ***Wrist/arm protection –** use if arms are bare (i.e., prevents short sleeve skin contamination)

***Disposable N95 filtering respirator -** to avoid inadvertent particulate inhalation and touching the mouth with potentially contaminated hands or gloves.

(Reference: https://www.cdc.gov/niosh/topics/fentanyl/images/III.-PPE_11nr.jpg)

C. Decontamination

1. **Staff** with direct skin contact with the unknown substance should immediately wash the affected area with cool water and soap, taking care not to break the skin or scrub an open wound. **DO NOT** use alcohol-based hand sanitizers to decontaminate as they do not remove opioids and may enhance absorption of the substance through the skin.

2. Removal or changing of the patient's clothes or bedding might be necessary during the care of the patient when a suspicious substance is found on or lying near the patient. Clothes and bedding should be handled in a manner which minimizes contact with these materials, dispersion of any illicit substance which may be present, and production of any aerosols from the materials.

3. Contaminated clothing should not be taken home! All staff contaminated clothing should be removed at work and laundered.

4. All contaminated disposable PPE should be placed in durable polyethylene bags and disposed of properly.

D. Summary of DOs and DON'Ts for First Responders

1. Assess the scene for hazards that may indicate the presence of illicit drugs
2. Do not touch or disturb white powder or liquid
3. Know what type of PPE to use and when to use it.
4. If illicit drugs are suspected or known to be present:
    - Do not smoke, eat, or drink while working in the area
    - Do not touch your eyes, nose, or mouth even if wearing gloves
    - Remove your PPE appropriately before leaving the area
    - Wash your hands with soap and water after leaving the area, and
    - Do not use hand sanitizer
5. Launder all contaminated clothing and NEVER take contaminated clothes home.

IX. POST USE OF EMERGENCY EQUIPMENT:

A. Disinfect all equipment used.

B. Check the AED Active Status Indicator is flashing green.

C. Check the condition of the AED and accessories.

D. Run manually initiated Self-Test on AED.

E. Replace AED battery (if indicated).

F. Replace AED pads (2 sets).

G. Replace contents in Jump Bag.

H. Order and replace any Emergency Medication/s used.

I. Check oxygen tank psi level (prior to bleeding the valve). If regulator shows oxygen tank psi at or near 200 psi, replace O2 tank at this time. Check valves for leaks and either tightened values or replace regulator as needed.

J. Report discrepancies immediately to Nurse Supervisor and/or Chief Health Officer/ Institutional Medical Director.

X. GUIDELINES FOR TRAINING ON, MAINTENANCE OF, AND INVENTORY OF EMERGENCY EQUIPMENT AND MEDICATION USED BY HEALTH CARE PROVIDERS:

Each institutional health services unit will be responsible for the following:

A. Quarterly mock emergency response training. Document training on the DC2-901, Training Attendance Report.

B. Training will include inventory and maintenance of contents of Jump Bag, Emergency Equipment and Emergency Medication.

C. Each nurse must complete a DC4-678, Emergency Procedures Skills Checklist form quarterly, and submit the completed form to the DON.

D. Ensure the AED Active Status indicator is flashing green each shift. Replace battery if indicated. DO NOT RUN A MANUALLY INITIATED SELF TEST.

E. Each shift AED must contain 2 sets of pads. Check expiration dates.

F. Monthly check of battery expiration for AED.

G. Each shift document on the DC4-680, Jump Bag and Emergency Equipment Inventory.

IX. SUGGESTED LESSON PLAN (OUTLINE):

A. Training shall provide knowledge of use of emergency medications and operation of the following equipment:

1. Suction machine.
2. AED locations and type
3. Emergency medications
4. Oxygen tanks (including: 1) removing and replacing the O2 regulator and 2) when and how to bleed the valve and other respiratory equipment
5. EKG
6. Jump Bag

7. N95 respirator mask

B. O2 therapy training shall include the following:

1. Types of equipment.
2. Reasons for use.

C. Emergency medications:

A list of emergency drugs will be located in the emergency room. (Form DC4-681)

D. 12-Lead EKG training shall include the:

1. Familiarization with EKG equipment.
2. Familiarization and demonstration of setup.
3. Use of DC4-679 and DC4-677.

E. Automatic External Defibrillator: Care, maintenance, and locations use safety hazards.

F. IV Therapy:

1. Anatomy of vessels—optimal sites in emergency situations.
2. Types of catheter, sizes, and various fluids.

G. Routine Inventory of Emergency Medications:

Monthly inventory of emergency medications by nursing supervisor and consultant pharmacist.

H. First Aid, CPR and AED instruction is a mandatory annual training requirement.

I. Securing accommodations and auxiliary aids and services for inmates with disabilities once the emergency has stabilized.

X. RELEVANT PROCEDURE AND FORMS:

A. DC4-677, Med Code 99 Critique
B. DC4-678, Emergency Procedures Skills Checklist
C. DC4-679, Med Code 99 Emergency Resuscitation Flowsheet
D. DC4-680, Jump Bag and Emergency Equipment Inventory
E. DC4-681, Emergency Medications
F. DC4-683, Series Forms
G. DC4-701, Chronological Record of Health Care
E. DC4-760B, Health Information Summary for Emergency Transfer to Outside Hospital
F. DC4-781M, Emergency Nursing Log
G. DC2-901, Training Attendance Report

H. Attachment 1, Jump Bag Contents

Health Services Director Date

This Health Services Bulletin Supersedes:

HSB 15.03.19 dated 4/1/88, 12/11/88 and 11/4/93.
HSB 15.03.20 dated 4/1/88, 12/5/88 and 5/26/89.
HSB 15.03.21 dated 12/11/88.
TI/HSB 15.03.22 dated 04/01/88, 12/11/88, 1/21/97, 04/19/01, 01/14/03, 12/10/03, 3/22/07, 06/01/10, 02/19/13, 01/09/14, 03/03/15, 02/02/2018, AND 10/02/2020