I. PURPOSE:

The purpose of this health services bulletin (HSB) is to establish policies and procedures for providing infirmary services.

Note: Medical services provided to inmates in identified mental health housing cells are addressed in departmental procedure **403.003, Health Services for Inmates in Special Housing.**

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

II. DEFINITIONS:

Acute Illness - a medical condition that is moderate to severe in onset. This could be anything from a broken bone to an asthma attack. An **Infirmary "Acute Illness Admission"** pertains to a patient who requires active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care, or long term care

> **NOTE**: A patient with a history of a chronic illness (e.g., diabetes, COPD, at. fib., etc.) should be admitted to the Infirmary as Acute Illness admission if their current illness/injury & admitting diagnosis is of an acute nature (e.g., n/v with dehydration; post-op appendectomy, L foot decubitus ulcer, etc). Even though the patient has a chronic illness, the prognosis for the patient is that s/he will improve and be discharged from the Infirmary.

ADA - refers to the Americans with Disabilities Act of 1990 (42 U.S.C. 12131 et seq.).

Attending Clinician – refers to the clinician who is credentialed in accordance with Health Services Bulletin (HSB) 15.09.05, "Credentialing and Privileging Procedures," to assume clinical management for mental health care delivery to an inmate assigned to a given level of mental health care.

Chronic Illness – a health condition or disease that is persistent or otherwise long-lasting in its effects. The term is usually applied to a health condition or disease that lasts for more than three (3) months. Common chronic diseases include arthritis, asthma, cancer, COPD, diabetes, and heart disease. An **Infirmary "Chronic Illness Admission"** pertains to a patient whose admitting diagnosis is expected to require a lengthy, if not permanent, Infirmary stay.

Infirmary - an area equipped to provide organized medical services (including observation services and boarding services) and skilled nursing care for inmates.

Inpatients – those patients admitted to the Infirmary with an acute medical or mental health illness or with a chronic, long-term care illness ("boarders").

Observation patient – An observation patient is one who presents with a medical condition showing:

1. a significant degree of instability;
2. a need to be monitored and evaluated; and
3. a need for ongoing short-term treatment, assessment, and reassessment while a decision is being made as to whether the patient needs to be admitted, transferred to a hospital, or can be discharged.

Outpatients – those patients admitted to the Infirmary for 23 hours or less for observation of an acute illness or for test preparation or specimen collection.

III. POLICY

Prior to conducting all screenings and evaluations, the inmate will be provided reasonable accommodations or auxiliary aid(s) or service(s) based on their disability as identified by the inmate or observed by the health care staff.

A. Infirmary Services

1. A separately defined medical area/infirmary shall be maintained at every facility that provides nursing care and observation for persons who do not require a higher level of inpatient care, i.e., hospitalization. This includes long-term care areas, i.e., Zephyrhills J Dorm and SFRC F Dorm, unless the inmate is admitted for palliative care services which are described in HSB 15.02.17, *Palliative Care Program Guidelines*.

2. When inpatient services are provided, the infirmary will be staffed twenty-four (24) hours per day by licensed health care personnel.

3. All Infirmary inmates must be within sight or sound of health services staff.

4. Health care staff shall make rounds at least every two (2) hours for all patients in the Infirmary. Health care staff rounds are to be documented on the DC4-717, *Infirmary Patient Rounds Documentation Log.*

5. Observations for mental health admissions shall be documented on DC4- 650, *Observation Checklist,* at the frequency ordered by the clinician.

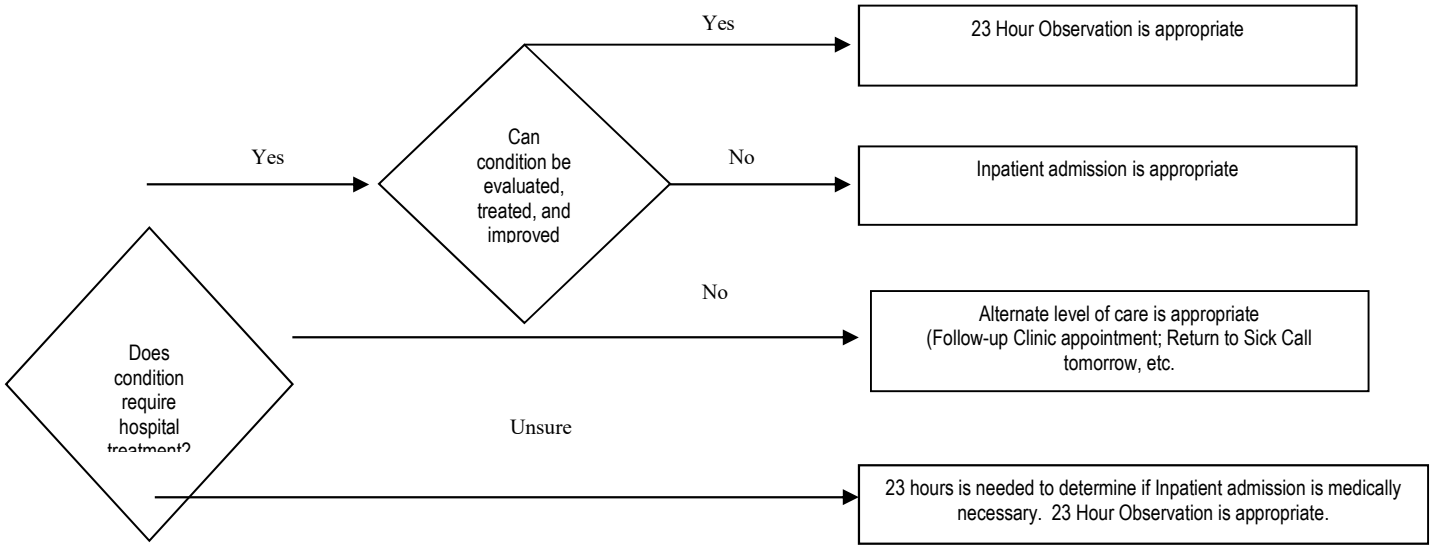
6. On weekends and holidays telephone clinician rounds will be conducted. It will be the responsibility of the day shift nurse to call the on-call clinician to give a report on all of the current infirmary patients, including SHOS patients.

7. A TCU, CSU or CMHTF inmate may be admitted to the Infirmary for various reasons; at that time, s/he becomes an admitted Infirmary patient and an Infirmary record will be initiated on them (see HSB 15.12.03, *Health Records* for additional information on Infirmary Records).

8. Some inmates may meet the criteria for Outpatient 23 Hour Observation status in the Infirmary (**See Section IV. PROCEDURE, B. 1. for additional information)**. The purpose of close observation care is to answer one question: Does this patient need to

be admitted to the Infirmary, transferred to an outside hospital, or discharged back to this dorm?

Outpatient 23 Hour Observation Decision Tree



9. The length of stay for an observation patient is **not to exceed 23 hours**. If further evaluation and care is required after 23 hours, the patient must be discharged from Outpatient Observation status (DC4-732B and DC4-797B) and admitted to Inpatient Acute Illness status (DC4-732 and DC4-797E).

10. At 23 hours, the Infirmary nurse or shift charge nurse is to notify the clinician (in person or by phone) that the 23-hour observation period has ended and s/he needs to make a disposition on the patient. At this time, the clinician must either:

    a. Discharge the patient back to their dorm,
    b. Transfer the patient to an outside hospital, or
    c. Admit the patient to the Infirmary as an Acute Illness Admission.

11. The 23-hour observation period **may not be extended**. If the nurse is unable to obtain an order for one of the 3 dispositions listed above, the Regional Medical Director (RMD) is to be notified at that time and apprised of the situation. The nurse is to thoroughly document all conversations with the clinician and RMD on the DC4-701*Chronological Record of Health Care.*

    NOTE: If the 23-hour period ends during the night shift, e.g. 0215, the evening shift nurse should consider calling the clinician late on the evening shift to obtain a new disposition at that time.

12. Each infirmary shall maintain current copies of HSB 15.03.26 *Infirmary Services* and the *Nursing Manual*. These copies shall be:

    a. Readily available, and

b. Reviewed annually by all clinical staff and such review shall be documented.

13. There is no provision for 23-hour observation of inmates for mental health reasons; inmates exhibiting significant exacerbation of mental disorder and/or risk of self-harm must be admitted as inpatients. See below concerning SHOS and MHOS admissions.

B. Staffing

1. Infirmary care will be directed by the institutional medical director or designee in her/his absence.

2. Physicians, advanced practice registered nurses (APRNs), dentists, and physician assistants are authorized to admit patients to the infirmary. For admissions due to mental health reasons (e.g. SHOS), psychologists are authorized to admit patients in both the inpatient and outpatient mental health system. Admission for placement to a CMHTF requires a psychiatrist to serve as the attending clinician.

3. A physician (institutional medical director or regional medical director) shall be available, at least by phone, twenty-four (24) hours a day to provide the necessary medical coverage.

4. Nursing services will be provided under the direction of a registered nurse. This is not to be interpreted as to require a registered nurse to be on the premises unless the level of care, as determined by the attending physician, requires such.

5. When mental health concerns are the primary focus of an admitted patient's health care needs, mental health staff will perform daily rounds (Monday through Friday, excluding holidays) for the purpose of evaluation and treatment in accordance with Procedure 404.001 *Suicide and Self-Injury Prevention*. For those patients admitted to an inpatient facility (i.e. TCU, CSU, or CMHTF) who are transferred to the infirmary for medical purposes, the mental health staff located at the same location as the medical infirmary will be responsible for daily well-being checks. These daily checks will be documented on the DC4-642S *Well-Being Check and Mental Status Exam*.

III. PROCEDURE

Note: The institutional ADA Coordinator will be notified of all admissions of ADA impaired and/or disabled inmates.

A. Inpatient Admissions – Acute Illness & Chronic Illness/Long Term Care

1. Acute illness

a. Each inmate admitted with an acute illness shall have a medical plan of care developed by the clinician for each inmate. This medical care plan shall be reflected in the clinician's orders and/or SOAP note. This plan shall include directions to health care staff regarding their roles in the care and supervision of the patient. The plan shall include addressing the needs of

ADA impaired and/or disabled inmates. The chief health officer will provide general supervision for all personnel authorized to admit patients to the Infirmary.

b. The physician or clinical associate shall make rounds on a daily basis (Monday through Friday, except holidays) to assess the care of all acute illness patients in the Infirmary.

2. Acute Illness - Mental Health, including SHOS patients

a. Mental health infirmary admissions may or may not involve the assignment of Self-Harm Observation Status (SHOS) (suicide precautions), depending upon whether the inmate is determined to be at significant risk for suicide or serious self-injurious behavior.

b. Inmates who present with acute symptoms of mental impairment (e.g., disorientation, delusions, hallucinations, disorganized speech) may be placed on Mental Health Observation Status (MHOS) and admitted to Infirmary Mental Health Care for observation without suicide precautions.

c. All mental health patients admitted to the Infirmary are to have a history and physical completed by the clinician and documented on DC4-713C, *Inpatient History/Physical* form.

d. All mental health patients are to be logged into the Infirmary on form DC4-781A, *Mental Health Emergency, Self-Harm, SHOS/MHOS Placement Log.*

e. The frequency of the observations and any other restrictions must be ordered by the admitting clinician. Observation frequency will range from continuous observation to no less than every fifteen (15) minutes.

3. Chronic Illness, Long Term Care

a. Each inmate admitted with a chronic/long term care illness shall have a medical plan of care developed by the clinician. This medical care plan shall be reflected in the clinician's orders and/or SOAP note. This plan shall include directions to health care staff regarding their roles in the care and supervision of the patient. The plan shall include addressing the needs of ADA impaired and/or disabled inmates. The chief health officer/institutional medical director will provide general supervision for all personnel authorized to admit patients to the Infirmary.

b. The physician or clinical associate shall make rounds on a weekly basis (Monday through Friday, except holidays) to assess the care of all chronic/long term care illness patients in the Infirmary.

B. Outpatient Admissions – 23 Hour Observation & Test Prep/Specimen Collection

1. 23 Hour Observation

a. 23 Hour Observation can still play an important role in the Infirmary by allowing the clinician the time to determine if the patient needs to be admitted, transferred, or discharged back to the dorm. However, medical and nursing staff must not take advantage of this non-admission status. Close monitoring and thorough documentation is still key to the patient's success. In addition, there is no provision for 23-hour observation of inmates for mental health.

b. The following conditions lend themselves to 23-Hour Observation:

(1) Inmates arriving from outside facilities such as hospitals or emergency departments after hours or on weekends with an anticipated visit or treatment decision (i.e., Admit, transfer, or Discharge from Infirmary) by the clinician **within 23 hours of their arrival**.

(2) Inmates who are postictal and require close continued observation prior to discharge back to their dorm/cell, but who do not need full admission for 24 hours or longer.

(3) Inmates with asthma, abdominal pain, and/or diarrhea who may require up to 23 hours of observation and management, with the expectation they will either be admitted or discharged by 24 hours.

(4) Inmates with chest pain with pending/normal labs, with a high degree of suspicion. Inmates who have just received nitroglycerin and you want to observe before sending to the emergency department or to their dorm.

(5) Inmates with a head injury with or without loss of consciousness, but with signs of concussion who merit neuro checks for 23 hours.

2. Test Preparation & Specimen Collection - Inmates may be admitted to the Infirmary by a licensed nurse for test preparation (e.g., colonoscopy) or for laboratory specimen collection (e.g., GTT blood test).

C. The Infirmary Medical Record – Inpatient vs. Outpatient

1. **Inpatient** Medical Record - An inmate admitted to the Infirmary shall have a separate and complete blue **Inpatient record** that shall contain, at the minimum:

a. Infirmary Admission Orders Sheet (DC4-714D) for medical admissions;
b. Chief complaint;
c. History of present illness;
d. Past history and review of systems (physical examination that includes a review of systems);
e. Vital signs (on admission and at least every shift thereafter unless otherwise ordered by the physician);

f. Initial impression;
g. Medical care plan (as per Section IV. A. above);
h. Initial nursing admission evaluation (DC4-732);
i. Daily shift nursing evaluations and clinician progress notes;
j. Discharge summary; and
k. For chronic, long-term boarder admissions, a brief note will be written documenting the need for infirmary housing.

2. **Outpatient** Medical Record - An inmate admitted to the Infirmary for 23 hour observation or for a test prep/specimen collection, documentation shall continue the green **Outpatient** medical record, unless their status changes to Inpatient.

D. Documentation

1. Admission

a. Inpatients – Acute Illness, Acute Mental Health Illness, and Chronic Illness/Long Term Care patients

(1) Both medical and mental health inmate admissions to the Infirmary will be evaluated within 2 hours of admission by a licensed nurse using form DC4-732, *Infirmary / Hospital Admission Nursing Evaluation*.

Note: If the institution has a nurse assigned to mental health, this individual will be responsible for evaluating and completing the admission paperwork on those inmates being admitted for mental health reasons/diagnoses, Monday – Friday, excluding holidays.

b. All inpatients are to be entered into the DC4-797E, *Infirmary Log – Inpatient*

c. The admitting clinician is to provide admitting orders (DC4-714D), upon the patient's admission to the Infirmary. At minimum, the orders **must** include:

(1) Patient's admitting diagnosis
(2) Frequency of vital signs
(3) Diet
(4) Activity level
(5) Medications (current and new)
(6) Orders specific to patient's admitting diagnosis

d. Outpatients – 23-Hour Observation patients and Test Preparation/ Specimen Collection patients

(1) 23-Hour Observation

(a) 23-hour observation status inmates are to be evaluated within 1 hour of being placed in the Infirmary by a licensed nurse using form DC4-732B, *23 Hour Observation Nursing Notes.*

(b) All patients placed in an Infirmary bed for observation are to be entered into the DC4-797B, *Infirmary Log – Outpatient*

(c) The on-site clinician or the on-call clinician is to provide the appropriate care orders upon the patient being placed in an Infirmary bed. At minimum, the orders **must** include:

1. The reason the patient's being placed in the infirmary for observation
2. Frequency of vital signs
3. Diet
4. Activity level
5. Medications (current and new)
6. Orders specific to patient's need for Observation (e.g., seizure precautions, keep left leg elevated, etc.)

(2) Test Preparation and Specimen Collection

(a) Inmates being admitted to the Infirmary for either a test preparation procedure or specimen collection are to be initially evaluated by a licensed nurse using DC4-732A, *Infirmary Admission – Test Preparation/ Specimen Collection* within one hour of admission.

(b) All patients placed in an Infirmary bed for a test preparation procedure or a specimen collection are to be entered into the DC4-797B, *Infirmary Log – Outpatients*.

2. Daily documentation and evaluations

Note: The institutional ADA Coordinator will be notified as soon as any new ADA impairment and/or disability has been diagnosed.

a. Inpatients

(1) **Acute illness medical** patients shall be evaluated daily by nursing staff using form DC4-684, *Infirmary/Hospital Daily Nursing Evaluation*. Patients will be evaluated and the applicable shift section completed every eight (8) hours unless

otherwise ordered by the clinician. Night shift charting is by exception. Additional nursing information/observations related to the care of the patient will be documented on the last page of the form; when additional lines are needed, the nurse may continue their note on DC4-714A, *Infirmary Progress Record*.

Note: A new patient complaint that isn't part of the admitting diagnosis (e.g., dx pancreatitis with new onset severe headache; fractured right arm with new onset abdominal pain) are to be evaluated initially with the applicable Nursing Protocol (DC4-683 series).

(2) **Acute illness mental health** patients shall be evaluated every eight (8) hours (night shift charting is by exception) using form *DC4-673B, Inpatient Mental Health Daily Nursing Evaluation*.

(a) During regular business hours (Monday – Friday, 0800 – 1700), the mental health nurse will be responsible for the day shift evaluation (DC4-673B) on those inmates admitted for mental reasons/diagnoses. Medical nursing staff will perform all other every eight (8) hour ("q8h") evaluations.

(b) Self-harm observation status will initially be ordered by the attending clinician and reviewed every day, with documentation by an incidental note. During weekends and holidays, this review may be accomplished via telephone. Nursing staff will contact the on-call attending clinician to confirm or revise continuation of current self-harm observation status, and will document this discussion with an incidental note (404.001, *Suicide and Self-Injury Prevention*) on form DC4-701.

(3) **Chronic illness/long term care** patients shall be evaluated thoroughly, at least once a week, using form DC4-684, *Infirmary/Hospital Daily Nursing Evaluation*. A daily SOAPE note on the DC4-714A, *Infirmary Progress Record* shall be completed on the day shift, the other six (6) days of the week.

(a) **All chronic illness/long term care** patients shall be weighed every seven (7) days. The weight is to be documented on the DC4-716A *Graphic Chart*. A significant weekly weight loss or weight gain (+ or – 3 or more pounds) or a noted gradual trend shall be reported to the clinician. This notification shall be

documented on the DC4-701 *Chronological Record of Health Care*.

(b) Chronic/long term care patients who develop a **new acute illness/diagnosis** (e.g., pneumonia, UTI, etc.) are to be evaluated every 8 hours and cared for as an Acute Illness admission patient as directed in section "2. a. (1) Acute illness medical patients…" above during their acute illness phase and until the acute illness has been resolved.

(c) If a chronic illness admission patient is **diagnosed with a new acute illness** (e.g., UTI, decubitus ulcer, GI bleed, etc.) the patient's admission status is to be changed from "Chronic Illness Admission" to "Acute Illness Admission" to ensure that the patient is evaluated by nurses and clinicians frequently and appropriately during the acute phase of the new illness. Documentation of the patient's Infirmary status change is to be noted in the DC4-797E *Infirmary Log – Inpatient* and on the DC4-701 *Chronological Record of Health Care.*

(4) A clinician shall make rounds and enter progress notes on a **daily** basis (Monday through Friday, except holidays) to evaluate the progress and needs of all **acute illness patients** in the Infirmary and record such information in the Infirmary record. Required clinician documentation shall be placed on DC4-714A, Infirmary *Progress Record* in chronological order.

(5) A clinician shall make rounds and enter a progress note on a **weekly** basis (Monday through Friday, except holidays) to assess the condition and needs of all **chronic, long-term care inpatients** in the infirmary and record such information in the infirmary record. Required clinician documentation shall be placed on DC4-714A, *Infirmary Progress Record* in chronological order.

b. Outpatients

(1) **23 Hour Observation patients** – all evaluations and care provided to these inmates are to be documented on DC4-732B, *23 Hour Observation Nursing Notes*. The patient must have, at minimum, a patient evaluation performed and documented in the Nurses Note section at least once every 8 hours. Additional documentation, including repeat vital signs, are to be documented in the Nurses Notes section of the form prn based on the patient's condition.

(2) **Test Preparation & Specimen Collection patients** – all evaluations and care provided to these patients are to be documented on DC4-732A, *Infirmary Admission – Test Preparation/ Specimen Collection.*

c. Weekend and Holiday Clinician Phone Rounds

(1) It is the responsibility of the weekend/holiday day shift nurse to call the on-call clinician to give a report on all of the current:
- Acute Illness Inpatient admissions,
- Acute Mental Health Inpatient admissions (SHOS/IMR), and
- 23 Hour Outpatient admissions.

(2) The nurse is also responsible for informing the clinician of any Chronic or Long Term Care patient with a new onset of symptoms, acute change in their condition, or any other issues of concern the nurse has.

(3) The clinician is to confirm or revise the continuation of the admitted patients' orders and statuses. Status of the 23 hour admission patients whose Infirmary stay is nearing the 23 hour limit should be discussed and disposition determined.

(4) Clinician phone rounds will be documented on form DC4-714A *Infirmary Progress Record,* using the appropriate "telephone clinician rounds" stamp. If there are changes in the attending clinician's orders during weekend and holidays, telephone orders shall be countersigned by a physician, advanced practice registered nurse (APRN), or clinical associate on the first business day following the weekend or holiday.

3. Morse Fall Scale

a. A Morse Fall Scale is used to evaluate the patient's risk for falling. A DC4-684A *Morse Fall Scale* form shall be completed by an RN or LPN:

(1) On all Acute and Chronic Admissions to an Infirmary, RMC Hospital, CSU, or CMHTF,

(2) Daily (on day shift) on all Acute Illness Admissions in an Infirmary, RMC Hospital, CSU, or CMHTF,

(3) Weekly (on day shift) on all Chronic Illness Admissions in an Infirmary, RMC Hospital,

(4) Monthly (on day shift) on all TCU patient's and

(5) PRN - with a change in the patient's mentation and/or alertness, change in patient's medication that may affect patient's balance, etc.

b. When a patient falls, an RN or LPN will complete a new DC4-684A *Morse Fall Scale* form as well as a DC4-684B *Post Fall Protocol* form in order to evaluate and document the patient's complaints and sustained injuries as well as physician notification and orders.

4. Discharge documentation

a. Inpatients

(1) Within 72 hours of discharge from the Infirmary, DC4-713B, *Discharge Summary,* shall be completed by the clinician.

(2) The discharge summary shall include the course of treatment in the Infirmary, final diagnosis, medications, and follow up care. In addition, the summary shall be signed and dated by the clinician completing the report.

(3) Form DC4-657, *Discharge Summary for Inpatient Mental Health Care* shall be completed instead of DC4-713B when mental health concerns versus physical health concerns were the primary focus of admission.

(4) The discharge nurse is to write a discharge note indicating the patient's condition on discharge, means of discharge (ambulating, wheelchair, crutches, etc.), patient education & discharge instructions, and disposition (transfer to outside hospital or discharged back to dorm) on the last page of the DC4-684, Infirmary/*Hospital Daily Nursing Evaluation*.

(5) **Notify institutional ADA Coordinator upon discharge of an inmate with a newly diagnosed impairment and/or disability for appropriate housing.**

(6) Patient discharge information is to be completed in the DC4-797E, *Infirmary Log – Inpatient*.

(7) The infirmary admission record will be assembled in accordance with HSB 15.12.03, *Health Records*.

b. Outpatients

(1) **23 Hour Observation patients** - the discharge nurse is responsible for ensuring that all discharge information, including patient condition upon discharge, patient disposition, and patient discharge instructions and education is documented on the back page of the DC4-732B, *23 Hour Observation Nursing Notes.*

(2) Test Preparation & Specimen Collection patients – the discharge nurse is responsible for ensuring that all discharge information, including patient discharge instructions and patient education, is documented on DC4-732A, *Infirmary Admission – Test Preparation/Specimen Collection*.

(3) Patient discharge information is to be completed in the DC4-797B, *Infirmary Log – Outpatient*.

E. Infirmary KOP Medications

1. When an inmate is placed in the Infirmary for Acute Illness, Chronic Illness, Test Preparation/Specimen Collection, or 23 Hour Observation, s/he is to bring all keep-on-person (KOP) medications with her/him.

2. If the inmate is unable to do so himself, Security will bring the inmate's meds to the Infirmary.

3. The nurse is to document in the nurse's notes that the patient's KOP medications have been received. This information is to be passed on in report to the oncoming shift so that the patient doesn't miss any medication dosages.

4. When these medications are for medical conditions unrelated to the medical/ mental health condition for which the inmate is placed in the Infirmary, e.g., chronic clinic meds, the medications may be continued from the inmate's own supply **when so indicated by a physician's order**. Inmate medications that are to be used during the Infirmary stay will be kept in a designated area in the nursing unit of the Infirmary in the original container. (This can include the medication cart).

5. When an inmate is using her/his own medication supply, nursing staff will take the inmate's bottles containing the meds to the inmate and the inmate will self-administer these medications from her/his own supply under the observation of nursing staff. If the inmate's condition (medical or mental health) precludes this process, the clinician will be advised and direct observed therapy (DOT) medications will be ordered.

6. The medication and treatment documentation (DC4-701A MAR) will reflect that the inmate is using her/his own meds by recording each medication on the DC4-701A with a notation under the medication name stating "Inmate's own med". The nurse's initials indicate that s/he observed the inmate taking the medication.

7. When orders are written to release the inmate from the infirmary, orders for medications not related to the infirmary stay will not be rewritten unless such medication supply has run out and the inmate needs a refill (e.g., HTN, asthma, seizure meds).

8. The inmate's own medications will be returned to the inmate upon her/his discharge. If refills are required during an infirmary stay, the refills can be ordered in a keep-on-person supply.

V. RELEVANT FORMS:

A. DC4-642S, *Well-Being Check and Mental Status Exam*
B. DC4-650, *Observation Checklist*

C. DC4-657, *Discharge Summary for Inpatient Mental Health Care*
D. DC4-673B, *Mental Health Daily Nursing Evaluation*
E. DC4-684, *Infirmary/Hospital Daily Nursing Evaluation*
F. DC4-684A, *Morse Fall Scale*
G. DC4-684B, *Post Fall Protocol*
H. DC4-701, *Chronological Record of Health Care*
I. DC4-701A, *Medication and Treatment Record (MAR)*
J. DC4-713B, *Discharge Summary*
K. DC4-713C *Inpatient History/Physical*
L. DC4-714A, *Infirmary Progress Record*
M. DC4-714D, *Infirmary Admission Orders Sheet*
N. DC4-716A, *Graphic Chart*
O. DC4-717, *Infirmary Patient Rounds Documentation Log*
P. DC4-732, *Infirmary/Hospital Admission Nursing Evaluation*
Q. DC4-732A, *Infirmary Outpatient Admission – Test Preparation/Specimen Collection*
R. DC4-732B, *Infirmary Outpatient Admission – 23 Hour Observation Nurses Note*
S. DC4-781A *Mental Health Emergency, Self-Harm, SHOH/MHOS Placement Log*
T. DC4-797B, *Infirmary Log - Outpatients*
U. DC4-797E, *Infirmary Log - Inpatients*

Health Services Director Date

This Health Services Bulletin Supersedes: HCS 25.03.03 dated 10/1/89
HSB 15.03.26 dated 12/5/88, 5/26/89, 9/13/93, 5/1/95, 8/29/95, and 1/21/98
TI 15.03.26 dated 1/26/01, 1/23/02, 8/11/03, 6/27/05.
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