ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 110.01	Page 1 of 4
	Effective Date: June 1, 2013	
	Distribution: A	
	Supersedes: 110.01 (10/15/08) PCN 11-28 (7/15/11)	
Approved by: Derrick D. Schofield		
Subject: PRE-SERVICE (BASIC) TRAINING POLICY AND EMPLOYEE ORIENTATION		

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, TCA 4-1-116, TCA 41-1-407, and Prison Rape Elimination Act of 2003 standard 115.31.

II. PURPOSE: To implement policy and procedures for the provision of training for newly hired and rehired Tennessee Department of Correction (TDOC) employees.

III. APPLICATION: To all TDOC employees.

IV. DEFINITIONS:

A. Basic Correctional Officer Training (BCOT): A program designed to prepare cadets for the conditions personnel can expect working in an adverse correctional environment and security protection procedures. The students learn the essentials needed to survive in the correctional environment. The first two weeks of the training program are conducted at the hiring facility and the remaining four weeks of the program are conducted at the Tennessee Correction Academy.

B. On-the-Job Training: A formalized training experience in which the field training officer/supervisor/experienced officer observes the correctional officer in the actual performance of his/her duties and provides and documents constructive and corrective feedback in required areas.

C. Orientation: An on-site formalized process designed to introduce and familiarize new employees with information required to function according to job expectations. The orientation schedule familiarizes new employees with a broad based operational view of the facility as a whole.

D. Pre-service: Basic training course designed to provide new institutional employees with fundamental knowledge and skills necessary to function according to job expectations.

E. Probation and Parole Officer (PPO): An officer who serves and protects the public by supervising adult felony offenders by ensuring that standard and special conditions of probation and or parole are met.

V. POLICY: All new TDOC employees shall receive orientation and pre-service training prior to being assigned to independent job responsibilities. Further, those placed in security classifications shall also receive on-the-job training prior to independent job assignments.

VI. PROCEDURES:

A. All new full-time institutional non-security series personnel shall receive a minimum of 40 hours work site orientation, preferably prior to attending the Academy. All new security series employees shall receive a minimum of 80 hours work site orientation and on-the-job training prior to attending the Academy. Part-time employees, volunteers, contract staff, employees who are permanently (not temporarily to cover staff shortages) transferring from one location to another and full-time employees returning from over a year of active military duty shall receive a minimum of 20 hours of work site orientation appropriate to their assignments

B. All new full time employees in Central Office and the Tennessee Correction Academy (TCA) shall receive 40 hours of orientation prior to being assigned independent job responsibilities.

C. The institutional orientation training shall include, at minimum, the following topics:

1. The institution's mission, goals, and vision
2. Security/contraband policies and procedures
3. Key and tool control
4. Appropriate conduct with offenders and co-workers
5. Employee rights and responsibilities
6. Universal precautions and communicable diseases
7. Personal protective equipment/bio-hazardous waste disposal.
8. Prohibitions concerning workplace harassment (including sexual harassment)
9. Fire safety and emergency evacuation procedures, and 4-minute response.
10. Supervised job-shadowing opportunities.
11. CISM (Critical Incident Stress Management)
12. Title VI (Civil Rights Act of 1964)
13. Suicide prevention
14. Emergency operation plans
15. Overview of roles of Rehabilitative Services and TRICOR
16. Prison Rape Elimination Act

D. All training specialists shall complete or have already completed the 40-hour Training for Trainers' course or its equivalent at TCA.

E. By June 30 of each year, TCA (in conjunction with institutional training specialists) shall review the new employee orientation schedule of each facility and modify as needed to assure all required items are being taught during orientation.

F. The institutional training specialists shall meet with all new full-time employees prior to pre-service training to discuss:

1. The general purpose of pre-service training.
2. How the person can prepare him/herself to gain the most from training.
3. The subject matter to be covered.
4. The kind of performance expected from the person in the classroom.
5. Opportunities to be provided to allow the employee to apply the new knowledge.
6. How newly gained skills shall be used when the training is completed.
7. The requirement that they read the *Academy's Trainee Handbook* prior to attending.

G. New facility employees and rehired non-security employees who have been separated from TDOC for more than one year, except clerical/support employees with minimal offender contact, must attend pre-service training in the appropriate category before being assigned independent job responsibilities and/or before unsupervised offender contact occurs. All pre-service training shall be provided by the Tennessee Correction Academy in compliance with American Correctional Association standards. Pre-service training requirements for TDOC employees who change position classifications shall be determined by the Warden.

H. All rehired employees in the security series, including correctional clerical officers and inmate relations coordinators, who originally completed their pre-service training curriculum and who have been separated from TDOC for less than one year shall attend an abbreviated version of pre-service training. This abbreviated training shall consist of Week One and Week Two of orientation/OJT at the institution, followed by Week Three BCOT at the Academy, to be followed by the 32 hours in-service Adult Security training. After completion of these ~~two~~ four weeks, the employee can be assigned independent job responsibilities and unsupervised offender contact. Rehired employees who have been separated for more than one year and less than two years are also eligible for an abbreviated version subject to the Warden's approval.

I. All correctional officer series employees returning from over a year of active military duty shall attend an abbreviated version of the Academy's pre-service training. This abbreviated training shall consist of Week Three BCOT at the Academy, to be followed by successful completion of firearms lab and weapons qualification. The firearms training may be accomplished either at the Academy or at the institution. A minimum 40 hour OJT Program will follow in accordance with Policy #110.01.1.

J. All rehired non-security institutional employees who originally completed their prescribed pre-service training curriculum and have been separated from TDOC for less than one year (i.e., counselors, maintenance personnel, food service staff, medical staff, etc.) shall complete the appropriate 40-hour in-service training course (including Day 1 mandatory core training) at the earliest scheduled offering. All non-security institutional employees returning from over a year of active military duty shall attend a minimum of 20 hours of work site orientation appropriate to their assignments, followed by the appropriate 40 hour in-service training at the earliest scheduled offering.

K. All new employees in the Field Services series, including PPO and support staff, shall receive a minimum of 40 hours of work site orientation appropriate to their assignments, followed by Weeks One through Six of Basic Probation Parole Officer Training at the Academy for PPOs and only Week Six for support staff. All personnel returning from over a year of active military service shall receive a minimum of 40 hours of work site orientation appropriate to their assignments and attend Weeks One through Two of the Probation Parole Officer Use of Force Training at the Academy.

It is the responsibility of the new employee's immediate supervisor to see that the requirement of 40 hours of on-the-job orientation is provided. Even in some categories that suggest other personnel as the trainer, the supervisor may still need to provide the training. For instance, outlying Field Services offices do not have a full-time Training Coordinator, and the supervisor may not wish to wait until a Training Coordinator is there. In that event, the supervisor can cover the material, and sign off on it, and refer the new employee to the Training Coordinator if there are any questions.

L. The Field Services orientation training for probation and parole officers (PPO) shall include, at minimum, the following topics:

1. General Orientation
2. Personnel Issues
3. Supervisor Orientation
4. Setting Up Office
5. Computer Assignment

6. TDOC Overview
7. Edison
8. NCIC and TIES
9. Probation/Parole Policies
10. Caseload Orientation
11. Interstate Compact
12. Violation Reports
13. Field/Court/Hearing Observation
14. Sex Offender Registry
15. Victim's Rights
16. Training
17. Community Service
18. Volunteer Program

M. The Field Services orientation training for support staff shall include, at minimum, the following topics:

1. General Orientation
2. Personnel Issues
3. Supervisor Orientation
4. Office Orientation
5. Computer Assignment
6. TDOC Overview
7. Edison
8. NCIC and TIES
9. Probation/Parole Policies
10. Overview of Programs
11. Support Staff Duties
12. Account Clerk Overview
13. Training
14. Victim's Rights

N. All rehired employees in the Field Services series, including PPOs and support staff, who originally completed their pre-service training curriculum and who have been separated from TDOC for less than one year shall attend an abbreviated version of pre-service training. This abbreviated training shall consist of the 40 hour orientation at a field services office, followed by Week Three Pre-Service Field Services training at the Academy.

O. All rehired employees in the Field Services series, including PPO and support staff, who originally completed their pre-service training curriculum and who have been separated from TDOC for more than one year shall receive a minimum of 40 hours of work site orientation appropriate to their assignments, followed by Weeks One through Three of Pre-Service Field Services training at the Academy for a PPO, and only Week Three for support staff.

VII. ACA STANDARDS: 2-CO-1D-05, 4-4088, and 1-CTA-3A-02.

VIII. EXPIRATION DATE: June 1, 2016.

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.08	Page 1 of 5
	Effective Date: May 15, 2014	
	Distribution: A	
	Supersedes: 113.08 (11/1/10) PCN 11-38 (11/1/11)	
Approved by: Derrick D. Schofield		
Subject: PROSTHETICS AND DURABLE MEDICAL EQUIPMENT		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To provide guidelines for the provision of health care prosthetics and durable medical equipment to inmates.

III. APPLICATION: Wardens, Associate Wardens, Health Administrators, health care staff, inmates, medical contractors, and privately managed institutions.

IV. DEFINITIONS:

A. Durable Medical Equipment: Devices prescribed by a qualified health professional to help minimize the effects of a debilitating condition. Such devices are not attached to the body and usually enhance an individual's mobility or assist the individual to breathe. Examples of durable medical equipment include wheelchairs, crutches, canes, CPAP machines, and portable oxygen tanks.

B. Prosthetic: For purposes of this policy only, an artificial device attached to the body to aid its function or to replace a missing part. Prosthetic devices include artificial limbs, false teeth, hearing aids, pacemakers, artificial eyes, eyeglasses, contact lenses, orthopedic appliances or shoes, etc.

C. Utilization Management Entity (UME): The person(s) or contractor designated by the Tennessee Department of Correction (TDOC) to process all requests for inpatient and outpatient specialty care.

V. POLICY: When deemed necessary by the attending health care provider, health care prosthetic devices and durable medical equipment shall be provided to inmates in order to correct, assist, or improve significant body impairment or debilitating condition.

VI. PROCEDURES:

A. General:

1. Prior to ordering a prosthetic device, verification should be made that the inmate will be remaining in the physical custody of the Tennessee Department of Correction (TDOC) for the length of time necessary to manufacture, fit, and adjust the device to the inmate.

2. Prosthetic devices shall remain the property of the TDOC until such time as the inmate is released from custody. The prosthetic device shall then become the personal property of the inmate. Durable medical equipment shall remain the property of the TDOC and shall not be given to the inmate upon release except as described in Section VI.(I).

3. Willful or negligent damage, destruction, or loss of issued prosthetic devices or durable medical equipment may result in disciplinary action being taken against the inmate. Additionally, replacement or repair costs shall be the responsibility of the inmate, except in unusual cases as determined by the Health Services Administrator.

4. There shall be a co-payment fee charged to the inmate upon issuance of certain prosthetics. (See Policy #113.15)

B. Eyeglasses:

1. Eyeglasses shall be provided for an inmate only by prescription of a licensed optometrist.

2. Only those inmates who have far or near vision of 20/40 acuity or greater in either eye as determined by screening (using a Snellen or Rosenbaum eye chart) or who have another debilitating pathology shall be referred to the optometrist.

3. The inmate will be provided a standard frame by the contract vendor at the expense of the state or private contractor. The following are the only exceptions:

a. Inmates who request to purchase personal eyeglasses shall be given a copy of the optical prescription. If an inmate requests a copy of his/her prescription in order to purchase personalized eyeglasses, it shall be noted in the health record. Inmates shall be permitted to forward optical prescriptions to a family member or to an optician, to be filled at their own expense. The purchase or delivery of personal eyeglasses is subject, however, to the following limitations:

1. Inmates are responsible for arranging the financial transaction for the purchase of personal eyeglasses through their trust fund accounts.

2. Delivery of personal eyeglasses to the inmate may be denied if the materials, design, or construction of the eyeglasses presents a security concern of substantial degree.

3. Personal eyeglasses will not be repaired at State expense.

b. Tinting of lenses shall only be done upon written request of a licensed ophthalmologist or optometrist and as approved by the Utilization Management Entity (UME). Generally, only the following types of conditions will be sufficient justification for tinting:

1. Ocular problems such as dystrophy or recurrent ulceration of the cornea, chronic iritis or traumatic iris loss, retinosis pigmentosa, or advanced macular degeneration

2. Systemic health conditions that have an ocular component such as diabetic retinopathy or albinism

4. Once a pair of eyeglasses is issued to an inmate, he/she shall only be issued another pair by TDOC under the following circumstances:

a. The inmate requests to be seen for vision care and a subsequent screening and optometric exam (if needed) reveal that the inmate's vision has changed sufficiently enough that a new prescription is required to correct the visual error. Co-payment fees for the initial assessment and issuance of glasses will be assessed according to Policy #113.15.

b. The glasses were damaged or lost while performing duties related to the inmate's job assignment, supported by an incident report on TOMIS conversation LIBJ or Accident/Incident/Traumatic Injury Report, CR-2592. No co-payment fee is assessed.

c. An inmate is seen for vision care because of a chronic care protocol or treatment guidelines (e.g., diabetes, AIDS) and the subsequent screening and optometric exam (if needed) reveal that the inmate requires a new prescription. No co-payment fees for the visit or for the glasses are assessed.

C. Contact lenses shall only be issued to inmates that have an approved medical necessity. This approval can only be given by an approved licensed optometrist or ophthalmology specialist through the Health Services Administrator.

D. Medical Prosthetics: Medical prosthetics, including orthopedic appliances, hearing aids (to include replacement batteries), braces, and orthopedic shoes, shall be provided as required for bonafide medical conditions. The Associate Warden shall be notified prior to an inmate receiving an orthopedic prosthesis device (other than eyeglasses, dentures, or hearing aids) to determine if the prosthetic compromises institutional security. If he/she believes it may create a security risk, he/she shall review the matter with the institutional physician or designee to find a solution.

E. Dental Prosthetics: Dental prosthetics shall be provided per Policy #113.62. Under normal circumstances, the inmate shall have a prosthetic case completed only once. Loss, destruction, or mutilation of the provided denture is solely the inmate's responsibility. Remaking of the denture will be done at the discretion and judgement of the dental authority of the institution. Should it become necessary to construct a second denture because of the inmate's negligence, it shall be made at the inmate's expense.

F. Durable Medical Equipment: Prior to ordering or issuing durable medical equipment, the health services administrator or designee shall advise the Warden or Associate Warden of the medical necessity for the equipment in order to determine if the medical equipment compromises institutional security. If the Warden or Associate Warden believes it may create a security risk, he/she shall review the matter with the institutional physician or designee to find a solution.

G. Procurement: The procurement of prosthetic devices and durable medical equipment shall be in accordance with state purchasing requirements or contract provisions, as appropriate.

H. Documentation: All prosthetic devices and durable medical equipment issued in accordance with this policy shall be properly documented in the inmate's health record. The inmate shall sign a completed Prosthetic Device/Durable Medical Equipment Receipt, CR-3428, for all items received. This form shall be retained in Section 5 of the health record.

I. Transfer of Durable Equipment for Humanitarian Reasons: Institutional staff should make every effort to ensure that any cane, crutch, or wheelchair-dependent inmate scheduled for release has access to needed durable medical equipment through charitable or social service agencies or through the inmate's family. In the event that an inmate is released from custody and he/she does not have access to simple equipment such as crutches or a cane, the Health Services Administrator may allow an inmate to retain equipment acquired while in the custody of the TDOC. Wheelchairs may be given to inmates if it is determined that the wheelchair has significantly depreciated in value and that the use of the chair will enhance the inmate's ability to successfully return to the community.

The Health Administrator shall maintain a log documenting staff efforts to ensure the inmate has access to the necessary equipment upon release. In addition, the Health Administrator shall log the location where the equipment is to be retained and the estimated depreciated value.

The log should contain the inmate's name, TDOC number, medical condition requiring the equipment, contacts and dates efforts were made to obtain the item for the inmate in the community, location(s) where no community assistance was found, and the original and (estimated) depreciated value of the item the inmate is to take with him/her upon release. Continuous Positive Airway Pressure (CPAP) machines and portable oxygen tanks will not be given to inmates.

J. At the discretion of the Warden and when appropriate, health care staff shall be involved in the removal of prosthetic devices. (See Policy #506.06)

VII. ACA STANDARDS: 4-4375.

VIII. EXPIRATION DATE: May 15, 2017.

TENNESSEE DEPARTMENT OF CORRECTION

ACCIDENT / INCIDENT / TRAUMATIC INJURY REPORT

_____
INSTITUTION

Name: _____ Number: _____ Date of Birth: _____
Last First Middle

☐ Employee ☐ Inmate ☐ Visitor ☐ Other _____

Location (of occurrence) _____ Date (of occurrence) _____ Time (of occurrence) _____

Type of Injury / Incident: ☐ Work-related ☐ Sports ☐ Violence
☐ Use of Force ☐ Other: _____

Weapon, Property, Equipment, Machinery Involvement (Specify): _____

Subject's Version (how situation occurred): _____

_____

_____ _____
Signature of Subject

Witness' Version: _____

_____

_____ _____
Signature of Witness

Health Service Provider's Report

Subjective: _____

_____

Objective: _____

_____

Assessment: _____

_____

Plan: _____

_____

_____ _____ _____
Date of Treatment Time Signature of of Health Service Provider

Disposition:
☐ Treated by Institutional Health Service Staff
☐ Transported to Community Facility for Outpatient Care: _____ Facility
☐ Transported to Community Hospital for Inpatient Care: _____ Hospital
☐ Other, explain: _____

Did death result? ☐ Yes ☐ No Relatives notified: ☐ Yes ☐ No

TENNESSEE DEPARTMENT OF CORRECTION
PROSTHETIC DEVICE/DURABLE MEDICAL EQUIPMENT RECEIPT

_____
INSTITUTION

INMATE: _____ NUMBER: _____
Last First Middle

I have received the following prosthetic device/durable medical equipment

_____
(Item)

for _____ or until released from the custody of Tennessee
Number of days, weeks, etc., if applicable

Department of Correction.

I understand the Prosthetic Device issued to me remains the property of the Tennessee Department of Correction until I am released from custody. I understand that durable medical equipment will remain the property of the Tennessee Department of Correction and I must relinquish it after I am released.

Received By: _____ _____
Inmate's Signature Date

Issued By: _____ _____
Signature / Title Date

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, TCA 63-6-201, TCA 63-10-209, TCA 63-10-210, and TCA 63-10-212.

II. PURPOSE: To specify qualifications for all persons working in institutional clinical service and to ensure compliance with laws governing the delivery of clinical services.

III. APPLICATION: Wardens, health administrators, mental health administrators, contract healthcare staff and mental health staff, substance use program staff, and privately managed institutions.

IV. DEFINITIONS:

A. Clinical Service Authority: The health administrator, mental health administrator, substance use program manager or other individual designated, locally, as responsible for the management or coordination of clinical services at a facility.

B. Mid-Level Provider: A clinical professional with advanced practice training that legally authorizes him/her to treat patients and prescribe medication under protocols developed by his/her supervising physician. Mid-level providers may include (but are not limited to) a physician assistant, a nurse practitioner, or clinical nurse specialist (CNS) with a master level of training and a certificate of fitness.

C. Preceptor**:** A licensed, healthcare provider, mental health care provider or licensed or certified alcohol and drug counselor who gives personal instruction, practical experience, training, and supervision to a student or intern of their same discipline.

D. Qualified Clinical Service Personnel: Personnel, whether in the employ of the State or of a contractor, who are legally authorized by licensure, registration, or certification to perform direct or supportive healthcare service, mental health service or support or substance use program services and whose primary responsibility it is to provide clinical services to inmates in the custody of the Tennessee Department of Correction (TDOC). Examples of qualified clinical service personnel include, but are not limited to, physicians, dentists, mid- level providers, nursing assistants, psychologists, licensed social workers, licensed or certified alcohol and drug counselors (LADAC, ICRC-AODAC, NAADAC I, II, or Master level NAADAC certification), Licensed social workers (LCSW), licensed professional counselors (LPC), licensed psychological examiners (LPE), or licensed marriage and family therapists (MFT).

E. Responsible Physician: The licensed physician who is primarily responsible for all matters of medical judgment relating to patient care at the institution.

V. POLICY: All qualified clinical personnel providing services to inmates in the custody of the TDOC shall meet licensure, certification, registration, and/or training requirements as established by state law and/or the Health Related Boards of the Tennessee Department of Health.

VI. PROCEDURES:

A. Written verification of the current license, certification, and/or registration of the institutional and contract clinical personnel shall be maintained by the health administrator, mental health administrator, and substance use program managers for their particular disciplines. This documentation shall be verified annually and available for inspections/reviews; quality assurance credentials reviews and accreditation audits.

B. The Medical, Mental Health, and Substance Use Contractors are responsible for providing copies of all required credentials of contract employees and/or subcontractors, including any agency and/or temporary providers.

C. All qualified clinical personnel shall practice within the scope of their credentials and applicable laws.

1. Physician's Assistant, Nurse Practitioners (NP), and advance practice nurses (practitioners, clinicians, and specialists) shall practice under the clinical supervision of a licensed physician and shall practice within the limits of applicable state laws and regulations.

2. The health authorities for each discipline shall provide and review annually a written functional job description for all qualified clinical personnel outlining services consistent with their level of training and experience. If the institution employs healthcare personnel other than a licensed provider (i.e. Nursing Assistants), the care is provided pursuant to approved written standing orders or direct orders by personnel authorized by law to give such orders. Each institution shall include such written standing orders in their Health Services Unit Manual. The "Scope of Services" section of a private provider's contract may be used in lieu of a job description.

3. At institutions where Health Authorities do not supervise all qualified clinical personnel, the Warden of Treatment or designee shall approve the job description or contract responsibilities of those individuals not under the supervision of the Health Authority.

D. The Health and mental health administrators, care staff, contract health and mental health staff, substance use management shall obtain the full legal signature and initials of each qualified clinical professional authorized to document in the health record. The Signature Legend, CR-2775, shall be utilized for this purpose and maintained by the health authorities for each discipline, or in the medical records clerk/administrator's files.

E. A copy of each physician's, psychiatrist's, dentist's, and mid-level provider's license, Drug Enforcement Agency card, cardiopulmonary resuscitation (CPR), verification of background checks from the National Crime Information Center, and other credentials shall be on file at all correctional facilities where he/she may provide treatment services. A copy of each shall remain in the human resource files of all facilities where the provider is scheduled to work.

F. Students and Interns: When health or mental health care students and/or interns are utilized in the delivery of clinical care, their services shall be supervised by their preceptor. Preceptors shall ensure interns act within the scope of their licensure or certification, as defined by state law and the Health Related Boards Division of the Tennessee Department of Health. Interns shall also be given training and orientation concerning appropriate behavior in TDOC institutions.

VII. ACA STANDARDS: 4-4368, 4-4382, 4-4384 through 4-4386, and 4-4392.

VIII. EXPIRATION DATE: June 15, 2018.

TENNESSEE DEPARTMENT OF CORRECTION
SIGNATURE LEGEND

SIGNATURE	INITIALS	PRINTED NAME	TITLE

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.11	Page 1 of 7
	Effective Date: November 1, 2011	
	Distribution: A	
	Supersedes: 113.11 (10/15/08)	
Approved by: Derrick D. Schofield		
Subject: CLINICAL AND NURSING PROTOCOLS		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To establish safe and effective medical treatment of incarcerated offenders by establishing uniform guidelines for the identification and care of minor ailments and emergency situations.

III. APPLICATION: Health Administrators, physicians, dentists, mid-level providers, registered nurses, licensed practical nurses, certified nursing assistants, medical contractors, and privately managed institutions.

IV. DEFINITIONS:

A. Clinical Protocols: A document in which a physician delegates specific acts of medical management to a mid-level provider. Clinical protocols are a formal method established for the management of a symptom complex or disease process. Clinical protocols outline diagnostic tests (including laboratory tests) and treatment for identified health conditions and are used under physician supervision only by professionals with formal advanced training and certification/license in primary health care delivery.

B. Mid-Level Provider: A clinical professional with advanced practice training that legally authorizes him/her to treat patients and prescribe medication under protocols developed by his/her supervising physician. Mid-level providers may include (but are not limited to) a physician assistant, a nurse practitioner, or clinical nurse specialist with a master level of training and a certificate of fitness.

C. Nursing Protocols: Written instructions that guide and educate nurses in the specific steps to be taken in evaluating an inmate's health status and providing clinical interventions. Such protocols are directed by a physician or dentist and authorize the nurse to provide definitive treatment for minor health conditions and/or emergency care.

D. SOAP Format: ~~A~~ Medical charting/documentation clinical assessments in the health record as follows:

S: = Subjective- patient reported complaint(s), history and symptoms
O: = Objective- examinations and diagnostic tests
A: = Assessment- diagnostic impression, rule-outs
P: = Plan- Treatment plan; interventions, follow-up

E. Supervising Physician: A licensed and actively practicing physician who has been identified as accepting the responsibility for supervising a mid-level provider or nurse practitioner.

V. POLICY: Medical treatment by health care personnel other than a physician, dentist, or other independent provider shall be performed pursuant to clinical/nursing protocols or direct orders by personnel authorized by law to give such orders.

VI. PROCEDURES:

A. Nursing Protocols

1. At least annually, nursing protocols shall be reviewed and approved in writing by the TDOC Director of Health Services in coordination with the Statewide Continuous Quality Improvement committee. Such written approval shall be maintained with the nursing protocols.

2. At least annually, the TDOC's nursing protocols shall be jointly reviewed by the responsible physician/dentist and the nursing staff and shall constitute a mutual agreement concerning the management of commonly occurring conditions and emergency care needs.

3. All health facilities shall maintain a current copy of the TDOC approved nursing protocols in their Health Services unit manual. Nursing protocols shall have a cover sheet which serves as a letter of agreement between the physician and the appropriate nursing staff (Attachments A and B).

4. All nursing staff shall be oriented to the nursing protocols prior to providing nursing care specified in the protocols. It is the option of either the responsible physician/dentist, Director of Nursing, or the health administrator to restrict an individual employee's use of the protocols, based on educational background, experience level, expertise, or demonstrated performance.

5. A copy of the TDOC's nursing protocols shall be readily available in all clinical areas for use as a reference.

6. Each protocol shall be written in the SOAP format.

7. When a nursing protocol includes medication therapy, the protocol shall clearly specify:

   a. Name of medication or drug
   b. Dosage(s) authorized
   c. Dosage form
   d. Route(s) of administration
   e. Duration of order
   f. Intervals of administration
   g. Contraindications for use, if appropriate

8. All nursing protocols utilized with medication therapy must be co-signed by the supervising physician.

B. Clinical Protocols: Mid-level providers shall practice pursuant to written protocols signed by the responsible physician, within the limits of applicable state and federal laws and regulations. Institutions that utilize the services of one or more mid-level providers shall maintain formal clinical protocols. Clinical protocols define the scope of practice for physician assistant or nurse practitioner/clinician, and are the means by which the physician/dentist delegates to the mid-level provider specific acts of medical management.

1. Each mid-level provider shall have a physician preceptor who is responsible for supervising his or her clinical practice. The physician/mid-level provider relationship shall be clearly established in writing, with a copy maintained by each party and the health administrator.

2. Before a mid-level provider is allowed to practice under clinical protocols, the training, credentials, and experience level of the individual shall be verified by (and to the satisfaction of) the sponsor physician and the health administrator. It is the option of both the responsible physician and the health administrator to restrict an individual mid-level provider in his or her use of clinical protocols.

3. At least annually, the clinical protocols shall be reviewed and revised as necessary, and then both the physician and mid-level provider shall sign and date the letter of agreement. This agreement shall also serve as a cover letter for the clinical protocols, which are mutually agreed upon by the responsible physician and the mid-level provider. Attachment C is a sample Physician/Mid-level Letter of Agreement. Should there be a change in the responsible physician or mid-level provider, a new letter of agreement shall be signed.

4. A supervising physician shall personally review at least 20% of charts monitored or written by the mid-level provider every 30 days.

5. The clinical protocols shall be readily available in all clinical areas at all times for reference by individual mid-level providers and other staff members as needed. Professional publications may serve as the clinical resource as approved by the physician in accordance with the procedures in this policy.

6. Only board certified psychiatrists may delegate (in clinical protocols) the prescribing of psychotropic medications, and then only to advanced practice psychiatric nurse clinicians who have specialized training in psychiatric practice who are authorized to do so under Tennessee regulations, and are under the psychiatrist's supervision.

C. Standing Orders: If the institution employs healthcare personnel other than a licensed provider (i.e. certified nursing assistants), the care is provided pursuant to approved written standing orders or direct orders by personnel authorized by law to give such orders. Each institution shall include such written standing orders in their *Health Services Unit Manual.*

VII. ACA STANDARDS: 4-4381 and 4-4382.

VIII. EXPIRATION DATE: November 1, 2014.

Attachment A

TENNESSEE DEPARTMENT OF CORRECTION
NURSING PROTOCOLS LETTER OF UNDERSTANDING

These nursing protocols are designed for use by the nursing staff of the Tennessee Department of Correction and associated contractors. Treatment by health care personnel other than a physician, dentist or other independent provider must be performed pursuant to written or direct orders or protocols. Registered and Licensed Practical Nurses may practice within the limits of state and federal laws. These nursing protocols constitute directives from the responsible physician to the nurse for the treatment of commonly occurring conditions or emergencies. Each nursing protocol is mutually agreed upon by the Facility Medical Director and facility nursing staff. Before a member of the nursing staff is allowed to practice under these protocols, the training credentials and experience level of each nurse shall be verified to the satisfaction of the responsible physician and nursing director/supervisor. It is the option of either the responsible physician or the nursing director/supervisor to restrict an individual nurse in his or her use of these nursing protocols based on the individual's education, experience, or ability.

It is essential that a good working relationship be maintained between the nursing staff and the responsible physician. At least annually, nursing protocols shall be reviewed jointly by the responsible physician and the nursing staff. The responsible physician shall in a timely manner review treatment provided by the nurses and co-sign in the health record orders and treatment initiated by the nurse pursuant to protocols. It is expected that when questions arise the nurse will obtain a consultation either face-to-face or via phone or refer that patient to the appropriate provider.

_____
Facility Medical Director's Name (Please Print)

_____ _____
Signature of Facility Medical Director Date

Attachment B

TENNESSEE DEPARTMENT OF CORRECTION
NURSING PROTOCOLS SIGNATURE SHEET

My affixed signature indicates that I have read and understand the scope of the TDOC Nursing Protocols. I have the necessary skills, knowledge, and understanding to use these protocols. I agree to abide by the conditions of supervision as expressed in the attached Letter of Understanding. I further acknowledge that any variance from the approved procedures is not acceptable. I understand that the protocols are by no means exhaustive, and I am expected to know my limitations and to seek assistance from other healthcare professionals as needed. Utilization of the TDOC's Nursing Protocols shall be documented in the inmate health record and signed, using my signature and title.

NURSE (*Print Name*)	**SIGNATURE AND TITLE OF NURSE**	**LICENSE #**	**DATE**

Attachment C

TENNESSEE DEPARTMENT OF CORRECTION
PHYSICIAN/MID-LEVEL AGREEMENT

These clinical protocols are designed for use by the mid-level providers at (Name of Correctional Facility). Treatment by health care personnel other than a physician, dentist or other independent provider (such as an Optometrist or a Podiatrist) must be performed pursuant to written or direct orders or established protocols. Physician Assistants and Nurse Practitioners/Clinicians with a Certificate of Fitness may practice within the limits of state and federal laws. These protocols constitute directives from the responsible physician to the mid-level provider, of identified conditions, including episodic illnesses, chronic illnesses, and emergency treatment. Each protocol includes the condition, any required diagnostics and treatment and referral data, if applicable, as mutually agreed by the responsible physician and the mid-level provider.

Before a mid-level provider is allowed to operate under these protocols, their training, credentials and experience level shall be verified to the satisfaction of the responsible physician and facility health administrator.

It is essential that a good working relationship be maintained between the mid-level provider and his/her supervising physician. Protocols shall be reviewed jointly by the responsible physician and the mid-level provider on a regular basis. The responsible physician shall in a timely manner review treatment provided by the mid-level provider, and co-sign in the health record, when appropriate and necessary, orders and treatment initiated by the mid-level provider pursuant to protocols. Physician Assistants and Nurse Practitioners practicing in Tennessee recognize that by state law they are personally responsible and liable for their actions.

_____ _____
Signature and Title of Physician Date

_____ _____
Signature and Title of Mid-Level Provider Date

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.13	Page 1 of 4
	Effective Date: June 15, 2014	
	Distribution: A	
	Supersedes: 113.13 (12/15/13)	
Approved by: Derrick D. Schofield		
Subject: TREATMENT OF FACILITY EMPLOYEES BY HEALTH CARE PERSONNEL		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To clarify the instances when health care personnel can provide services to Tennessee Department of Correction facility employees or facility contract employees.

III. APPLICATION: To all Tennessee Department of Correction (TDOC) facility employees, the Tennessee Correction Academy (TCA), and medical contractors.

IV. DEFINITIONS: Health Care personnel: All full and part-time, State of Tennessee or contracted staff engaged in the delivery of health care services within the correctional system.

V. POLICY: Provision of health care services to employees, contract employees and visitors in the facility setting shall be limited to the provision of first aid, emergency services, and other services permitted by the office of clinical services. Health care personnel shall not engage in the provision of routine healthcare to Tennessee Department of Correction (TDOC) employees, contract employees, or visitors.

VI. PROCEDURES:

A. Employees seeking routine health care services from health care personnel will be referred to the employee's personal physician.

B. Exceptions to the above procedure include the following:

1. Emergency Treatment: Emergency medical treatment shall be provided to employees, using Department of Correction resources whenever necessary, to protect life or limb and relieve undue suffering. Treatment shall be provided as necessary to stabilize the employee until such time as the employee can be transported to his/her private physician or an emergency room. Prescription medications shall only be provided in the case of an emergency by a prescribing clinician. Any treatment provided for accidents/traumatic injuries shall be documented on Accident/Incident Traumatic Injury Report, CR-2592.

2. Tuberculosis screening: Tuberculosis screening shall be conducted for employees as outlined in Policies #113.44, #305.06, and #305.09.

3. First Aid: Band-Aids and other first aid items required for self care of minor conditions while on duty may be provided to employees on a limited basis. Each institution shall have a policy outlining those items that may be made available to staff members while on duty. Institutional policies shall clearly identify the access process including individuals responsible for providing items for self care, maintaining supplies, and record keeping. Institutional policies shall comply with all TDOC policies with specific reference to Policies #113.70 and #113.71.

4. If the presenting problem or condition is reported to be work-related, the employee will be referred to the facility personnel office for follow-up in accordance with Workers' Compensation Claims, Policy #303.04.

5. Exposure to Bloodborne Pathogens:

   (a) When an exposure incident (as defined in the *Tennessee Department of Correction Health Services Exposure Control Plan for Occupational Exposure to Bloodborne Pathogens)* results in one or more correctional employees being exposed to the blood of one or more inmates, the inmate(s) shall be tested for blood borne pathogens in accordance with Policy #113.51. The results of the tests shall be disclosed to the exposed correctional employee(s) by a physician or mid-level provider no later than 24 hours after such results are known, unless, following a reasonable effort, all such employees cannot be notified within such time.

   (b) Each institution shall identify the responsible member of the health services staff who will disclose test results to the exposed correctional employee. A back-up individual(s) shall also be designated. Employees involved in an exposure incident shall be counseled by the facility infection control nurse and/or the health services division designated infection control officer regarding communicable disease issues

   (c) Response to exposure incidents shall be conducted in accordance with the *Tennessee Department of Correction Health Services Exposure Control Plan for Occupational Exposure to Bloodborne Pathogens*.

   (d) Individual requests for HIV testing as a result of a documented exposure incident shall be accommodated by a referral to the individual's personal physician, or by advising the individual of workman's compensation testing sites.

6. Medical Screening of Institutional Employees: New institutional employees will receive a physical examination or medical screening at the TCA in accordance with Policy #305.06 (security staff) or Policy #305.09 (non-security staff).

C. All employees at risk for potential occupational exposure to bloodborne pathogens as defined by the *Tennessee Department of Correction Health Services Exposure Control Plan for Occupational Exposure to Bloodborne Pathogens* shall receive appropriate training and shall be offered the hepatitis B vaccine at the Department's expense. A copy of this plan shall be available in the facility's employee training library and the health administrator shall maintain a copy in the clinic.

VII. ACA STANDARDS: 4-4386, 4-4387, 4-4390, and 4-4062.

VIII. EXPIRATION DATE: June 15, 2017.

TENNESSEE DEPARTMENT OF CORRECTION

ACCIDENT / INCIDENT / TRAUMATIC INJURY REPORT

_____
INSTITUTION

Name: _____ Number: _____ Date of Birth: _____
Last First Middle

☐ Employee ☐ Inmate ☐ Visitor ☐ Other _____

Location (of occurrence) _____ Date (of occurrence) _____ Time (of occurrence) _____

Type of Injury / Incident: ☐ Work-related ☐ Sports ☐ Violence
☐ Use of Force ☐ Other: _____

Weapon, Property, Equipment, Machinery Involvement (Specify): _____

Subject's Version (how situation occurred): _____

_____

_____ _____
Signature of Subject

Witness' Version: _____

_____

_____ _____
Signature of Witness

Health Service Provider's Report

Subjective: _____

_____

Objective: _____

_____

Assessment: _____

_____

Plan: _____

_____

_____ _____ _____
Date of Treatment Time Signature of of Health Service Provider

Disposition:
☐ Treated by Institutional Health Service Staff
☐ Transported to Community Facility for Outpatient Care: _____ Facility
☐ Transported to Community Hospital for Inpatient Care: _____ Hospital
☐ Other, explain: _____

Did death result? ☐ Yes ☐ No Relatives notified: ☐ Yes ☐ No

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.15	Page 1 of 7
	Effective Date: December 1, 2015	
	Distribution: A	
	Supersedes: 113.15 (6/1/11)	
Approved by: Derrick D. Schofield		
Subject: INMATE CO-PAYMENT FOR HEALTH SERVICES		

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, and TCA 41-21-237.

II. PURPOSE: To establish procedures to assist inmates in the participation of their own health care decisions and to allow for appropriate use of correctional health care resources.

III. APPLICATION: Wardens, health administrators, trust fund custodians, all inmate work supervisors, all Tennessee Rehabilitative Initiative in Correction (TRICOR) inmate supervisors, all health services staff, privately managed facilities, medical contractors, and inmates.

IV. DEFINITIONS:

A. Chargeable Visit: An encounter with institutional health care staff that is provided for an inmate pursuant to the inmate's request or initiation of a visit either through scheduled sick call or an unscheduled walk-in visit. [See Section VI.(H)(3) regarding chargeable visits]

B. Co-payment: A fixed fee for medical care paid by inmates for health care designated as chargeable services.

C. Fee Designee: Any member of the healthcare team, that does not possess any type of medical license or certification from a Tennessee licensure board or function in a clinical role and are employed by the Tennessee Department of Correction (TDOC) or privately managed facility staff through TDOC policy designated by the Associate Warden of Treatment (AWT) to collect fees associated with this policy.

D. Job-Related Injury: Health problems directly caused by the performance of the inmate's assigned job. These may include injuries such as sprains, strains, and lacerations, as well as insect and animal bites, heat stroke, severe sunburns, and/or skin reactions to poisonous plants.

E. Non-Chargeable Visit: An encounter with institutional health care staff which is generated by Tennessee Department of Correction (TDOC) or privately managed facility staff through TDOC policy, as a documented health services staff-directed follow-up to a previously identified condition, or a job-related injury. [See Section VI. (H)(2) regarding non-chargeable visits]

F. Self-Induced Illness/Injury: An illness or injury sustained from characterized illicit substance use, self-injurious behavior.

V. POLICY: The Department shall provide health care treatment to inmates at minimal charge without regard to an inmate's ability to pay.

VI. PROCEDURES:

A. All inmates are advised of the guidelines of the co-payment policy through the inmate orientation program and receipt of the *Tennessee Department of Correction Inmate Rules and Regulations handbook* (See Policies #113.22, #404.05, and #502.04)

B. Sick Call:

1. If an encounter is not chargeable, due to documented follow-up or staff initiated care documented in the inmate health record, the health care provider shall document such on the institution's encounter log.

2. Prior to assessment/treatment for any chargeable encounters a Trust Fund Account Personal Withdrawal Request, CR-2727, shall be completed in accordance with Section (J) of this policy.

C. Segregation Visits:

1. When a health service encounter is provided pursuant to a request by an inmate who is in administrative or disciplinary segregation or protective custody, a CR-2727 shall be initiated as described in Section (I) of this policy. There shall be no charge to the inmate for daily visits by the health provider to the unit unless the inmate requests to be seen.

2. Co-payments shall not be initiated for inmates who are segregated for medical or behavioral health reasons.

D. All inmates requiring DNA testing as defined in Policy #113.92 shall be charged the actual cost of the Tennessee Bureau of Investigation (TBI) journal voucher to the Department.

E. If an inmate believes he/she was improperly charged a co-payment for a health service encounter, he/she shall notify the institution's health administrator in writing and request that the charge be reviewed. The health administrator shall determine if the inmate was charged appropriately. If the health administrator determines the inmate should not have been charged, he/she shall notify the Fiscal Director/Accounting Manager/designee in writing and the amount shall be credited to the inmate's trust fund account.

F. The health administrator, or designee, shall periodically audit documentation to ensure that the co-payment charges are being made for all chargeable encounters, and that no charges are being assessed for non-chargeable encounters.

G. Excluded Populations: The following TDOC populations are exempt from all co-payment charges described in this policy:

1. Inmates housed in the acute, intensive, and intermediate behavioral health units at DSNF and TPFW
2. Inmates housed in the Health Care Center at DSNF
3. Inmates housed in any institutional infirmary
4. Inmates participating in the step up/step down programming at SCCF
5. Inmates housed in the basic skills unit at DSNF

H. Non-Chargeable and Chargeable Health Services

1. General: The following outlines common health care encounters in all institutions which are categorized as either non-chargeable or chargeable services. Although this listing was created to be as comprehensive as possible, it will not cover every situation. Generally, inmate initiated encounters are chargeable, and staff initiated encounters (i.e., physicians orders, treatment plans, etc.) pursuant to TDOC policies, ~~or~~ protocols, and standards of clinical practice are not chargeable. If there is any question as to whether to complete a CR-2727 for an encounter, the health administrator should contact the TDOC Director of Clinical Services for clarification.

2. Non-Chargeable Services

a. General Health Maintenance/Preventive Care

(1) Intake physical examination/health classification
(2) Initial dental examination
(3) TB testing/screening
(4) Periodic health appraisal
(5) Health Classification
(6) Food handler's permit screenings
(7) Health education
(8) Screening prior to inmate transfer
(9) Health/Behavioral Health Screening
(10) Chronic care visits initiated by health care staff
(11) Infirmary care
(12) Vaccinations including flu shots (per Policy #113.43)
(13) Lab work and X-ray tests
(14) Sexual assault examinations, including mental health services necessary to treat the offender

b. Follow-Up or Staff Initiated Care: An encounter with a physician or mid-level provider after initial triage and referral by a nurse, or a subsequent encounter for a single health problem that was directed by the health provider with documentation in the medical record. This may be after a designated period of time, such as "return in two weeks." If an inmate presents at a later date complaining of the same problem, but there was no documented plan for follow-up in the health record, the encounter is chargeable. (See VI.(H)(3)(a)(7) of this policy)

c. Behavioral Health and Substance Use Services:

(1) Self referrals
(2) Psychiatric or psychological services
(3) Group therapy

d. Job-Related Injuries: If an inmate has an injury or health problem that directly results from performing a duty related to his or her assigned job, there will be no charge as long as all the following are met:

(1) The top portion of the Accident/Incident/Traumatic Injury Report, CR-2592, is completed by the inmate's work supervisor and accompanies the inmate to the institutional clinic. (See Policy #113.53)

(2) The inmate is directed by staff to obtain medical attention for the job-related injury. The inmate must also seek attention within 24 hours of the injury.

e. If an inmate suffers from an injury caused by another person, he/she may not be responsible for the co-payment as determined by the Warden.

f. Dental Services: All dental procedures that are documented in the dental treatment plan shall be considered follow-up treatment and therefore, non-chargeable when they are performed according to the institutional dental priority listing and the health services staff calls the inmate to be seen.

3. Chargeable Services

a. The following inmate-initiated health services encounters (medical, nursing, dental, etc.) shall be assessed a co-payment of $3.00:

(1) Regular sick call visit regardless of outcome or treatment provided

(2) Nurse sick call visit to inmate in segregation who requests to be seen

(3) The copayment charge for emergency encounters initiated by staff (e.g., a declared Code 4) shall continue to be $3.00.

(4) Emergency treatment that is not a result of on-the-job injuries. Emergency encounters are chargeable, even if staff initiates response by calling a code.

(5) Health assessment/treatment provided due to self-induced illness or injury

(6) Inmate requests to be seen for a problem that had been previously treated and the treatment has been completed; however, the problem has manifested again, and there was no written indication for follow up from the original treating provider.

(7) Dental services requested by an inmate through sick call shall be charged and co-payment shall be assessed on the day the inmate first receives dental services rather than when he/she is placed on the dental waiting list.

(8) Optometry services, excluding those provided at intake and the during periodic health appraisal.

(9) Pregnancy-Related Conditions: An inmate who initiates health services to confirm pregnancy shall be charged for the initial visit to the provider for the pregnancy test. If the pregnancy is confirmed, all subsequent visits will be considered follow-up care and are non-chargeable.

(10) HIV testing for inmates who are subject to the provisions of TCA 39-13-112 as amended and are tested for HIV following an arrest for aggravated assault.

b. The following health care services shall be assessed a $5.00 co-payment for each encounter:

(1) If an inmate initiates an encounter by requesting emergency medical assistance or an emergency assessment and does not follow the procedures established for routine sick call, the co-payment charge for each such encounter shall be $5.00.

(2) The distribution of hearing aids, eyeglasses/contact lenses, or dentures to any inmate.

c. Any refusal of specialty services/ appointments shall be assessed a $10.00 co-payment:

(1) Institutional health care staff shall review scheduled transfers to DSNF (for males), TPFW (for females), or to local providers for services/appointments with the inmate as described in Policies #113.12 and #113.51.

(2) If it is documented in the health record that the inmate affirmed that he/she would go to the scheduled appointment and subsequently refuses on the day of transfer, the inmate shall be charged.

(3) The inmate may also be charged if he/she has been transferred for a specialty consult/appointment and either refuses or is unable to complete the appointment as scheduled.

d. Self-Injurious Behavior: Inmates who engage in self-injurious behavior may be held responsible for repayment of all costs associated with the incident. This may include those patients cited in Section VI.(G)(1) of this policy upon clinical determination by a psychiatrist and/or psychologist.

I. Collection of Co-payment fees:

1. All Trust Fund Account Personal Withdrawal Requests, CR-2727, shall be completed by the fee designee, as listed below:

a. Prior to treatment of chargeable services or a refusal of specialty services outlined in this policy, a CR-2727 shall be completed and the inmate asked to sign.

b. If the inmate requests treatment but refuses to sign the CR-2727, the fee designee shall advise the inmate that regardless of whether he/she refuses, it is a chargeable encounter. The inmate should be given the appropriate treatment or referral for his/her problem.

c. The CR-2727 shall then be signed by the fee designee, and sent to the health administrator

d. Upon receipt of the CR-2727, the health services administrator shall review it for appropriateness and then forward it to the institution's trust fund custodian.

VII. ACA STANDARDS: 4-4345 and 4-4375.

VIII. EXPIRATION DATE: December 1, 2018.

TENNESSEE DEPARTMENT OF CORRECTION
TRUST FUND ACCOUNT
PERSONAL WITHDRAWAL REQUEST

_____
INSTITUTION

$ _____ DATE: _____

PLEASE DEDUCT THE FOLLOWING AMOUNT FROM MY ACCOUNT:

_____ DOLLARS

THIS CHECK IS TO BE MAILED TO:

_____ NAME

_____ STREET ADDRESS

_____ CITY, STATE, ZIP

THE PURPOSE OF THIS WITHDRAWAL IS:

_____

_____

_____

_____

_____ _____
INMATE SIGNATURE INMATE #

Building: _____

Room #: _____

WITNESSED: _____

APPROVED: ☐ YES ☐ NO

REASON FOR DENIAL:

_____

_____ _____
WARDEN / DIRECTOR DESIGNEE DATE

CR-2727 (Rev. 6-02) White-Inmate Canary-Trust Fund Office

TENNESSEE DEPARTMENT OF CORRECTION
TRUST FUND ACCOUNT
PERSONAL WITHDRAWAL REQUEST

_____
INSTITUTION

$ _____ DATE: _____

PLEASE DEDUCT THE FOLLOWING AMOUNT FROM MY ACCOUNT:

_____ DOLLARS

THIS CHECK IS TO BE MAILED TO:

_____ NAME

_____ STREET ADDRESS

_____ CITY, STATE, ZIP

THE PURPOSE OF THIS WITHDRAWAL IS:

_____

_____

_____

_____

_____ _____
INMATE SIGNATURE INMATE #

Building: _____

Room #: _____

WITNESSED: _____

APPROVED: ☐ YES ☐ NO

REASON FOR DENIAL:

_____

_____ _____
WARDEN / DIRECTOR DESIGNEE DATE

CR-2727 (Rev. 6-02) White-Inmate Canary-Trust Fund Office

TENNESSEE DEPARTMENT OF CORRECTION

ACCIDENT / INCIDENT / TRAUMATIC INJURY REPORT

_____
INSTITUTION

Name: _____ Number: _____ Date of Birth: _____
Last First Middle

☐ Employee ☐ Inmate ☐ Visitor ☐ Other _____

Location (of occurrence) _____ Date (of occurrence) _____ Time (of occurrence) _____

Type of Injury / Incident: ☐ Work-related ☐ Sports ☐ Violence
☐ Use of Force ☐ Other: _____

Weapon, Property, Equipment, Machinery Involvement (Specify): _____

Subject's Version (how situation occurred): _____

_____

_____ _____
Signature of Subject

Witness' Version: _____

_____

_____ _____
Signature of Witness

Health Service Provider's Report

Subjective: _____

_____

Objective: _____

_____

Assessment: _____

_____

Plan: _____

_____

_____ _____ _____
Date of Treatment Time Signature of of Health Service Provider

Disposition:
☐ Treated by Institutional Health Service Staff
☐ Transported to Community Facility for Outpatient Care: _____ Facility
☐ Transported to Community Hospital for Inpatient Care: _____ Hospital
☐ Other, explain: _____

Did death result? ☐ Yes ☐ No Relatives notified: ☐ Yes ☐ No

hiv

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.20	Page 1 of 14
	Effective Date: June 15, 2015	
	Distribution: A	
	Supersedes: 113.20 (8/1/10); PCN 12-14 (8/15/12) 113.23 (5/15/11) 113.41 (5/1/11)	
Approved by: Derrick D. Schofield		
Subject: INITIAL HEALTH SCREENING AND PHYSICAL EXAMINATIONS		

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, and TCA 41-21-107a.

II. PURPOSE: To ensure that each inmate receives an initial ~~a~~ comprehensive clinical screening and intake physical during the intake/diagnostic process and upon intersystem transfers as well as, periodic health appraisals thereafter, with a goal of preventing the onset or worsening of an existing condition.

III. APPLICATION: Wardens, Health and Mental Health Administrators, Therapeutic Program Directors, health care staff at all institutions performing diagnostic functions, all inmates, medical contractors, and privately managed institutions.

IV. DEFINITIONS:

A. Advanced Directive: An individual instruction or written statement relating to the subsequent provision of health care for the individual in which the inmate or his/her healthcare agent expresses his/her choice(s) regarding healthcare services to apply in the event he/she is no longer capable of expressing a choice. Advance directives may include but not be limited to, a living will, an advance care plan, or durable power of attorney for health care.

B. Medical Practitioner: A licensed physician or mid-level provider.

C. Periodic Health Appraisal: Physical health examination in which inmates are evaluated for risk factors and disease, with the goal of preventing the onset of disease or worsening of an existing disease.

D. Qualified Health Professional: Clinical staff who are legally authorized by licensure, registration, or certification to perform direct or supportive health care services and whose primary responsibility is to provide clinical services to inmates in the custody of the Tennessee Department of Correction (TDOC). Examples of qualified health professionals may include physicians, dentists, physician assistants, nurse practitioners, nurses, psychiatrists, senior psychological examiners, psychologists, clinical social workers, etc.

V. POLICY: All inmates entering the Tennessee Department of Correction shall be provided with an initial comprehensive clinical screening and periodic physical examinations as indicated by their physical condition and/or age and in accordance with the schedule outlined in this policy.

VI. PROCEDURES:

A. Initial Health Screening and Questionnaire

1. The health administrator for each institution shall ensure:

a. That a LPN, RN, or mid-level provider performs an initial health screening on each inmate immediately upon arrival at the institution.

b. The health screening shall consist of a completed Health Questionnaire, CR-2178.

c. Review of the CR-2178, in accordance with institutional procedures shall generate referrals to appropriate medical, mental health and substance use personnel.

d. A copy of the TDOC and/or institutional Inmate Rules and Regulations handbook shall be provided to the inmate.

e. Process is completed prior to the inmate being placed into general population.

2. Nursing staff shall complete the Mental Health Questionnaire, CR-2178.

3. Transient inmates do not need to be issued an institutional inmate handbook but do need to sign the CR-2178 indicating that an explanation of how to access health care at the receiving facility was given in accordance with Policy #113.22.

B. Health Examinations

1. Intake Physical Examination: The intake health examination shall be completed within 14 calendar days of the inmate's arrival at the reception/classification center and shall consist of the following procedures:

a. An outpatient health record shall be originated by completing a Health History, CR-2007, and Report of Physical Examination, CR-3885.

b. Physiological measurements shall be completed by health care providers and shall include height, weight, temperature, pulse, blood pressure (sitting), and visual acuity screening (Snellen) of both eyes. All of the results shall be fully recorded on Page 1 of CR-2007.

c. The following screening tests shall be performed:

(1) All Inmates:

(a) Complete Blood Count w/differential (CBC)

(b) Automated Blood Chemistry Profile (including lipid profile)

(c) Serology for Syphilis

(d) Screening for Gonorrhea and Chlamydia using an appropriate laboratory test

(e) Urinalysis

(f) Hearing Screening followed by a reflex audiometric Test if indicated, noting binaural hearing loss

(g) Initial Tuberculosis screening according to Policy #113.44

(h) If indicated, screen for viral Hepatitis B or Hepatitis C using the appropriate laboratory screening test (Use the Hepatitis C Antibody for viral Hepatitis C and use the Hepatitis B Surface Antigen for Hepatitis B)

(i) HIV Testing according to Policy #113.45. (NOTE: Tennessee statute requires testing of all inmates under the age of 21 years, unless the inmate has previously been tested pursuant to TCA 39-13-521, Mandatory HIV Testing, and the results are available and verifiable).

(j) DNA testing (according to Policy #113.92 and TCA 40-35-321).

(k) Age 50 and Older: Fecal Occult Blood Test (FOBT)

(l) Additionally for all female inmates:

(1) Pelvic Examination with PAP Smear
(2) Breast Examination and education on breast self-exam.

(m) Female Inmates Age 40 and Older:

(1) Mammogram
(2) Chest X-ray, if indicated
(3) Electrocardiogram, if indicated

(n) Male Inmates Age 45 and Older:

(1) Chest X-ray, if indicated
(2) Electrocardiogram, if indicated

(o) The following guidelines should be used in assessing prostatic health.

(1) Male Inmates Age 40: begin discussions with African American Males, and inmates with positive family history with a first degree relative or BRCA1 in BRACA2 mutations.

(2) Male Inmates Age 50: Begin discussion regarding testing risk versus benefits unless there is less than a 10 year life expectancy or 75 years of age.

(3) Male Inmates Over Age 75: No Screening.

(4) When risk factors indicate a PSA test is needed and the PSA test values are greater than 4.0 ng/ml, repeat PSA in six weeks. Before repeating PSA, eliminate possible factors contributing to elevation i.e. recent ejaculation, trauma, or prostatitis. The inmate should be counseled appropriately to avoid erroneous elevations. If the PSA remains elevated, refer to urologist for evaluation to determine necessity for biopsy. Repeat PSA every 2 years with digital rectal examination

d. A diphtheria tetanus booster, and other immunizations as recommended by the Tennessee Department of Health, shall be administered to inmates in accordance with Policy #113.43. The MMR (measles, mumps, and rubella) vaccination should be administered at intake to women of child-bearing age (16-45) who have reported never having received the vaccine as an adult.

e. Following a review of the health history, the physician or mid-level provider shall perform a complete physical examination of each inmate. The clinical evaluation shall include all items as defined on CR-3885. A clear description of findings should be documented on the CR-3885 in all categories. All examination findings shall be fully and legibly documented on the physical examination report, including normality, abnormality, and summary of physical defects, diagnoses, and health classification. Each item should be evaluated separately by checking normal, abnormal, or documentation of refusal, CR-1897, as appropriate. The date of examination, full signature, and the professional title (printed and signed) of the physician or mid-level provider conducting the physical examination is required.

f. At the time of the physical examination, the physician or mid-level provider shall determine the appropriate health classification of the inmate. (See Policy #113.21 for detailed procedures and forms usage)

g. The eTOMIS screen LHSE (Health Assessment) shall be used to document the health classification. Limitations shall be documented on Option 3, "Comments".

h. Additional diagnostic procedures may be requested at this time, based on the inmate's identified health-related risk factors, or other health, mental health, or substance use problems.

i. All diagnosed major clinical problems identified during the intake physical shall be recorded by a health services provider on the Major Clinical Problem List, CR-1894. See Policies #113.84 and #513.07 for mental health or substance use documentations directions.

j. ~~Patients~~ Inmates with significant health care problems as identified by the physician or mid-level provider conducting the health history review and physical examination shall have a treatment plan developed and implemented within 14 days after the inmate's arrival at the reception/classification center. (See Policy #113.32) These inmates are generally expected to be those given a health classification of Class B or Class C. (See Policy #113.21)

k. When an inmate is moved prior to the completion of their Health Screening, the Health Services Administrator shall notify the receiving Health Services Administrator that the inmate en route does not have a complete health screening and document in comments on CR-2176 and CR-1895 that inmate's health screening is incomplete.

l. Returning Inmates: If an inmate returns to TDOC custody within 90 days of release, the health care staff is not required to perform a complete intake physical examination. At a minimum, syphilis, GC/chlamydia, and TB testing shall be performed, and a brief, self-reported history shall be taken from the inmate to determine if any significant health problems have developed during the period of release into the community.

2. Periodic Health Appraisal: A PHA shall be performed for all inmates according to the following age groups:

Age Group	Frequency
49 and under	Every three years
50-64	Every two years
65 and over	Every year

a. The PHA shall be performed during the inmate's birth month by either a mid-level provider or physician at approximately the same time of the inmate's annual TB screening, unless a PHA (initial or periodic) was performed within the past six months. The PHA shall then be performed on the next birth month the inmate is due for a PHA.

(1) Each month, a birth month list for all assigned inmates with a birthday two months out, is obtained from Management Information Systems and distributed to health administrators via the Central Office Health Services. This report may be used to assist each facility in identifying inmate's requiring a PHA.

(2) The Health Status/Transfer Summary, CR-1895, shall be reviewed for all incoming inmates to determine if the PHA is current. Inmates requiring a PHA shall be scheduled along with the next group to receive physicals

(3) The annual screening/review listing shall be maintained on file in the clinic/infirmary and the date of the PHA shall be entered or checked "NI" (not indicated).

b. At a minimum, the following procedures shall be conducted during the PHA for all inmates:

(1) Review the health record to identify current health problems and risks to health.

(2) Record the vital signs, including weight, pulse, temperature, and blood pressure. The results shall be documented on CR-3885, the Report of Physical Examination.

(3) Complete laboratory tests including:

(a) Chemistry profile (including lipid profile)

(b) Complete blood count (CBC) with differential

(c) Complete urinalysis

(d) Fecal Occult Blood Test (FOBT) over age 50

(e) Other tests as ordered by the prescribing clinician

(4) Additional procedures for females:

(a) Annual PAP smear and pelvic examination

(b) Counseling and education on breast self-examination

(c) Annual breast examination followed by a mammogram, if indicated by breast examination

(d) Mammograms may be conducted either during the birth month or the month prior to the birth month, and:

(1) Females 40-49 years old - every two years

(2) Females 50 years and older - every year

(5) Additional procedures for males:

(a) Digital rectal examination

(b) Counseling and education on testicular self-examination

(c) Prostatic health assessment as outlined in VI.(B)(1)(o) of this policy

c. During every PHA, each inmate shall be counseled regarding Advanced Directives. A new form PH-4194, Advanced Care Plan, or a review of this form for update, shall be completed, expressing the inmate's informed decisions regarding options for end-of-life services, to ensure their wishes are honored. The qualified health Professional shall document completion, or update, of the PH-4194 on CR-3885, The Report of Physical Examination, and file this form in the inmate's health record in accordance with Policy #113.50.

d. Special health needs: At the time of the health appraisal, inmates requiring close medical supervision shall be identified. A written, individual treatment plan, which includes directions to health care staff and other personnel regarding their roles in the care and plan represents one aspect of the special health program for inmates requiring close medical supervision. (See Policy #113.32 Levels of Care)

VII. ACA STANDARDS: 4-4285, 4-4347, 4-4350, 4-4356, 4-4357, 4-4362, 4-4363, 4-4364, 4-4365, 4-4366, 4-4367, 4-4370, 4-4371, 4-4372, 4-4399.

VIII. EXPIRATION DATE: June 15, 2018.

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

_____
INSTITUTION

SS# _____ **Sex** _____ **Age** _____ **D.O.B.** _____

Next of Kin: Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: **Area Code** _____ **Number** _____

Date Completed: _____ Month _____ Day _____ Year

Height: _____ Weight: _____ Hair Color: _____ Color of Eyes: _____

Blood Pressure (Sitting): _____ Temp: _____ Pulse _____ Resp. _____

DATE, if done on Admission			
Serology		EKG	
Urinalysis		Chest X-Ray	
CBC		Hemocult	
Chem. Scan			
Td Booster			
Other			

ALLERGIES:

Date or TB Skin Test			
Date Read		Results	
			(Record in MM.)

Visual Acuity (Snellen) **R.** _____ **L.** _____

CURRENT MEDICATIONS: (Specify drug, strength, dosage form and frequency)

_____

_____

_____

_____

_____

_____

_____

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

1. Family History: Have any of your family or relatives had any of the following? If so, specify who:

Heart Disease		Tuberculosis		Cancer	
Sickle Cell		Diabetes		Seizures	
Hypertension		Mental Illness		Other	
Substance Use		Are your parents still alive?			

2. Social History:

Highest Grade Completed _____ Usual Occupation _____ Marital Status _____

Previous Incarcerations _____ Old Number (TN, Other State, Federal) _____

Prior to Incarceration:

Used alcohol: Yes _____ No _____ If yes, Daily ___ Weekly _____ Rarely _____

Other habit forming drug(s): Yes _____ No _____ Name(s) of Drug(s): _____

Ever injected drugs (even once)? Yes _____ No _____

3. When did you last see a doctor? _____

For What Reason: _____

4. Have you ever been told by a doctor that you now have or have had any of the following:
Answer questions by checking **yes** or **no**

NO		YES	COMMENT(S)
☐	a. Rheumatic Fever	☐	
☐	b. Heart trouble	☐	
☐	c. High Blood Pressure	☐	
☐	d. Thyroid trouble or Goiter	☐	
☐	e. Diabetes	☐	
☐	f. Kidney infections or Stones	☐	
☐	g. Jaundice, hepatitis or liver disease	☐	
☐	h. Ulcer	☐	
☐	i. Pneumonia	☐	
☐	j. Tuberculosis	☐	
☐	k. Gallbladder Disease	☐	
☐	l. Sexually Transmitted Infection/Disease (Venereal Disease)	☐	
☐	m. Asthma	☐	
☐	n. Emphysema	☐	
☐	o. Anemia	☐	
☐	p. Hemophilia	☐	
☐	q. Cancer	☐	
☐	r. Epilepsy or Seizure disorder	☐	
☐	s. Allergies, (if yes, what? _____)	☐	
☐	t. Any other serious illness, or injuries, operations or hospitalizations?	☐	
☐	u. Any history of treatment in a Mental Health Clinic or Psychiatric Hospital?	☐	
☐	v. Any history of Substance Use Treatment either in or out patient?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

Hospitalizations

DATE	NAME OF HOSPITAL	LOCATION	REASON

Surgical History

DATE	TYPE OF SURGERY	HOSPITAL/SURGICAL CTR	SURGEON

NO		YES	COMMENT(S)
5.			
☐ a.	Has there been any change in your weight in the past year? 1. Lost ☐ How much? _____ 2. Gain ☐ How much? _____	☐	
☐ b.	Have you ever had excessive anxiety/nervousness, depression or worrying?	☐	
☐ c.	Have you noticed a change in size or color of any wart or mole, or the appearance of a new one?	☐	
☐ d.	Any itching, skin rash or boils?	☐	
☐ e.	Do you use tobacco?	☐	
☐	1. Chew	☐	
☐	2. Pipe	☐	
☐	3. Cigars	☐	
☐	4. Cigarettes	☐	
	5. How many cigars, cigarettes, or pipes do you smoke in 24 hours? _____		
6.	**HEAD AND NECK**		
☐ a.	Do you have dizzy spells?	☐	
☐ b.	Do you have frequent headaches?	☐	
	How often? _____ What medicine helps your headaches? _____		
☐ c.	Do you have any lumps or swelling in your neck, armpits, groin or other areas?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

NO		YES	COMMENT(S)
7.	**EYES**		
☐ a.	Do you wear glasses or contact lens?	☐	
.	For how long? _____		
☐ b.	Do you see double?	☐	
☐ c.	Do you ever see colored halos around lights?	☐	
☐ d.	When your eyes were last examined?	☐	
☐ e.	Do you have trouble seeing objects at a distance or near objects such as a newspaper?	☐	
☐ f.	Do you have vision in both eyes?	☐	
8.	**EARS**		
☐ a.	Do you have difficulty hearing?	☐	
☐ b.	Have you had any earaches lately?	☐	
☐ c.	Do you have repeated buzzing or ringing in your ears?	☐	
☐ d	Do you have a hearing aid(s)?	☐	
9.	**MOUTH, NOSE AND THROAT**		
☐ a.	Do you have any trouble with your teeth or gums?	☐	
☐ b.	When did you last see a dentist?	☐	
☐ c.	Have you ever had sinus problems?	☐	
☐ d.	Does your nose ever bleed for no reason at all?	☐	
☐ e.	Is your voice more hoarse now than in the past?	☐	
10.	**RESPIRATORY**		
☐ a.	Do you have a chronic cough?	☐	
☐ b.	Do you cough up any material?	☐	
☐ c.	Ever have trouble getting your breath after climbing one flight of stairs or walking one city block?	☐	
☐ d.	Do you have frequent colds or influenza attacks?	☐	
☐ e	Do you have sleep apnea?	☐	
☐ f.	Do you use a CPAP/BiPAP Machine?	☐	
11.	**CARDIOVASCULAR**		
☐ a.	Ever get pains or tightness in your chest?	☐	
☐ b.	Ever been bothered by a racing heart?	☐	
☐ c.	Do you have shortness of breath while doing your usual work?	☐	
☐ d.	Need more pillows at night to breathe?	☐	
☐ e.	Do you have swollen feet and ankles?	☐	
☐ f.	Do you use a lot of salt on your food?	☐	
☐ g.	Do you have a pacemaker?	☐	
☐ h.	Do you have a defibrillator?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

NO		YES	COMMENT(S)
12.	**DIGESTIVE**		
☐ a.	Do you suffer discomfort in the pit of your stomach?	☐	
☐	1. Nausea	☐	
☐	2. Vomiting	☐	
☐	3. Indigestion	☐	
☐	4. Heartburn	☐	
☐ b.	Is it painful or difficult for you to swallow liquids or solid foods?	☐	
☐ c.	Do you have trouble with bowel movements?	☐	
☐	1. Hemorrhoids	☐	
☐	2. Bleeding	☐	
☐	3. Constipation	☐	
☐	4. Diarrhea	☐	
☐	5. Bloody or Black Stools	☐	
☐	6. Rectal Pain	☐	
13.	**URINARY**		
☐ a.	Frequently get up at night to urinate?	☐	
☐ b.	Ever had burning or pains when urinating?	☐	
14.	**MUSCULOSKELETAL**		
☐ a.	Have stiff or painful muscles or joints?	☐	
☐ b.	Are your joints ever swollen?	☐	
☐ c.	Have you ever had any broken bones?	☐	
☐ d.	Have difficulty bending or moving?	☐	
15.	***FOR MALES ONLY***		
☐ a.	Is your urine stream very weak and slow?	☐	
☐ b.	Has a doctor ever told you that you have prostate trouble?	☐	
☐ c.	Ever had discharge from your penis?	☐	
☐ d.	Do you have any pain, swelling, sores or lumps on your testicles or penis?	☐	
16.	***FOR FEMALES ONLY***		
☐ a.	Have you had a hysterectomy?	☐	
☐ b.	Are your menstrual periods regular? Date of last menstrual period: _____	☐	
☐ c.	Ever have pain with your periods?	☐	
☐ d.	Do you have excessive bleeding during your period?	☐	
☐	1. Between periods?	☐	
☐	2. After sexual relations?	☐	
☐	3. After going through the “change of life”?	☐	
☐ e.	What type of birth control method are you using? (Check appropriate)	☐	
☐	1. None	☐	
☐	2. Birth control pills	☐	
☐	3. IUD (Loop)	☐	
☐	4. Foam	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

NO		YES	COMMENT(S)
☐	5. Diaphragm	☐	
☐	6. Condoms	☐	
☐	7. Tubes Tied	☐	
☐	8. Other: _____		
☐ f.	Do you have a discharge now?	☐	
☐ g.	When was your last Pap Smear?	☐	
	_____		
☐ h.	Ever had an abnormal Pap smear?	☐	
☐ i.	How many times have you been pregnant? _____		
☐	1. Full term _____	☐	
☐	2. Premature _____	☐	
☐	3. Miscarriages _____	☐	
☐	4. Abortions _____	☐	
☐	5. Are you pregnant now?	☐	
☐ j.	Do you examine you breasts regularly?	☐	
☐ k.	Ever found any lumps in your breasts?	☐	
☐ l.	Ever had discharge from your nipples?	☐	
☐ m.	Have you had the Measles, Mumps, and Rubella Vaccine (MMR) as an adult?	☐	
17.	***SKIN***		
☐	Tattoos, piercings, lesions, ulcers, tags, moles, insect bites, rashes, or infections?	☐	

Do you have an Advanced Directive, Do Not Resuscitate Order or Living Will? (Circle all that apply)

If **NO**, was an Advance Care Plan form and counseling provided? (PH-4194) ☐ Yes ☐ No

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

I certify that the foregoing information supplied by me is true and complete to the best of my knowledge.

Date	Signature of Patient	Signature of Person Reviewing History

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

INSTITUTION: _____

NAME _____ **TOMIS#:** _____ **DATE OF EXAM** _____

Blood Pressure (sitting): _____ Height: _____ Weight: _____ Temp: _____ Pulse: _____ Resp: _____

CLINICAL EVALUATION			
NORMAL	(Check each item in appropriate column; enter ***"NE"*** if not evaluated.)	**ABNORMAL**	**NOTES**: Describe every abnormality in detail. Enter pertinent item number before each comment. Use progress notes for additional information.
	1. GENERAL: Appearance, Nails, Skin, and Identifying Marks, Tattoos, etc.		
	2. EYES: General, Ophthalmoscopic; Pupils, and Ocular Motility		
	3. HEAD AND NECK		
	4. EARS: External and Otoscopic		
	5. MOUTH AND THROAT		
	6. NOSE AND SINUSES		
	7. LUNG AND CHEST		
	8. CARDIOVASCULAR: Heart and Vascular System		
	9. ABDOMEN: Inspection, Auscultation and Palpation		
	10. RECTUM AND ANUS: Hemorrhoids, Fistulae and Prostate, if indicated.		
	11. G.U. SYSTEM a. Genitalia b. Hernia		
	12. PELVIC		
	13. ENDOCRINE		
	14. MUSCULOSKELETAL SYSTEM: Spine, Upper Extremities and Lower Extremities		
	15. NEUROLOGICAL: Cranial Nerves, Motor Functions, Cerebella and DTR's		
	16. PSYCHIATRIC		

Summary of Defects/Conditions and Diagnosis continued on back. ☐

Is there an Advance Directive, DNR order or Living Will on file? ☐ Yes ☐ No

If not, was inmate counseled regarding Advance Directives? ☐ Yes ☐ No Advance Care Plan (PH-4194) Provided? ☐ Yes ☐ No

HEALTH CLASSIFICATION BASED ON PHYSICAL EXAMINATION:

_____ _____

PRINTED NAME OF MEDICAL PROVIDER SIGNATURE OF MEDICAL PROVIDER

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

Summary of Defects/Conditions and Diagnosis

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
CONSENT FOR TREATMENT

_____
INSTITUTION

Name: _____ Number: _____ Date of Birth: _____
Last First Middle

I hereby authorize _____ and assistants to perform the following operation, procedure,
(Practitioner)
treatment, or psychiatric intervention.

_____
Use Laymans Terms

_____

The nature and extent of the intended operation, procedure, treatment, or psychiatric intervention has been explained to me in detail. I have been advised by _____ of the following
(Practitioner)
alternatives, if any, probable consequences if I remain untreated, risks and possible complications of proposed treatment as indicated:

_____
(Use Layman's Terms)

_____

_____

I acknowledge that no guarantee or assurance has been made as to the result that may be obtained.

If any unforeseen condition arises in the course of the operation calling for the judgment of the practitioner for procedures in addition to or different from those now contemplated, I further request and authorize the practitioner to do whatever is deemed necessary.

I consent to the administration of anesthesia to be applied under the direction and supervision of _____.
(Practitioner)

I have read and fully understand the terms of this consent and acknowledge that the explanations referred to were made and that all blanks have been filled.

Date: _____ Time: _____ _____
(Signature of Patient)

Witness: _____ _____ _____
(Signature of Practitioner and Professional Title) Date

If the patient is a minor or incompetent to consent:

_____ Date: _____ Time: _____ a.m p.m.
(Signature of parent or person authorized to consent for patient)

Witness: _____ Witness: _____

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

MAJOR PROBLEM LIST

_____
INSTITUTION

Name: _____ TOMIS#: _____
Last First Middle

Date of Birth: _____ Gender: ☐ M ☐ F Race: _____

Allergies: _____

PROBLEM NUMBER*	DATE IDENTIFIED/ RECORDED	MAJOR CLINICAL CONDITIONS/PROBLEMS	RESOLVED *(Please check "ô" if resolved)*	RESOLVE DATE

Conservator Name: _____

Primary Phone: _____ Secondary Phone: _____

* Major medical problems considered medical or surgical in nature are identified by Roman numerals, i.e., **I** – Diabetes, **II** – Laminectomy.
* Psychiatric, or serious psychological problems, are identified by capital letters, i.e., **A** – Schizophrenia, **B** – Self-Mutilative Behavior.

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH RECORDS MOVEMENT DOCUMENT

DESTINATION: _____

THIS PACKET CONTAINS HEALTH RECORDS ON THE FOLLOWING INMATE(S):

	Inmate Name	Number	CHECK ALL THAT APPLY: Health Record	Dental Record	Medication	* Purpose (Indicate **A, B, C** or **D**)
1.			☐	☐	☐	
2.			☐	☐	☐	
3.			☐	☐	☐	
4.			☐	☐	☐	
5.			☐	☐	☐	
6.			☐	☐	☐	
7.			☐	☐	☐	
8.			☐	☐	☐	
9.			☐	☐	☐	
10.			☐	☐	☐	

*** PURPOSE OF RECORDS MOVEMENT:**

A. Permanent Transfer **B.** Temporary Transfer for Clinical Services **C.** Record to Archives **D.** Other (*See Comments*)

Comments: _____

Sending Institution: _____ Date: _____

Prepared / Checked by: _____ Date: _____

Transported by: _____ Date: _____

Received by: _____ Date: _____

**** THIS DOCUMENT SHALL NOT CONTAIN PROTECTED HEALTH INFORMATION ****

CR-2176 (Rev. 11-09) RDA

White-Exterior Packet **Canary**-Exterior Packet **Pink**-Inside Records Packet **Goldenrod**-Sending Institution Medical Records Office

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
TRANSFER / DISCHARGE HEALTH SUMMARY

Name of Inmate: _____ TDOC # _____ DOB: _____
Last First Initial

Current Institution: _____ Transfer Date: _____

Receiving Institution (*if applicable*): _____

Reason for Transfer/Discharge: _____

Requires Chronic Illness Monitoring: ☐ yes ☐ no Last TB Screening/PPD: _____

Requires Mental Health/Psychiatric Monitoring: ☐ yes ☐ no Last Periodic Health Appraisal: _____

HEALTH HISTORY

Check (v) all conditions present

☐ HIV/AIDS	☐ Depression	☐ Hernia	☐ Prosthesis *(specify)* _____
☐ Alcoholism	☐ Diabetes	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Anemia	☐ Emphysema	☐ Hypertension	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Suicide Attempt
☐ Cancer *(specify)* _____	☐ Heart Disease	☐ Liver Disease	☐ Tuberculosis
☐ Chemical Dependency	☐ Hepatitis C	☐ Multiple Sclerosis	☐ Venereal Disease
☐ COPD			☐ Other *(specify)* _____

--- CURRENT PHYSICIAN/DENTIST MEDICATION ORDERS ---

	Name of Drug	Strength/ Route	Frequency	Last Dose Date/Time	Medication Sent (v)	Amounts	KOP
1.					Y ☐ N ☐		☐ Y ☐ N
2.					Y ☐ N ☐		☐ Y ☐ N
3.					Y ☐ N ☐		☐ Y ☐ N
4.					Y ☐ N ☐		☐ Y ☐ N
5.					Y ☐ N ☐		☐ Y ☐ N
6.					Y ☐ N ☐		☐ Y ☐ N
7.					Y ☐ N ☐		☐ Y ☐ N
8.					Y ☐ N ☐		☐ Y ☐ N

Brief Summary of Current Health Problems:

SPECIAL INSTRUCTIONS (e.g., Allergies, Diet, Impairments, Medical Appointments, etc.) :

Referred to Community Resources: ☐ **Yes** ☐ **No** **Specify Below:**

Report Prepared By: _____ Date: _____
Signature/Professional Title

Receiving Institution Review: _____ Date: _____
Signature/Professional Title

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.24	Page 1 of 4
	Effective Date: September 1, 2015	
	Distribution: A	
	Supersedes: 113.24 (7/15/11)	
Approved by: Derrick D. Schofield		
Subject: MEDICAL CLEARANCE OF INMATES ASSIGNED TO JOBS IN FOOD SERVICES		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To prevent the transmission of communicable diseases by inmates who are assigned to work in food service.

III. APPLICATION: Wardens, Associate Wardens, health administrators, food service managers, health services staff, job coordinators, inmates, medical contractors, and privately managed institutions.

IV. DEFINITIONS: Food Handler's Permit: An authorization that verifies medical clearance of inmate workers assigned to food service.

V. POLICY: No inmate (while infected with active tuberculosis, open wounds, or other infectious diseases that can be transmitted by foods) shall work in any capacity in which there is a likelihood of transmitting his/her disease to other persons via food, kitchen utensils, or food contact surfaces.

VI. PROCEDURES:

A. Health Record Review:

1. Prior to job assignment and annually thereafter, a health record review and assessment shall be completed by a licensed health professional for all inmates assigned to jobs in food service areas.

2. The health record review and assessment shall be conducted with particular emphasis on the detection of:

a. Acute or chronic infectious skin diseases

b. Gastrointestinal infections

c. Contagious respiratory conditions

d. Current tuberculosis screen in accordance with Policy #113.44

B. Documentation:

1. Upon completion of the health record review and assessment, the licensed health professional shall include a statement in the health record indicating whether or not the inmate is suitable for a job assignment in food the services area. If the inmate is deemed unsuitable, the licensed health professional shall include the reason(s) in his/her statement, such as:

a. Active Hepatitis A

b. Open and/or draining lesions/sores/wounds

c. Clinical jaundice

d. Chronic and/or actively infectious diseases that could be transmitted by food or utensils

e. Active tuberculosis

f. Active syphilis

g. Any other gastrointestinal infections or respiratory conditions transmissible via food products.

2. If the inmate is suitable for assignment in food service, a Food Handler's Permit, CR-2239, shall be prepared by the licensed health professional and submitted to the food service manager with a copy to the inmate jobs coordinator. This permit shall be valid for one year unless the inmate has an intervening health condition that requires re-assessment of the inmate and subsequent revocation of the food handler's permit.

3. Food Handler Permits will be issued during initial classification and a comment shall be added to Option 3 of TOMIS LHSE Health Assessment indicating the date the permit was issued.

C. Inmates who are denied food service assignment for medical reasons may be evaluated again six months after the date of their last review.

D. Revocation of Food Handler's Permits:

1. In the event the inmate has an intervening health condition which requires revocation of his/her food handler's permit, the licensed health professional shall immediately notify both the food service manager and inmate jobs coordinator that the permit has been revoked and that the inmate shall be removed from his/her food service assignment.

2. Any inmate food service worker whose permit has been revoked for medical reasons shall not resume food handling until re-instatement of the Food Handler's Permit.

E. Food Service Manager Responsibilities: In accordance with Policy #116.11, the food service manager or a designated staff member shall be responsible for the following:

1. The daily monitoring of inmates assigned to food service for cleanliness, freedom from apparent communicable disease and infection (open sores, skin infections, and other illnesses transmissible by food or utensils). He/she shall also enforce health-related regulations.

2. Referral of the inmate to health services for re-evaluation if there is a reasonable cause for the food service manager or designee to suspect the possibility of disease transmission from any assigned inmate worker.

3. Coordinating with health services to schedule food service workers for their annual health review, assessment, and renewal of the food handler's permit

VII. ACA STANDARDS: 4-4322.

VIII. EXPIRATION DATE: September 1, 2018.

TENNESSEE DEPARTMENT OF CORRECTION

FOOD HANDLER'S PERMIT

_____

INSTITUTION

NAME: _____ NUMBER: _____ DOB: _____

TYPE OF HEALTH REVIEW: Designate with a check (√) mark.

INITIAL _____ ANNUAL _____ INTERVAL _____

This certifies that the aforementioned inmate has been evaluated and I I find no infectious conditions that would prevent his/her handling of food products.

NOTE: This permit is valid for one (1) year unless inmate has an intervening health condition requiring removal from food service assignment

AUTHORIZED BY: _____ DATE: _____

Health Care Provider Signature/Professional Title

CR-2239 (Rev. 04-11) White-Food Service Manager Canary-Health Services File Pink-Inmate Jobs Coordinator RDA 1100

TENNESSEE DEPARTMENT OF CORRECTION

FOOD HANDLER'S PERMIT

_____

INSTITUTION

NAME: _____ NUMBER: _____ DOB: _____

TYPE OF HEALTH REVIEW: Designate with a check (√) mark.

INITIAL _____ ANNUAL _____ INTERVAL _____

This certifies that the aforementioned inmate has been evaluated and I I find no infectious conditions that would prevent his/her handling of food products.

NOTE: This permit is valid for one (1) year unless inmate has an intervening health condition requiring removal from food service assignment

AUTHORIZED BY: _____ DATE: _____

Health Care Provider Signature/Professional Title

CR-2239 (Rev. 04-11) White-Food Service Manager Canary-Health Services File Pink-Inmate Jobs Coordinator RDA 1100

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.31	Page 1 of 6
	Effective Date: February 15, 2014	
	Distribution: A	
	Supersedes: 113.31 (6/1/10)	
Approved by: Derrick D. Schofield		
Subject: SICK CALL/ASSESSMENT OF HEALTH COMPLAINTS		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To specify sick call times and procedures to ensure that all inmates have the opportunity to report a medical, dental, or mental health complaint and to receive diagnosis and/or treatment for their condition.

III. APPLICATION: Wardens, health administrators, health care staff, inmates, the medical contractor, and privately managed facilities.

IV. DEFINITIONS:

A. Health Assessment: The process whereby the health status of an inmate is evaluated, including questioning the inmate regarding symptoms.

B. Infirmary (inpatient unit): A specific area within an institution, separate from other housing areas, where offenders are admitted for health observation and care under the supervision and direction of health care personnel.

B. Qualified Health Care Professional: Includes physicians, mid-level providers, nurses, dentists, mental health professionals, and others who by virtue of their education, credentials, and experience are permitted by Tennessee law to evaluate and care for inmates.

C. Sick Call: An organized method by which inmates are evaluated and treated for non-emergency health care requests by qualified health care professionals.

V. POLICY: All inmates shall be provided access to health care services through scheduled sick call and treatment as required.

VI. PROCEDURES:

A. Scheduled Access to Sick Call:

1. The Warden, in conjunction with the health administrator, shall establish regular sick call hours. Segregation units shall be visited daily by qualified health care personnel. Sick call shall be conducted a minimum of five days per week, excluding holidays.

2. As a part of institutional orientation, all inmates shall be informed (both orally and in writing) on how to gain access to health care services. Information regarding access to health care shall also be included in the *Inmate Rulebook* as cited in Policy #502.04 and shall be posted in all housing units. Information regarding co-payment for health services shall be included as well. (See Policy #113.15)

B. Non-scheduled Access to Care:

1. Institutional health services staff shall develop procedures for the timely assessment of non-scheduled inmate physical and mental health complaints by the qualified health care professional(s).

2. The institutional procedures for the unscheduled and emergency assessment of physical and mental health complaints shall include details of communication methods to be used by inmates and institutional employees. This procedure shall also address varying procedural differences on shifts, weekends, and holidays.

3. Dental complaints from inmates shall be presented at the regularly scheduled sick call, in accordance with Policy #113.60. A qualified health care professional shall be assigned to refer dental complaints to the facility dentist, who shall assess and treat the inmate according to established dental clinical priorities.

C. Sick Call Procedures:

1. Each facility shall develop specific procedures relative to sick call, which include the following information:

   a. Time and location

   b. The population served

   c. Instructions for using the Sick Call Roster, CR-1893

   d. Special call or appointment system utilized for specialty and scheduled follow-up care and also for other examinations or treatment

   e. Qualified health care professional(s) conducting the sick call

   f. Sick call and treatment of inmate(s) in segregation status

2. In an Infirmary (Inpatient Unit) setting, each facility shall develop specific procedures relative to initiating requests for additional health services through the daily rounds of the Qualified Health Care Professional.

D. Treatment:

1. Sick call shall be conducted by a licensed practical nurse (LPN), registered nurse (R.N.), or mid-level provider, as designated by the facility health administrator or nursing director/supervisor.

2. According to institutional staffing, a physician or mid-level provider shall be available to see immediate referrals from the LPN or RN. If there is not a mid-level provider available, the LPN or R.N. shall refer directly to the physician those cases requiring further evaluation.

3. The responsibilities/duties of the health care provider conducting sick call shall include the following:

a. Record on the Problem Oriented-Progress Record, CR-1884, the inmate's name and number; date, time, and place of visit/encounter (if other than clinic); and specific health problems, related health history, and other pertinent health information.

b. Examine inmates to the extent indicated, providing necessary privacy.

c. Provide the appropriate treatment in accordance with protocol, or refer/schedule the inmate for an appointment with the appropriate health care provider.

d. Document on the CR-1884 all assessments, referrals, and treatment provided using SOAP format.

e. Complete Limited Activity Notice, CR-2893, for inmates requiring temporary absence (i.e., 30 days or less) from work or other physical restrictions, and complete TOMIS conversation LHST. If the inmate has a condition that exceeds thirty days in duration, the health classification may be re-evaluated.

f. All documented health care encounters shall be signed using full legal signature and title (e.g., M.D., R.N., etc.).

E. Segregated Inmates:

1. Each facility shall have a written procedure that addresses provisions for sick call and treatment to all segregated inmates. This procedure shall include health care personnel announcing their presence during daily visits. Qualified health care personnel shall visit the segregation unit daily and record each visit in the appropriate log.

2. The qualified health care professional responsible for conducting sick call shall record fully in the inmate health record all complaints and dispositions, using the procedure described in Section (D) of this policy.

F. Clinic Encounter Log:

1. An encounter logbook shall be maintained to record all daily sick call assessment encounters, as well as scheduled, non-scheduled, and emergency visits provided by health care professionals.

2. The encounter log record shall include the date, time, and location of the clinic visit; inmate name and number; type of visit, treatment and/or diagnostic service provided, type of referral, and the name and professional title (M.D., PA-C, R.N.) of the qualified health care provider.

3. A separate daily dental encounter log shall also be maintained to categorize and list all dental care services provided. It shall include all the information required in (F)(2) above, with professional title (e.g., D.D.S., DMD, RDH, CDA, etc.).

4. DSNF and TPFW shall maintain outpatient encounter logs for all ambulatory encounters including specialty clinic, sick call for the ambulatory population, emergency services, radiology, laboratory, dialysis, and physical/occupational therapy services. The encounter log shall contain all the information described in (F)(2) above.

5. Information contained on encounter logs shall be utilized for the health service monthly report and quality improvement purposes.

G. Inmates shall be charged a co-payment fee for health services as defined in Policy #113.15.

VII. ACA STANDARDS: 4-4344, 4-4346, 4-4258, and 4-4400.

VIII. EXPIRATION DATE: February 15, 2017.

TENNESSEE DEPARTMENT OF CORRECTION

DAILY SICK CALL ROSTER

_____

INSTITUTION

DATE: _____ UNIT: _____

INMATE NAME	TDOC #	WORK LOCATION

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ INMATE NUMBER: _____

DATE	TIME/PLACE	PROB NO.	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION

CLINICAL RESTRICTIONS AND LIMITED NOTICE

INMATE NAME: _____ TDOC NUMBER: _____
LAST FIRST MIDDLE

Please be advised that the above named inmate is: (Specify)

_____ Confined to his/her living area except for: _____

_____ Restricted from physical activity including participation in sports

_____ Restricted to complete bed rest except for: _____

_____ Allowed showering separately

_____ Unable to work a regularly scheduled assignment

_____ On Clinical Alert (Do NOT move inmate without contacting the Health Service Administrator)

_____ Other: _____

Length of restriction/limited activity: _____

Health problem/diagnosis: _____

Special instructions: _____

_____

_____

_____

Authorized by: _____ Date: _____

White—Inmate's Health Record Canary—Inmate Pink—Correctional Officer Goldenrod—Work Supervisor

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.31	Page 1 of 1
	Effective Date: June 1, 2015	
	Distribution: A	
	Supersedes: N/A	
Approved by: Derrick D. Schofield		
Subject: SICK CALL/ASSESSMENT OF HEALTH COMPLAINTS		

POLICY CHANGE NOTICE 15-6

INSTRUCTIONS:

Please change Section VI.(C)(1)(c) to read as follows:

"c. Instructions for using the Sick Call Request, CR-3793, and appropriate submission to the Qualified Healthcare Professionals"

Please change Section VI.(C)(1)(f) to read as follows:

"f. Sick call and treatment of inmate(s) in segregation status as outlined in Section VI.(E) of this policy"

Please change Section VI.(E)(1) to read as follows:

"1. Each facility shall have a written procedure that addresses provisions for sick call and treatment to all segregated inmates. This procedure shall include qualified health care personnel announcing their presence, and ensuring access and receipt of CR-3793 if requested, during daily visit to each segregated inmate. Qualified health care personnel shall visit the segregation unit daily and record each visit in the appropriate log."

Please add the attached page to the current policy and renumber policy pages accordingly.

TENNESSEE DEPARTMENT OF CORRECTION

SICK CALL REQUEST
(SOLICITUD POR SERVICIOS DE SALUD)

FOR MEDICAL / MENTAL HEALTH USE ONLY
DATE RECEIVED: _____
TIME RECEIVED: _____

_____
INSTITUTION (INSTITUCIÓN)

Print Name (Escriba su nombre): _____ Date of request (fecha de solicitud): _____

ID# _____ (fecha de nacimiento): _____ (Unidad de Vivienda) _____
Date of Birth Housing Location

Nature of problem or request (Naturaleza del problema): _____

_____

_____

I request to see (Le pido que vea): Medical (Medico) ☐ Dental ☐ Mental Health ☐

_____
Signature (firma)

PLACE THIS SLIP IN THE MEDICAL REQUEST BOX. ***DO NOT WRITE BELOW THIS LINE.***
PON ESTA SOLICITUD PARA SER TRATADO POR EL PERSONAL DE SALUD POR LAS CONDICIONES DESCRITAS EN LA CAJA MEDICA
(NO ESCRIBA DEBAJO DE ESTA LINEA).

Triaged by: _____ Referred to: (Circle one): Nurse Mid-level Physician MH Dental
Specialty Clinic: _____ Other _____

CR-3793 RDA 1167

TENNESSEE DEPARTMENT OF CORRECTION

SICK CALL REQUEST
(SOLICITUD POR SERVICIOS DE SALUD)

FOR MEDICAL / MENTAL HEALTH USE ONLY
DATE RECEIVED: _____
TIME RECEIVED: _____

_____
INSTITUTION (INSTITUCIÓN)

Print Name (Escriba su nombre): _____ Date of request (fecha de solicitud): _____

ID# _____ (fecha de nacimiento): _____ (Unidad de Vivienda) _____
Date of Birth Housing Location

Nature of problem or request (Naturaleza del problema): _____

_____

_____

I request to see (Le pido que vea): Medical (Medico) ☐ Dental ☐ Mental Health ☐

_____
Signature (firma)

PLACE THIS SLIP IN THE MEDICAL REQUEST BOX. ***DO NOT WRITE BELOW THIS LINE.***
PON ESTA SOLICITUD PARA SER TRATADO POR EL PERSONAL DE SALUD POR LAS CONDICIONES DESCRITAS EN LA CAJA MEDICA
(NO ESCRIBA DEBAJO DE ESTA LINEA).

Triaged by: _____ Referred to: (Circle one): Nurse Mid-level Physician MH Dental
Specialty Clinic: _____ Other _____

CR-3793 RDA 1167

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.32	Page 1 of 8
	Effective Date: August 15, 2014	
	Distribution: A	
	Supersedes: 113.32 (2/1/11)	
Approved by: Derrick D. Schofield		
Subject: LEVELS OF CARE		

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, and TCA 41-21-204.

II. PURPOSE: To ensure that appropriate levels and continuity of health care are available to accommodate inmate health care needs.

III. APPLICATION: Wardens, health administrators, health care staff, and privately managed institutions.

IV. DEFINITIONS:

A. Chronic Care: Health care services that are provided to inmate/patients for a specifically identified illness that is ongoing or recurring.

B. Clinic Care: Care for ambulatory patients with health care complaints that are evaluated and appropriately treated.

C. Convalescent Care: Health care to assist a patient in recovery from an illness or injury.

D. Emergency Care: Immediate medical evaluation and treatment for a medical condition that reasonably appears to a prudent person to represent an immediate threat to life or possible permanent impairment in one or more body functions.

E. First-Aid: Emergency care or treatment given to an ill or injured person before treatment by professional health care personnel.

F. Infirmary Care: Care for an illness or medical condition as diagnosed by an appropriate health care provider that requires medical/nursing observation and/or management in the facility infirmary but does not require admission to DeBerry Special Needs Facility or to an acute care hospital.

G. Self-Care: Care for a condition which can be solely treated by the inmate and may include "over the counter" (OTC) products which may be purchased from the institutional commissary.

V. POLICY: The health administrator, in cooperation with the Warden, shall develop a coordinated health care delivery program that ensures access of the inmate to the appropriate level of care for his/her health needs.

VI. PROCEDURES:

A. Self-care: All inmates shall be encouraged to assume responsibility for their own health through self-care.

1. A self-care program shall include health education. (See Policy #113.40)

2. Each TDOC facility shall have a written procedure indicating how commonly used over-the-counter preparations are made available to inmates. Personal hygiene products (including feminine hygiene items at institutions with female inmates) and approved OTCs may be made available in the institutional commissary upon approval by the Director of Health Services.

3. When health care professionals feel that self-care is appropriate for an inmate, the inmate shall receive the necessary training and equipment. If any self-care requires a level of privacy in order to be performed, the health administrator/designee will notify the Associate Warden of Treatment/unit manager so that appropriate accommodations may be arranged.

B. First-Aid: The institutional emergency care policy/plan shall clearly describe provisions for access to first aid, including staff responsibilities and the location of first aid equipment and supplies. First aid supplies, including those carried on vehicles shall be regularly inspected and replenished as necessary. (See Policy #113.02)

C. Emergency Care: Each Tennessee Department of Correction (TDOC) facility shall have a written plan to ensure the availability of emergency medical, mental health, and dental services on a 24-hour basis. (See Policy #113.30)

D. Clinic Care: Each TDOC facility shall provide regularly scheduled ambulatory care services. (See Policy #113.31) Protocols and procedures shall be developed indicating referral procedures to the appropriate level of care.

E. Infirmary Care:

1. Each TDOC facility with an infirmary shall make suitable arrangements for the provision of 24-hour nursing coverage whenever there is a patient in the infirmary.

2. Procedures which guide institutional infirmary services and which define the scope of services available shall be developed by each applicable institution and shall include but not be limited to the following:

a. All care shall be rendered in compliance with applicable local, state, and federal laws.

b. If infirmary care is not available on-site at the institution where the inmate is housed, procedures shall specify the transfer mechanism for movement to an institution where such care is available in accordance with Policy #113.34.

c. A nursing care procedure manual containing the infirmary scope of care, admission and discharge procedures, technical nursing functions, and treatment procedures shall be located in the clinic of each institution designated to provide infirmary care.

d. All inmates requiring infirmary care shall be within the sight or sound of staff at all times.

3. The institutional or contract physician shall be responsible for the quality of care in their infirmary and shall be available on-call 24-hours per day.

4. Nursing services shall be under the direction of a full-time registered nurse, with health care personnel on duty 24-hours per day whenever an inmate remains in the infirmary.

5. The health record shall be maintained and documentation shall reflect the care rendered during the infirmary stay.

6. The following institutions shall provide on-site infirmary care:

a. Bledsoe County Correctional Complex
b. DeBerry Special Needs Facility
c. Morgan County Correctional Complex
d. Northeast Correctional Complex
e. Northwest Correctional Complex
f. Riverbend Maximum Security Institution
g. South Central Correctional Center
h. Tennessee Prison for Women
i. Turney Center Industrial Complex
j. West Tennessee State Penitentiary
k. Hardeman County Correctional Facility
l. Whiteville Correctional Facility

7. The Medical Director at the DeBerry Special Needs Facility (DSNF) shall have authority to direct the transfer of a patient from another TDOC institution to the DSNF Health Care Center for skilled nursing care. If the inmate is a patient in a local hospital, the concurrence of the treating physician shall be obtained prior to the transfer.

8. DSNF shall designate a sheltered living unit for special needs inmates who are not in need of skilled nursing care but have unique physical restrictions and/or medical conditions which create a need for them to be in special housing.

a. Upon identifying a need for placement in the Sheltered Living Unit, the institutional physician or designee shall submit a written request to the DSNF Medical Director. The request shall include a detailed justification for the placement, including a copy of the inmate's most recent physical examination; the Health Classification Summary, CR-1886; the Major Problem List, CR-1894; treatment plan; and any other pertinent consultations or reports that substantiate the need for Sheltered Living Placement.

b. The DSNF Medical Director shall evaluate the request based on the following criteria:

(1) Aging factor, its effect and relation to disability

(2) Multiple chronic illnesses and/or degeneration

(3) Type(s) and severity of physical disabilities, restrictions, and individual dependency

(4) Type(s), severity, and number of medical restrictions and risk factors

(5) Mental status, capabilities, and restrictions

(6) Level of need for medical observation

(7) Utilization of sick call and on-site health services

(8) Frequency of specialty appointments, hospital, or emergency care

(9) Accessibility of emergency resources in institution and community

c. The DSNF Medical Director or designee shall notify the classification coordinator at DSNF and the appropriate institutional physician or designee of all approvals for placement in, and clearances for discharge from, the Sheltered Living Unit. The classification coordinator shall then make the transfer in accordance with Policy #403.01. The DSNF Medical Director may also direct internal transfers between the Health Care Center and the Sheltered Living Unit when necessary.

d. Placement shall occur upon the availability of space in the designated unit and based on priority of need.

9. TPFW shall be utilized to provide extended patient services to female inmates who require medical or psychological care that is beyond the level of care that can be provided by the Mark Luttrell Correctional Center (MLCC) (See Policy #113.34)

F. Health Criteria for Placement in a Minimum Security Annex

1. The institutional classification coordinator at each time-building institution shall provide a list of all inmates recommended for transfer to its annex to the health administrator. Prior to transferring an inmate to an annex, the health administrator shall ensure that a review of the current health status of the inmate is done to ensure that the individual is compatible with the mission of the annex. This review shall be conducted by the physician, mid-level provider, or a registered nurse and shall consist of an evaluation of the inmate's health record.

2. The following health-related conditions are not considered compatible with placements in a minimum security annex:

   a. Inmates with a frequent or predictable need for close access to emergency care, including those with severe cardiac conditions, uncontrolled seizure disorders, or uncontrolled diabetes

   b. Inmates who require frequent access to specialty physicians, or dental care, or other services not readily available

   c. Inmates in poor health requiring frequent medical attention

   d. Inmates requiring access to 24-hour nursing services

   e. Inmates on extensive/complicated drug therapy requiring frequent monitoring

   f. Inmates on extended controlled drug medication therapy

   g. Inmates with unstable mental health conditions that are not compatible with annex placement

G. Chronic Care: Each TDOC/privately managed institution shall have a written plan to provide for chronic care for those inmates requiring ongoing or recurring care. The Chronic Disease Clinic Treatment Plan, CR-3624, shall be developed for each chronic care patient and shall be maintained consistent with Policy #113.50.

1. Inmates who are chronically ill, inmates with serious communicable diseases, the physically disabled, pregnant offenders, the terminally ill, offenders with serious mental health needs and those that are developmentally disabled, shall have a chronic care treatment plan. The treatment plan shall include:

   a. Current medications
   b. Any special therapies (e.g., physical, speech)
   c. Special orders (e.g., diet, exercise, laboratory and other diagnostic tests)
   d. Frequency of follow-up
   e. Evaluation and outcome criteria
   f. Patient education needs and goals
   g. Other identified pertinent information about the individual patient

2. All inmates with the chronic conditions congestive heart failure, diabetes mellitus, and/or hypertension, shall have chronic care treatment plans as outlined above with assessment intervals by the mid-level provider at least every three months and every six months by the physician to ensure continuity of care. Any deviation from this schedule shall be approved by the TDOC Medical Director.

3. If the level of chronic care exceeds that available through the facility's health care resources, appropriate arrangements and procedures, consistent with Policy #113.04, shall exist to ensure that the care is available by transfer to DSNF (TPFW for females) or another TDOC institution

H. Convalescent Care: Each TDOC/privately managed institution shall have a written plan to ensure that convalescent care for inmates recovering from an illness or injury is available either on-site, by interdepartmental referral, or by community arrangements. Patients requiring convalescent care shall receive care based on an individual treatment plan approved by the appropriate physician, dentist, or mental health practitioner.

I. Nursing Coverage: Each facility with a capacity of 500 or more shall have a supervising registered nurse on site 24 hours per day, seven days per week.

J. Transfers of Inmates: Each institution shall have a written plan to ensure that transfers of inmates who are physically disabled, geriatric, seriously mentally/physically ill, or developmentally disabled are reviewed, prior to transfer, by the responsible clinician (or designee) for appropriate care availability at the receiving institution.

VII. ACA STANDARDS: 4-4144, 4-4350, 4-4351, 4-4352, 4-4359, 4-4399, and 4-4414.

VIII. EXPIRATION DATE: August 15, 2017.

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH CLASSIFICATION SUMMARY

Name: _____ TOMIS#: _____ Date of Birth: _____

Physical Exam Date: _____ Dental Exam Date: _____

Allergies: _____

Health Classification (Code): _____

Code	Description
A	Class A – No Restrictions
B	Class B – Moderate Restrictions
C	Class C – Severe Restrictions

Level of Care (LOC): _____

Based on health record information provided by Mental Health Treatment Team

LOC 1	No Mental Health Services
LOC 2	Outpatient
LOC 3	Supportive Living Services (SLU) Moderate Impairment
LOC 4	Supportive Living Services (SLU) Severe Impairment
LOC 5	None

Clinical Alert: _____ Date: _____ Note: _____

Health Related Restrictions (Codes):_____
(Circle all applicable codes)

Code	Health Conditions
A	Visual Impairment
B	Hearing Impairment
C	Speech Impairment
D	Orthopedic Disease/Disorder ☐ Documented Hx of Back Problems
E	Amputation/Missing Extremity
F	Pregnancy ☐ 1st ☐ 2nd ☐ 3rd (Trimester)
G	Cancer
H	Asthma/Hay Fever
I	Allergies a) Drug _____ b) Other _____
J	Diabetes ☐ BS >300
K	Seizure Disorder
L	Cardiovascular Disease/Disorder
M	Hypertension
N	Pulmonary Disease/Disorder
P	Neurological Disease/Disorder ☐ Dementia
Q	Arthritis
R	Obesity (BMI >40)
S	Aging (>60)
T	Dermatological Disease/Disorder
U	Prosthetic Device Associated with Disability
V	(Specify)
W	Permanently confined to a Wheelchair/Mobility
X	Sleep Apnea
Y	G. U. Disease
Z	Surgery within last 6 months (abdominal, chest, back, or upper extremity)
AA	Other_____
BB	Acute Injury/Serious Medical Condition: Specify

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH CLASSIFICATION SUMMARY

Name: _____ TOMIS#: _____ Date of Birth: _____

Specific Restrictions (Codes): _____
(Circle all applicable codes)

Specific Accommodations (Codes): _____
(Circle all applicable codes)

Code	Restrictions
A	Complete bed rest or limited activity(C)
B	Sedentary work only-lifting 10 lbs. maximum, occasional walking or standing (C)
C	No heavy lifting-20lbs. maximum, able to frequently lift or carry objects up to 10 lbs. (B)
D	Light work only-lifting 50 lbs. maximum, able to frequently lift or carry objects weighing up to 20 lbs.(B)
E	Medium work only-lifting 100 lbs. maximum, able to frequently lift or carry objects weighing up to 50 lbs.(B)
F	Limited strenuous activity for extended periods of time:>1hr (B); 1hr (C); <1hr (C) Note:
G	Continuous standing or walking for extended periods of time:>1hr (B); 1hr (C); <1hr (C) Note:
H	Repetitive stooping or bending (B)
I	Acute need to be housed on first floor/bottom bunk(B)
J	Climbing and balancing (uneven ground) (B)
K	Exposure to loud noises or work detail with prolonged exposure (B)
L	Avoid areas or work details with exposure to skin irritants (B)
M	Participation in weight lifting or strenuous athletics(B)
N	Activity involving potentially dangerous machinery or equipment
O	Operation of motor vehicles (B)
P	Activity involving food preparation/handling (B)
Q	Prolonged exposure to sun or high temperatures (B)
R	Outside work detail during Spring or Summer (B)
S	Exposure to chemicals producing fumes or equipment producing dust (B)

Code	Accommodations
A	Prosthetic Limbs
B	Altered Accommodation (furniture, cell, etc.)
C	Air way assists (Oxygen, CPAP, BiPAP, etc.)
D	Sleeping Accommodation (pillow, blanket, mattress, etc.)
E	Ostomy Supplies
F	Catheter Supplies
G	Assist Devices (cane, crutches, walker, braces, wheel chair)
H	Inmate helper
I	Minimal Assistance for transporting in a van or bus
J	Wheel chair, bus or van required for transport
K	Non-emergency ambulance required for transport
L	Housed on first floor
M	Bottom bunk in housing assignment
N	Special footwear required

Notes:

_____

_____

_____

_____

_____ _____
Medical Practitioner Signature Date

REVIEWED

_____ _____
Medical Practitioner Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

CHRONIC DISEASE CLINIC
TREATMENT PLAN

Inmate Name _____

TDOC Number _____ Institution _____

LIST CHRONIC DISEASES

1) _____ 3) _____ 5) _____
2) _____ 4) _____ 6) _____

Either list or refer to pharmacy profile for current medications:

_____

***SUBJECTIVE*:**

Asthma: # attacks in last month? _____
short acting beta agonist canisters in last month? _____
times awakening with asthma symptoms per week? _____
CV/hypertension (Y/N): Chest pain? _____ SOB? _____ Palpitations? _____ Ankle edema? _____
HIV/HCV (Y/N): Nausea/vomiting? _____ Abdominal pain/swelling? _____ Diarrhea? _____ Rashes/lesions? _____

Seizure disorder: # seizures since last visit? _____
Diabetes mellitus: # hypoglycemic reactions since last visit? _____
Weight loss/gain ↑↓ _____ lbs.

For all diseases, since last visit, describe new symptoms:

_____

***OBJECTIVE*:**

Patient adherence (Y/N): with medications? _____ with diet? _____ with exercise? _____
Vital signs: Temp _____ BP _____ Pulse _____ Resp _____ Wt _____ PEFR _____ INR _____
Labs: Hgb A1C _____ HIV VL _____ CD4 _____ Total Chol _____ LDL _____ HDL _____ Trig _____
Range of fingerstick glucose/BP monitoring: _____

Physical Evaluation (PE): _____

HEENT/neck:	Extremities:
Heart:	Neurological:
Lungs:	GU/rectal:
Abdomen:	Other:

Additional Comments: _____

ASSESSMENT:	**Degree of Control***				**Clinical Status***			
	G	**F**	**P**	**NA**	**I**	**S**	**W**	**NA**
1 _____	☐	☐	☐	☐	☐	☐	☐	☐
2 _____	☐	☐	☐	☐	☐	☐	☐	☐
3 _____	☐	☐	☐	☐	☐	☐	☐	☐
4 _____	☐	☐	☐	☐	☐	☐	☐	☐

***Degree of Control**: *G-Good* *F-Fair* *P-Poor* *NA-Not Applicable*
***Clinical Status**: *I-Improved* *S-Same* *W-Worse* *NA-Not Applicable*

PLAN:

Medication changes:

Diagnostics: _____

Labs: _____

Monitoring: BP _____ x day/week/month Glucose _____ x day/week/month Peak flow _____ Other: _____

Education provided: ☐ Nutrition ☐ Exercise ☐ Smoking ☐ Test results ☐ Medication management ☐ Other: _____

Referral (list type): _____ Specialist: _____

days to next visit? ☐ 90 ☐ 60 ☐ 30 ☐ Other: _____ Discharged from Chronic Clinic (specify clinic): _____

Additional Comments: _____

_____ _____
Mid-Level / Physician Signature Date

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

MAJOR PROBLEM LIST

_____
INSTITUTION

Name: _____ TOMIS#: _____
Last First Middle

Date of Birth: _____ Gender: ☐ M ☐ F Race: _____

Allergies: _____

PROBLEM NUMBER*	DATE IDENTIFIED/ RECORDED	MAJOR CLINICAL CONDITIONS/PROBLEMS	RESOLVED *(Please check "ô" if resolved)*	RESOLVE DATE

Conservator Name: _____

Primary Phone: _____ Secondary Phone: _____

* Major medical problems considered medical or surgical in nature are identified by Roman numerals, i.e., **I** – Diabetes, **II** – Laminectomy.
* Psychiatric, or serious psychological problems, are identified by capital letters, i.e., **A** – Schizophrenia, **B** – Self-Mutilative Behavior.

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.35	Page 1 of 6
	Effective Date: September 30, 2016	
	Distribution: A	
	Supersedes: 113.35 (4/1/16)	
Approved by: Tony Parker		
Subject: THERAPEUTIC DIETS		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To provide therapeutic diets for inmates whose health condition requires a diet other than that those prepared for the general population.

III. APPLICATION: Wardens, health care staff, unit managers, correctional officers, TDOC food service personnel, inmates, medical contractors, food service contractors, and privately managed facilities.

IV. DEFINITIONS:

A. Authorized Health Care Professional: For purposes of this policy, a physician, dentist, mid-level provider, or registered dietitian.

B. Therapeutic Diet: Special meal or food combination lists developed by the contract Dietician and prescribed by an authorized health care professional as part of the inmate's medical or dental treatment.

V. POLICY: Therapeutic diets shall be prescribed by an authorized health care professional when medically/dentally indicated, and shall be provided by the food service staff.

VI. PROCEDURES:

A. Authorization and Indications:

1. The institutional physician/designee shall develop an institutional plan in cooperation with the contract Food Service Director, with the intent to minimize unnecessary therapeutic diet orders in the institution by educating the inmate in proper self-care and nutrition.

2. Therapeutic diets shall not be ordered to accommodate an inmate's food preference or special requests.

3. Inmates requesting therapeutic diets to comply with religious beliefs shall be referred to the chaplain.

B. Documentation: In all cases, documentation of the condition requiring a therapeutic diet shall be recorded in the health record. When a therapeutic diet order is requested, a Therapeutic Diet Order, CR-1798, shall be initiated and signed by the physician, dentist, or mid-level provide with copies distributed as indicated on the form. Therapeutic diet orders shall be documented on the Physician's Orders, CR-1892.

C. Requests/Orders:

1. Therapeutic diets shall be ordered by an authorized health care professional only when a medical or dental condition precludes the inmate from eating the food prepared for the general population.

2. The therapeutic diet shall begin with the next scheduled meal, unless otherwise indicated. The Therapeutic Diet Order, CR-1798, must be delivered to the contract Food Service Director or designee at least two hours prior to the serving time in order to be effective for that meal.

3. Orders are valid for a maximum of three months, or until they expire, are discontinued, or changed by the authorized health care professional, or refused in writing by the inmate, in accordance with Section VI.(D)(5) of this policy.

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4. Diets other than those listed on the Therapeutic Diet Order, CR-1798, may be utilized as needed on a restricted basis and may be requested as titled in the Contractor's medical diet manual or by contacting the contract Dietitian.

5. If a required diet is not included on form CR-1798, or if other modifications are needed, the prescriber must contact the contract Food Service Director or the contract Dietitian.

6. If at any time the prescriber determines that there is no clinical reason to continue the therapeutic diet, he/she shall document the discontinuation on the Physician's Orders, CR-1892, and notify the Contract Food Service Director.

D. Refusal and Non-Compliance:

1. When a therapeutic diet request is refused or canceled, the food service department shall be notified per institutional procedure.

2. Health services staff shall document diet tray refusals in their respective infirmary wards.

3. Diet tray refusals in living units shall be documented as indicated in Policy #116.01.

4. When the health care staff encounters inmates who are non-compliant with their therapeutic diets they shall counsel the inmate regarding the importance and necessity of compliance with the diet. This counseling shall be documented in the health record on the Problem Oriented Progress Record, CR-1884, and the Teaching Counseling Plan, CR-2742. In accordance with Policy #113.51, inmates may refuse medical diets by signing a Refusal of Medical Services, CR-1984. The signed Refusal of Medical Services, CR-1984, will remain in effect until the Therapeutic Diet Order expires or until the next follow-up with the medical provider. The inmate will not be charged as long as the CR-1984 is in effect.

5. If an inmate signs a CR-1984 then chooses to resume their therapeutic diet more than twice in a 30 days period then the therapeutic diet trays will continue per the original Therapeutic Diet Order or until the next follow-up with the medical providers.

6. Inmates with an order for a therapeutic diet tray may refuse the tray in favor of a regular diet tray. In this instance, he/she shall be charged $5.00 for the unused therapeutic diet tray and must see the prescribing provider before the therapeutic diet is discontinued.

7. If an inmate refuses or fails to pick-up his/her therapeutic meal for nine consecutive meals, the individual responsible for documenting the meal service shall notify the health service staff by using a reproduced copy of the Therapeutic Diet Request, CR-1798. The inmate will have effectively demonstrated non-compliance with the therapeutic diet although a Refusal of Medical Services, CR-1984, has not been signed. The provider shall follow the same documentation procedure indicated in Policy #113.51 and provide a copy to the food service department. The food service manager shall be notified by phone or e-mail in addition to written documentation.

8. Inmates that receive total parenteral nutrition (TPN) or a tube feeding as a sole source of nutrition and have an order for NPO may refuse the TPN or tube feeding by signing a Refusal of Medical Services, CR-1984, but will not receive a meal tray and a charge will be assessed. The healthcare staff will counsel the inmate regarding the importance and necessity of compliance with TPN and/or tube feeding."

E. Dietary Education: When initiating a new diet, the prescriber shall have the responsibility of educating each inmate on the clinical indication for his/her diet, and the duration, special instructions, and recommended food restrictions (including commissary items) of his/her diet. Education should include written materials with emphasis on foods to avoid, foods that are of benefit, and weight management, when appropriate. The educational intervention shall be documented in the inmate health record. The inmate shall sign the Therapeutic Diet Order, CR-1798, indicating that the therapeutic diet has been fully explained.

F. Transfers:

1. When an inmate on a therapeutic diet is transferred to another facility, all pertinent information regarding the diet shall be entered in the health record that accompanies the inmate. (See Policy #113.04)

2. Upon an inmate's transfer, the current and valid diet order shall be included in the record for transfer to the receiving institution. The therapeutic diet shall be continued until the inmate can be reevaluated by a physician, dentist, or mid-level provider at the receiving institution.

G. Special Considerations for Potential Food Allergies:

1. Clinical personnel notified of inmates with the common food allergies of shellfish, peanuts, or eggs, during initial intake/classification shall have a therapeutic diet order written.

2. Inmates post intake/classification that notify clinical personnel of food allergies during sick call must be specific when identifying the food allergen, and agree to food allergy testing for the specific allergen unless proof of previous testing can be verified from an outside provider. A therapeutic diet order will not be written outside of these parameters.

3. During the period awaiting the test results the inmate shall receive a 30 day order for a therapeutic diet that excludes the potential allergen.

4. If the test results are negative for the specific food allergen, the temporary therapeutic diet shall be discontinued and a regular diet tray ordered.

5. If the test results are positive for the specific food allergen, the temporary therapeutic diet shall be transitioned to a permanent therapeutic diet, void of the identified allergen.

6. All orders must be written by a physician or mid-level provider for specific food allergen testing, and arrangements will be made by the medical vendor for the allergy testing to occur.

H. Religious Diet Requests: Inmates requesting no, beef, pork, poultry, and/or other specific food items for religious reasons shall apply via the exception pathway outlined in Policies #116.01 and #116.08.

G. Food Service Responsibilities: Institutions shall follow policies #116.01, #116.03, #116.05, and #506.16, regarding menu and diet planning as well as meal service environment and sanitation.

VII. ACA STANDARDS: 4-4318, 4-4320, and 4-4414.

VIII. EXPIRATION DATE: September 30, 2019.

TENNESSEE DEPARTMENT OF CORRECTION

THERAPEUTIC DIET ORDER

INSTITUTION: ______________________ **LOCATION:** ______________________

NAME: ______________________ NUMBER: ______________ DATE OF BIRTH: ______________

ALLERGIES: ____

POTENTIAL FOOD/DRUG INTERACTION: ______________________________

TYPE OF REQUEST: ☐ New ☐ Renewal ☐ Change ☐ Cancel

TYPE OF DIET:

☐ Clear Liquid (3 days only) ☐ Full Liquid ☐ Mechanical Soft ☐ Bland ☐ Renal (includes HS snack)

☐ Pureed ☐ Finger Food ☐ Snacks - ☐ High-Fiber ☐ Hepatic-includes HS snack

☐ Low-fat/Low Cholesterol, No Added Salt ☐ AM ☐ PM ☐ HS ☐ Prenatal Diet

☐ Moderate Calorie/Carbohydrate (ADA) with No Added Salt (includes 3 meals with HS Snack)

DURATION: ______________Days START DATE: ______________ STOP DATE: ______________

SIGNATURE:_______________________________________ DATE: ______________

Health Care Provider/Title

THIS SPECIAL DIET HAS BEEN EXPLAINED TO ME AND I UNDERSTAND I WILL BE CHARGED THE COST OF ANY MODIFIED MEAL I FAIL TO PICK UP.

_______________________________________ ______________

Inmate's Signature Date

THIS SECTION TO BE COMPLETED BY DIETARY SERVICES

DIETARY SERVICES (Comments compliance/noncompliance, i.e., failure to pick up diet, diet refusal, irregular use, etc.):

Diet Compliance/Noncompliance: (Circle Letter to Indicate Noncompliance)

B = Breakfast **L** = Lunch **D** = Dinner

MONTH ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

SIGNATURE: _______________________________________ DATE: ______________

Authorized Food Service Representative/Title

Order Form 1206/4 (If 4-part set) or
Order Form 1206/5 (If 5-part set

PHYSICIAN'S ORDERS

NAME

ROOM NO.
(ADDRESS)

HOSP. NO.

PHYSICIAN

Drug Allergies

Date & Time	Another brand of drug identical in form and content may be dispensed unless checked ☐	DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS → (1)	Nurse's Initials

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.40	Page 1 of 6
	Effective Date: June 1, 2013	
	Distribution: A	
	Supersedes: 113.40 (4/1/10) PCN 11-40 (11/1/11)	
Approved by: Derrick D. Schofield		
Subject: HEALTH EDUCATION		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To enhance and promote inmate wellness and disease prevention and management through individual teaching and group health education programs.

III. APPLICATION: Wardens, Health Administrators, health care staff, inmates, and privately managed institutions.

IV. DEFINITIONS:

A. Health Education: Learning activities which foster an individual's motivation, skills, and confidence to take action to improve his/her personal health and well-being, and to make informed decisions that are conducive to community health.

B. TDOC Statewide Director of Nursing: A nursing administrator whose responsibilities include the coordination of training for health professionals through direct training and/or identification of resources within the Department or other state agencies as directed by the State Medical Director or designee.

V. POLICY: An inmate health and wellness education program shall be developed that is consistent with the health needs of the inmates and the availability of health care resources.

VI. PROCEDURES:

A. General: Because of professional and legal demands for health care accountability, patient education/teaching concerning health problems and health maintenance is a major responsibility of health care providers.

1. Individual teaching is an integral component of any treatment plan. Before any teaching intervention can be planned, the health care provider must assess the patient and his/her environment.

2. Patient teaching is necessary for the prevention of accidents and disease, for the optimal maintenance of the chronically ill and convalescent patient, and for the optimal restoration of the injured, acutely ill, and those suffering from disabling physical and/or mental conditions.

3. The Teaching/Counseling Plan, CR-2742, shall be used to document a specifically designed plan of action for health teaching/counseling of individual patients.

4. The individual teaching plan shall be relevant to the specifically identified individual health needs.

5. To maximize the quality and effectiveness of the individual patient teaching process, the teaching plan shall contain only factual and current related information, and be appropriate to the educational and comprehension level of the individual patient.

6. Formulating health teaching plans will often require flexibility and creativity in teaching patients with special needs. Individuals with an altered ability to learn, congenital disorders, or pathology and disability will require specially designed teaching plans. Teaching mechanisms and plan content may have to be altered to meet their special needs.

   a. Individuals with decreased visual and auditory capabilities pose special challenges that require the health care provider to make sure he/she can hear and understand the words being used. It may be necessary to speak face-to-face with the patient and check frequently to make sure he/she can hear and understand the words being used. Any printed materials should have print large enough for the patient to see, especially if instructions are involved.

   b. Impaired cognitive abilities may be affected by various medications and general failing physical and mental health. If teaching a skill, multiple return demonstrations may help the patient to learn the material. In certain instances, the physician may determine that the patient's condition is severely impaired and prevents education. In those instances, the Teaching/Counseling Plan, CR-2742, should be updated to indicate the rationale for the teaching/counseling plan exemption.

7. Teaching goals should always encourage patients to be their own advocates and to assume responsibility for their own health care when possible.

8. Whenever any health teaching/counseling is done in conjunction with a health assessment and/or treatment intervention, documentation of the health care provider's teaching or counseling intervention shall be recorded in the inmate's health record, on the Problem Oriented-Progress Record, CR-1884.

B. Health Education

1. By January 7th of each year, the Director of Nursing shall develop the annual health education program curriculum. Once approved the curriculum shall be distributed to all TDOC facilities by January 21st for implementation by January 31st.

   a. An effective health education program shall include the following elements:

      (1) Curricula that is relevant and concise, containing only factual and current national health and disease prevention education standards.

(2) Curricula that is appropriate to the general educational and comprehension level of the targeted participants attending the program.

(3) Curricula that is only presented by health care providers, health educators, or trained facilitators, all of whom must have a thorough knowledge of the subject matter/topic being taught.

(4) Curricula that provides opportunity for questions or concerns to be discussed.

(5) Curricula that lists the reference/resources used in the topic preparation.

b. Health education topics may include, but not be limited to:

(1) Access to Health Care Services

(2) Disease prevention - HIV/AIDS, TB, Hepatitis A, B, and C

(3) Prevention of sexually transmitted diseases (STDs) such as gonorrhea, syphilis, chlamydia, and genital herpes

(4) Principles for maintaining health and well being (physical fitness, stress reduction, male reproductive exam, and chronic disease management)

(5) Principles basic to health and nutrition (required nutrients, weight management)

(6) Smoking cessation

(7) Principles basic to maintaining dental/oral hygiene

(8) Basic principles of personal hygiene and grooming

(9) Prevention of accidents and injuries (inmate assigned work-sites)

(10) Topics relative to women's health issues (periodic health appraisals, self-breast examination, planned pregnancies, etc.).

(11) Dangers of self medication and substance abuse

c. Methods of presenting the health education programs may include the following :

(1) Group lecture
(2) Demonstrations/simulations (effective in teaching techniques)
(3) Closed circuit TV (programs scheduled throughout the day and evenings)
(4) Audiovisual presentations
(5) Models, printed materials (brochures, posters, pamphlets, diagrams)
(6) State, county, and community health promotional presentations

2. Each facility shall use curriculum provided by the Statewide Director of Nursing to develop a well-designed health education and disease prevention program that will promote individual health and wellness. The program design and content shall have a clear message regarding disease prevention, disease management, and wellness. An effective health promotion program will encourage inmates in self-care, decision making skills, and promote the self-esteem needed to make healthy life-style choices.

3. All health education programs shall be documented on Health Education Roster, CR-3013, to include the course title, name(s) of instructor(s), date and time the class was conducted, method of presentation, and training aids used (video, handouts, etc.). The names and TDOC numbers of all inmate participants are required to be listed on the CR-3013; however, closed circuit TV presentations are exempt from this requirement. The Health Administrator shall be responsible for maintaining documentation for all health promotional activities within the facility, including all Health Education Rosters, CR-3013, memoranda or other documentation relative to the planned health education activities within the facility.

4. Annually, the TDOC Statewide Director of Nursing in coordination with the institutional Health Administrators, the Directors of Nursing/Nurse Supervisors, Continuous Quality Improvement/Infection Control Coordinators will evaluate the health education program, making revisions as necessary to ensure the content is consistent with the population's health needs in terms of age and gender, incidence of disease, and potential for high risk health and/or workplace injuries. They shall also ensure the program is consistent with the inmate(s) response to program/evaluations and includes topics suggested by inmates.

VII. ACA STANDARDS: 4-4361.

VIII. EXPIRATION DATE: June 1, 2016.

TENNESSEE DEPARTMENT OF CORRECTION

TEACHING/COUNSELING PLAN

Patient's Name

Subject

ELEMENT	DATES TAUGHT

Note: Each entry must be signed.

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ INMATE NUMBER: _____

DATE	TIME/PLACE	PROB NO.	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH EDUCATION ROSTER

Course Title: _____ Institution: _____

Course Contents: _____ Location: _____

Instructor: _____ Date: _____ Time: _____

Name	Number	Name	Number

Original Health Administrator or Nursing Director file

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.43	Page 1 of 7
	Effective Date: May 1, 2013	
	Distribution: A	
	Supersedes: 113.43 (4/1/10)	
Approved by: Derrick D. Schofield		
Subject: IMMUNIZATIONS: INMATE POPULATION		

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606.

II. PURPOSE: To enhance prevention of vaccine-preventable diseases.

III. APPLICATION: Wardens, health administrators, job coordinators, health care staff, inmates, and privately managed institutions.

IV. DEFINITIONS: None.

V. POLICY: Immunizations shall be administered to inmates in accordance with immunization regulations and instructions published by the Tennessee Department of Health.

VI. PROCEDURES

A. General: Immunizations administered by health care personnel shall be pursuant to physician's orders, TDOC policy, and be consistent with the immunization recommendations of the Tennessee Department of Health.

B. Tetanus Diptheria Toxoid for Inmates 18 Years Old or Older:

1. All inmates 18 years old or older entering the TDOC system shall receive a tetanus diptheria toxoid (Td) booster. Prior to the administration of any injection, the inmate shall be asked if he/she has any known allergies or other known reason why he or she should not be given a Td. The initial Td booster shall be documented in the appropriate space on the Health History/Physical Examination, CR-2007, and the Immunization/TB Control Record, CR-2217. (See Policies #113.20 and #113.44)

2. Td boosters shall be given on a voluntary basis; however, any refusal must be documented in the health record using the CR-1984, Refusal of Medical Services. (See Policy #113.51)

C. Influenza and pneumococcal vaccines shall be administered on an individual basis as deemed clinically appropriate by the physician.

D. Hepatitis A and B: Inmates who are exposed to a diagnosed case of Hepatitis A or B virus shall be treated by the physician in accordance with the current guidelines published by U.S. Department of Health and Human Services Centers for Disease Control. (See Policy #113.42)

E. Inmate Workers/Hepatitis B Vaccine: If an inmate is assigned to a job where duties place him/her at a significant risk of exposure to Hepatitis B, the TDOC may provide the Hepatitis B vaccine on a case by case basis. The institutional job coordinator shall annually send the listing of duties for each job at that institution to the health administrator. The health administrator shall assign the institutional infection control coordinator to determine if any of the institutional job duties place the inmate at significant risk of exposure to Hepatitis B. If a job duty is identified as placing an inmate at significant risk, the health services staff shall make the Hepatitis B vaccine available to inmates who perform that job. The health administrator, in collaboration with the job coordinator, shall establish institutional procedure(s) for notifying health services staff of those inmates who should be offered the Hepatitis B vaccine. The Hepatitis B vaccine series shall be administered by a health care provider only on a physician's orders following the appropriate vaccination administration pre-screening and inmate consent using CR-3499, Initial Evaluation Prior to Job Assignment.

F. Work release inmates shall obtain necessary immunizations in the community at their own or their employer's expense.

G. Employees in State operated facilities are provided immunization in accordance with Policy #113.13.

VII. ACA STANDARDS: 4-4354 and 4-4356.

VIII. EXPIRATION DATE: May 1, 2016.

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

_____
INSTITUTION

NAME _____ **NUMBER** _____ **AGE** _____

SS# _____ **Sex** _____ **RACE** _____ **D.O.B.** _____

Next of Kin: Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: **Area Code** _____ **Number** _____

Defined Data Base: Date _____ (Month) _____ (Day) _____ (Year)

Height: _____ Weight: _____ Hair Color: _____ Color of Eyes: _____

Blood Pressure (Sitting): _____ Temp: _____ Pulse _____ Resp. _____

DATE, if done on Admission			
Serology		EKG	
Urinalysis		Chest X-Ray	
CBC		Hemocult	
Chem. Scan			
Td Booster			
Other			

ALLERGIES: _____

Date or TB Skin Test _____

Date Read _____ Results _____ (Record in MM.)

Visual Acuity (Snellen) **R.** _____ **L.** _____

Audiometric Screening (20 db.)

71.	AUDIOMETER							
	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT								
LEFT								

CURRENT MEDICATIONS: (Specify drug, strength, dosage form and frequency)

_____

_____

_____

_____

NAME _____ **NUMBER** _____

1. Family History: Have any of your family or relatives had any of the following? If so, specify who:

Heart Disease		Tuberculosis		Cancer	
Sickle Cell		Diabetes		Seizures	
Hypertension		Mental Illness		Other	

Are your parents still living? _____

2. Social History:

Highest Grade Completed _____ Usual Occupation _____ Marital Status _____

Previous Incarcerations _____ Old Number (TN, Other State, Federal) _____

Prior to Incarceration:

Used alcohol: Yes _____ No _____ If yes, Daily _____ Weekly _____ Rarely _____

Other habit forming drug(s): Yes _____ No _____ Name(s) of Drug(s): _____

Ever injected drugs (even once)? Yes _____ No _____

3. When did you last see a doctor? _____

For What Reason: _____

4. Have you ever been told by a doctor that you now have or have had any of the following:
Answer questions by checking **yes** or **no**

NO		**YES**	**COMMENT(S)**
☐ a.	Rheumatic Fever	☐	
☐ b.	Heart trouble	☐	
☐ c.	High Blood Pressure	☐	
☐ d.	Thyroid trouble or Goiter	☐	
☐ e.	Diabetes	☐	
☐ f.	Kidney infections or Stones	☐	
☐ g.	Jaundice, hepatitis or liver disease	☐	
☐ h.	Ulcer	☐	
☐ i.	Pneumonia	☐	
☐ j.	Tuberculosis	☐	
☐ k.	Gallbladder Disease	☐	
☐ l.	Venereal Disease	☐	
☐ m.	Asthma	☐	
☐ n.	Emphysema	☐	
☐ o.	Anemia	☐	
☐ p.	Hemophilia	☐	
☐ q.	Cancer	☐	
☐ r.	Epilepsy or Seizure disorder	☐	
☐ s.	Allergies, (if yes, what? _____)	☐	
☐ t.	Any other serious illness, or injuries, operations, or hospitalizations?	☐	
☐ u.	Any history of treatment in a Mental Health Clinic or Psychiatric Hospital?	☐	

NAME _____ **NUMBER** _____

DATE	NAME OF HOSPITAL	LOCATION	REASON

NO		YES	COMMENT(S)
5.			
☐ a.	Has there been any change in your weight in the past year? 1. Lost ☐ How much? _____ 2. Gain ☐ How much? _____	☐	
☐ b.	Have you ever had excessive anxiety/nervousness, depression or worrying?	☐	
☐ c.	Have you noticed a change in size or color of any wart or mole, or the appearance of a new one?	☐	
☐ d.	Any itching, skin rash or boils?	☐	
☐ e.	Any surgical scars or tattoos?		
☐ f.	Do you use tobacco?	☐	
☐	1. Chew	☐	
☐	2. Pipe	☐	
☐	3. Cigars	☐	
☐	4. Cigarettes	☐	
	5. How many cigars, cigarettes, or pipes do you smoke in 24 hours? _____		
6.	**HEAD AND NECK**		
☐ a.	Do you have dizzy spells?	☐	
☐ b.	Do you have frequent headaches?	☐	
	How often? _____ What medicine helps your headaches? _____		
☐ c.	Do you have any lumps or swelling in your neck, armpits, groin or other areas?	☐	
7.	**EYES**		
☐ a.	Do you wear glasses or contact lens?	☐	
.	For how long? _____		
☐ b.	Do you see double?	☐	
☐ c.	Do you ever see colored halos around lights?	☐	
☐ d.	When were your eyes last examined?	☐	
	_____		
☐ e.	Do you have trouble seeing objects at a distance or near objects such as a newspaper?	☐	
☐ f.	Do you have vision in both eyes?	☐	

NAME _____ **NUMBER** _____

NO		YES	COMMENT(S)
8.	**EARS**		
☐ a.	Do you have difficulty hearing?	☐	
☐ b.	Have you had any earaches lately?	☐	
☐ c.	Do you have repeated buzzing or ringing in your ears?	☐	
9.	**MOUTH, NOSE AND THROAT**		
☐ a.	Do you have any trouble with your teeth or gums?	☐	
☐ b.	When did you last see a dentist?	☐	
☐ c.	Have you ever had sinus problems?	☐	
☐ d.	Does you nose ever bleed for no reason at all?	☐	
☐ e.	Is your voice more hoarse now than in the past?	☐	
10.	**RESPIRATORY**		
☐ a.	Do you have a chronic cough?	☐	
☐ b.	Do you cough up any material?	☐	
☐ c.	Ever have trouble getting your breath after climbing one flight of stairs or walking one city block?	☐	
☐ d.	Do you have frequent colds of influenza attacks?	☐	
11.	**CARDIOVASCULAR**		
☐ a.	Ever get pains or tightness in your chest?	☐	
☐ b.	Ever been bothered by a racing heart?	☐	
☐ c.	Do you have shortness of breath while doing your usual work?	☐	
☐ d.	Need more pillows at night to breathe?	☐	
☐ e.	Do you have swollen feet and ankles?	☐	
☐ f.	Do you use a lot of salt on your food?	☐	
12.	**DIGESTIVE**		
☐ a.	Do you suffer discomfort in the pit of your stomach?	☐	
☐	1. Nausea	☐	
☐	2. Vomiting	☐	
☐	3. Indigestion	☐	
☐	4. Heartburn	☐	
☐ b.	Is it painful or difficult for you to swallow liquids or solid foods?	☐	
☐ c.	Do you have trouble with bowel movements?	☐	
☐	1. Hemorrhoids	☐	
☐	2. Bleeding	☐	
☐	3. Constipation	☐	
☐	4. Diarrhea	☐	
☐	5. Bloody or Black Stools	☐	
☐	6. Rectal Pain	☐	
13.	**URINARY**		
☐ a.	Frequently get up at night to urinate?	☐	
☐ b.	Ever had burning or pains when urinating?	☐	

NAME **NUMBER**

NO		YES	COMMENT(S)
14.	**MUSCULOSKELETAL**		
☐ a.	Have stiff or painful muscles or joints?	☐	
☐ b.	Are your joints ever swollen?	☐	
☐ c.	Have you ever had any broken bones?	☐	
☐ d.	Have difficulty bending or moving?	☐	
15.	***FOR MALES ONLY***		
☐ a.	Is your urine stream very weak and slow?	☐	
☐ b.	Has a doctor ever told you that you have prostate trouble?	☐	
☐ c.	Ever had discharge from your penis?	☐	
☐ d.	Do you have any pain, swelling, sores or lumps on your testicles or penis?	☐	
16.	***FOR FEMALES ONLY***		
☐ a.	Have you had a hysterectomy?	☐	
☐ b.	Are your menstrual periods regular? Date of last menstrual period: _____	☐	
☐ c.	Ever have pain with your periods?	☐	
☐ d.	Do you have excessive bleeding during your period?	☐	
☐	1. Between periods?	☐	
☐	2. After sexual relations?	☐	
☐	3. After going through the “change of life”?	☐	
☐ e.	What type of birth control method are you using? (Circle appropriate)	☐	
☐	1. None	☐	
☐	2. Birth control pills	☐	
☐	3. IUD (Loop)	☐	
☐	4. Foam	☐	
☐	5. Diaphragm	☐	
☐	6. Method left up to man	☐	
☐	7. Sterilization	☐	
☐	8. Other: _____		
☐ f.	Do you have a discharge now?	☐	
☐ g.	When was your last Pap Smear? _____	☐	
☐ h.	Ever had an abnormal Pap smear?	☐	
i.	How many times have you been pregnant? ____		
☐	1. Full term _____	☐	
☐	2. Premature _____	☐	
☐	3. Miscarriages _____	☐	
☐	4. Abortions _____	☐	
☐	5. Are you pregnant now?	☐	
☐ j.	Do you examine you breasts regularly?	☐	
☐ k.	Ever found any lumps in your breasts?	☐	
☐ l.	Ever had discharge from your nipples?	☐	
17.	***SKIN***		
☐	Inspection, lesions, ulcers, tags, moles, insect bites, rashes, infections.	☐	

I certify that the foregoing information supplied by me is true and complete to the best of my knowledge.

Date	Signature of Patient	Signature of Person Reviewing History

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

INSTITUTION: _____

NAME _____ **NUMBER** _____ **DATE OF EXAM** _____

CLINICAL EVALUATION			
NORMAL	(Check each item in appropriate column; enter **"NE"** if not evaluated.)	**ABNORMAL**	**NOTES**: Describe every abnormality in detail. Enter pertinent item number before each comment. Use progress notes for additional information.
	1. GENERAL: Appearance, Nails, and Identifying Marks, Tattoos, etc.		
	2. EYES: General, Opthalmoscopic; Pupils, and Ocular Motility		
	3. HEAD AND NECK		
	4. EARS: External and Otoscopic		
	5. MOUTH AND THROAT		
	6. NOSE AND SINUSES		
	7. LUNG AND CHEST		
	8. CARDIOVASCULAR: Heart and Vascular System		
	9. ABDOMEN: Inspection, Auscultation and Palpation		
	10. RECTUM AND ANUS: Hemorrhoids, Fistulae and Prostate, if indicated.		
	11. G.U. SYSTEM a. Genitalia b. Hernia		
	12. PELVIC		
	13. ENDOCRINE		
	14. MUSCULOSKELETAL SYSTEM: Spine, Upper Extremities and Lower Extremities		
	15. NEUROLOGICAL: Cranial Nerves, Motor Functions, Cerebella and DTR's		
	16. PSYCHIATRIC		
	17. SKIN: Inspection, lesions, ulcers, tags, moles, insect bites, rashes, infections.		

SUMMARY OF DEFECTS / CONDITIONS AND DIAGNOSIS

WORK CLASSIFICATION BASED ON PHYSICAL EXAMINATION: _____

_____ PRINT NAME OF MEDICAL PRACTITIONER

_____ SIGNATURE OF MEDICAL PRACTITIONER

TENNESSEE DEPARTMENT OF CORRECTION

IMMUNIZATION / TB CONTROL RECORD - INMATE

_____
INSTITUTION

NAME _____ TDOC NUMBER _____

IMMUNIZATIONS

DATE	VACCINE	DOSE	SIGNATURE

TUBERCLOSIS SCREENING AND SURVEILLANCE

INITIAL SCREENING: READ AFTER 48 – 72 HOURS

Tuberculin Test Date / Antigen / Method / Initials	Date Read / Initials	Reaction in MM	Chest X-Ray Date / Results	Preventive Treatment Started / Completed

PERIODIC SCREENING: READ AFTER 48 – 72 HOURS IN MM

TUBERCULOSIS SURVEILLANCE: FILL IN IF POSITIVE PPD OR IF DISEASE OCCURS

Bacteriologic Examination Date / Results	Diagnosis Date / Diagnosis	Treatment Started / Completed

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

REFUSAL OF MEDICAL SERVICES

INSTITUTION _____

Date _____ 20 _____ Time _____ AM/PM

This is to certify that I _____, _____
(Inmate's Name) (TDOC Number)
have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

_____

_____

_____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: _____ _____ _____
(Inmate) (TDOC number) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

The above information has been read and explained to,

_____ _____ but has refused to sign
(Inmate's Name) (TDOC number)
the form.

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

TENNESSEE DEPARTMENT OF CORRECTION

EXPOSURE CONTROL

INITIAL EVALUATION PRIOR TO JOB ASSIGNMENT

_____
INSTITUTION

CONFIDENTIAL

The following criteria regarding occupational/medical history and medical problems, which could interfere with the ability to use protective clothing, equipment, or the receipt of the Hepatitis B Virus (HBV) vaccination has been reviewed.

Any **YES** Response – **DO NOT** Give Vaccine

		YES	NO
1.	Are you allergic to yeast? (Baker's yeast?)	_____	_____
2.	Have you *ever* had a serious reaction (anaphylaxis) to pervious dose of Hepatitis B vaccine?	_____	_____
3.	Are you currently moderately/severely ill with/without fever?	_____	_____

_____ Does/ Does Not meet the criteria for receiving the HBV vaccination.
Name

_____ _____
Legal Signature/Professional Title of Health Care Provider *Date*

PART I. HEPATITIS B VACCINE CONSENT

I, _____ received HBV training and had the opportunity to
(Employee Name - please print)

ask questions and understand the benefits and risks of Hepatitis B vaccination. I fully release and discharge the State of Tennessee, to employees and agents from any liability for illness, injury, loss or damage that may result therefrom, to the extent remitted by law.

_____ _____
Employee Signature Date

_____ _____
Witness Signature Date

HBV VACCINATION SCHEDULE

	DATE	LOT NO.	ADMINISTERED BY (Signature / Title)
First Dose	_____	_____	_____
Second Dose	_____	_____	_____
Third Dose	_____	_____	_____

Post-vaccination serum titer results _____ Date: _____

Employee Hepatitis B Vaccination schedule is:

1ST DOSE	2ND DOSE	3RD DOSE
Date: _____	Date: _____	Date: _____

TENNESSEE DEPARTMENT OF CORRECTION

EXPOSURE CONTROL

INITIAL EVALUATION PRIOR TO JOB ASSIGNMENT

CONFIDENTIAL

PART II. HEPATITIS B VACCINE REFUSAL

STAFF MUST SIGN THE FOLLOWING IF HEPATITIS B VACCINATION IS REFUSED.

I, _____ understand that due to my occupational exposure
(Employee Name - please print)

To blood, or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated, at no charge to myself, with the Hepatitis B vaccine. However, I decline the Hepatitis B vaccination at this time. I also understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can, at no charge to me, receive the Hepatitis B vaccination series.

☐ I have received the Hepatitis B vaccine series.

☐ Other: _____

_____ _____
Name - Signature Date

_____ _____
Witness Signature Date

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.43	Page 1 of 1
	Effective Date: September 1, 2014	
	Distribution: A	
	Supersedes: N/A	
Approved by: Derrick D. Schofield		
Subject: IMMUNIZATIONS: INMATE POPULATION		

POLICY CHANGE NOTICE 14-35

INSTRUCTIONS:

In Section VI.(B)(1), please change to read as follows:

"1. All inmates 18 years old or older entering the TDOC system shall receive a tetanus diphtheria toxoid (Td) booster. Prior to the administration of any injection, the inmate shall be asked if he/she has any known allergies or other known reason why he or she should not be given a Td. The initial Td booster shall be documented in the appropriate space on the Health History, CR-2007, and the Immunization/TB Control Record, CR-2217. (See Policies #113.20 and #113.44)"

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, TCA 68-11-301, TCA 68-11-303, TCA 68-11-311, TCA 24-7-110, TCA 68-11-209, TCA 32-11-102, and TCA 32-11-105.

II. PURPOSE: To prescribe contents and handling procedures for inmate health records.

III. APPLICATION: Wardens, Health Administrators, health care and archives staff, and privately managed institutions.

IV. DEFINITIONS:

A. Advanced Directive: An individual instruction or written statement relating to the subsequent provision of health care for the individual in which the inmate or his/her healthcare agent expresses his/her choice(s) regarding healthcare services to apply in the event he/she is no longer capable of expressing a choice. Advance directives may include by not be limited to, a living will, an advance care plan, or durable power of attorney for health care.

B. Document Storage and Retrieval System (DSRS): An electronic document repository.

C. DSNF Health Record: A health record maintained by the DSNF facility for sub-acute or extended care inmates being treated in a medical or mental health temporary or permanent status.

D. Health Record: A chronological documentation of an inmate's medical history and treatment. The record includes documentation of intake health screenings, progress notes, x-ray and laboratory reports, physicians' orders, clinic and infirmary records, medication administration records, treatment plans, immunization records, dental records, hospital and emergency room reports, specialty consultation reports, mental health records, etc.

E. Healthcare Agent: A fiduciary or legal surrogate. A fiduciary is a legal guardian or conservator, or an attorney-in-fact who has been granted a valid power of attorney for health care decisions pursuant to applicable law.

F. S.O.A.P. Notes: A particular format of recording clinical documentation regarding treatment procedures. The four components of S.O.A.P. notes are:

S = Subjective-describes the patient's current condition in narrative form, including the patient's reported complaint(s), history, symptoms, onset, and previous remedies.

O = Objective-findings from physical examinations, diagnostic tests, vital signs, age, weight, height, etc.

A = Assessment-summary of the clinician's diagnostic impression and rule-outs.

P = Plan-specifies the treatment plan for the inmate's condition, intervention, medication, required follow-up, etc.

G. Verbal Orders: Instructions from an authorized provider given verbally by telephone to a licensed nurse, pharmacist, or mid-level provider.

V. POLICY: A health record shall be maintained for each inmate. The health record shall contain a chronological documentation of the inmate's health status and treatment throughout the duration of his or her incarceration. The health record shall be maintained separately from the inmate's institutional record.

VI. PROCEDURES:

A. GENERAL:

1. The health record shall be initially created at diagnostic centers as part of the diagnostic process, per Policy #401.04. In the event that inmates return to TDOC custody, their original health records shall be requested from TDOC health record archives. Diagnostic centers shall procure and utilize a ten compartment brown letter size folder for the health record as specified in Policy #512.01. These folders shall also be available to other institutions for replacement or creation of additional volumes of a health record. The Director of Health Services shall approve the method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping.

2. The original health record shall accompany the inmate whenever he/she is transferred to another TDOC facility either permanently or temporarily (e.g., court, hospital, etc.). Mental health programmatic records shall also be forwarded. (See Policies #113.04 and #113.81)

3. The health record shall be organized in a problem-oriented format and contain documentation of all occasions of medical service provided to inmates both onsite and off site for either inpatient or ambulatory care.

4. Prior to filing the health record, all documents are to be reviewed to assure that the medical record is in order and complete. Medical records staff will scan the documents into DSRS, stamp the documents as "scanned" in red ink in the top right hand corner, then file the scanned document in the proper section of the health record.

B. Confidentiality/Release of Health Records: All health records shall be considered confidential and are to be handled in accordance with Policy #113.52.

C. Maintenance of Health Records:

1. All active health records shall be stored in a secure area and separately maintained from the institutional record. Only authorized personnel shall have access to these records. Each facility shall maintain a list of personnel, by position or function, authorized to have access to the health record, and only those authorized individuals shall have access to the DSRS database as well as the original health record.

2. Records In/Records Out, CR-1006, shall be used anytime an inmate health record is removed from the health records area.

3. All institutions shall utilize the color-coded terminal digit system for storage and retrieval.

D. Health Services Forms:

1. All institutions shall use the TDOC approved CR forms in the health record. Exceptions can be made only as described in Policy #101.06.

2. The Director of Health Services or designee shall periodically, or as needed, review health services forms for content and appropriateness to correspond with TDOC policy, ACA standards, and current health service standards.

3. S.O.A.P. notes shall be used for documenting clinical assessments in the health record; other notes may be narrative.

E. Organization of the Health Record: All documents placed in an inmate's health record shall be legible and attached face up, in chronological order, with the most recent information on top. A health record consists of ten sections. Items are placed in the most appropriate general category as follows:

1. Section 1 - Assessment Data, Treatment Plan(s), Advance Directives, conservatorships
2. Section 2 - Diagnostic Reports
3. Section 3 - Provider Orders/Medication Administration Records
4. Section 4 - Chronological Progress Notes
5. Section 5 - Consultations
6. Section 6 - Dental
7. Section 7 - Infirmary
8. Section 8 - Discharge Summaries
9. Section 9 - Miscellaneous
10. Section 10- Mental Health

F. Contents of Health Record Volumes:

1. Additional health record volumes should be made when documents do not fit on fasteners/prongs in sections.

2. All volumes must have typed name labels and color-coded tabs with complete inmate/patient name and TDOC number visible. Volumes shall be continued in sequence, e.g., I of II or II of II.

3. The current forms shall be transferred from the previous volume to the new volume and placed in the appropriate general category as follows:

   a. Section I – Assessment Data

      1. Major Problem List, CR-1894
      2. Immunization/TB Control Record, CR-2217
      3. Health History, CR-2007
      4. Report of Physical Examination, CR-3885
      5. Health Classification Summary, CR-1886
      6. Chronic Disease Clinic Treatment Plan, CR-3624
      7. Teaching/Counseling Plan, CR-2742
      8. Advance Directives

   b. Section II –Diagnostic Reports

      1. All initial and current laboratory reports (past 12 months)
      2. All diagnostic reports (past 12 months)

   c. Section III – Provider Orders/Medication Administration Records: Initial and at least most recent 6 months

   d. Section IV – Progress Notes: Initial clinical assessment note and at least 6 months of Problem Oriented Progress Record, CR-1884 (in chronological order)

   e. Section V – Consultations- All specialty consultation requests and reports (past 12 months)

   f. Section VI – Dental- transfer all forms

   g. Section VII – Infirmary- All in house infirmary progress notes

   h. Section VIII – Discharge Summaries- All hospital discharge summaries, as well as the DeBerry Special Needs Facility health record

   i. Section IX- Miscellaneous - Miscellaneous initial or most current Health Questionnaire, CR-2178

   j. Section X- Mental Health

      1. Initial Psychological Evaluation
      2. Consent for Treatment, CR-1897
      3. Initial and current Mental Health Treatment Plan(s), CR-3326
      4. Mental Health Treatment Review Committee form, CR-3329
      5. Conservator information, if applicable
      6. Initial and 12 months – Progress Notes, CR-1884
      7. Any other miscellaneous forms

G. Documentation of the DSNF Health Record:

1. The DSNF health record shall be standardized and uniform in format for medical and mental health services, and approved annually in writing by the TDOC Director of Health Services.

2. When an inmate is discharged from DSNF, a copy of the discharge summary and any pertinent consultations or diagnostic examinations shall be copied from the DSNF health record and placed in the inmate's original health record. The DSNF health record shall be retained by the DSNF medical records department.

3. DSNF shall develop its own individual chart arrangement according to its unique treatment modalities. At the time of discharge, the DSNF health record shall be reviewed to ensure completeness, proper form arrangement, and that a discharge summary is present.

H. Documentation of Infirmary Services: All entries concerning care while the inmate is admitted to the infirmary will be maintained in Section VII.

I. Psychiatric/Psychological Treatment Records: Psychiatric/psychological summaries, reports, evaluations, and progress notes shall be included in the inmate health record in order to facilitate follow-up, promote continuity of care, and to document ongoing treatment.

J. Record Review: Prior to transfer from any institution, the health record shall be reviewed by the Health Administrator or designee. The reviewer shall verify that the health record is complete and organized in accordance with Section VI.(E) of this policy.

K. Health Record Retention and Disposition:

1. After the release, parole, death, or discharge of an inmate, the health record shall be retained for a period of ten years. However, prenatal records shall be retained for a period of 19 years.

2. Following any inmate's release, death, or escape for longer than 30 days, the outpatient health record shall be scanned in its entirety into the DSRS database. The outpatient health record shall be forwarded to the TDOC health record Archives Center, utilizing the Health Records Movement Document, CR-2176. Such records shall be made available thereafter as needed, or upon the inmate's return to TDOC custody. Requests for such records shall be forwarded to the TDOC health record Archives Center.

3. X-ray films must be retained for at least four years.

L. Coding and Indexing:

1. If coding is done for medical diagnosis, the most current edition of *The International Classification of Diseases, Clinical Modification*, shall be used.

2. If coding is done for psychiatric diagnoses, the most current edition of the *Diagnostic and Statistical Manual of Disorders* (DSM), by the American Psychiatric Association, shall be used.

M. Advance Directives and Health Care Agent Documentation: In accordance with Policy #113.51, inmates may make advance directives to express their choices regarding their healthcare services; to apply in the event they are no longer capable of expressing a choice. Such advance directives may include a "Living Will", or an "Advance Care Plan." As also described in Policy #113.51, a "healthcare agent" may in some cases be appointed to make healthcare decisions for an inmate in circumstances where the inmate is not able to do so for him/herself Such appointments include an "Appointment of Healthcare Agent," Durable Power of Attorney for Healthcare," or an "Appointment of a Conservator".

1. Advance directives and Healthcare Agent documents shall be entered into the health record and shall be filed in Section 1 of the health record.

2. Health records containing advance directives and/or documentation of a healthcare agent appointment shall be prominently marked on the outside front of the health record file "Contains Advance Directives," and/or "Contains documentation of Healthcare Agent appointment." Marking shall be by a paste-on label or bold print in red. The label or printing shall be in the upper right hand corner of the jacket.

3. Health Services staff shall ensure that the inmate's treatment plan includes a reference to advance directives and is approved by signature of the inmate's healthcare agent, where required.

4. When an inmate is transferred to a community hospital, a copy of the advance directive and/or healthcare agent appointment shall be forwarded to that hospital. A responsible individual at the community hospital shall sign for the receipt of the advance directive and/or documentation of health care agent appointment. This receipt shall be filed in Section 1 of the health record.

5. The inmate may revise or revoke advance directives at any time. If the inmate decides to revoke an advance directive, any mention of it shall be removed from the health record file.

6. If necessary, facilities shall develop additional process outlining how inmates with conservators or other healthcare agents will be readily identified. If a healthcare agency has been terminated, the documentation thereof shall be transferred to Section IX, together with documentation that the agency has been terminated.

VII. ACA STANDARDS: 4-4352, 4-4413, 4-4414, and 4-4415.

VIII. EXPIRATION DATE: August 15, 2017.

NAME: _____ **NUMBER:** _____ **NO.**

DATE OUT	NAME & PHONE # OF PERSON WITH RECORD	DATE IN	DATE OUT	NAME & PHONE # OF PERSON WITH RECORD	DATE IN

SIGN IN/SIGN OUT FOR RECORDS

CR-1006 (Rev. 11/04)

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

MAJOR PROBLEM LIST

_____
INSTITUTION

Name: _____ TOMIS#: _____
Last First Middle

Date of Birth: _____ Gender: ☐ M ☐ F Race: _____

Allergies: _____

PROBLEM NUMBER*	DATE IDENTIFIED/ RECORDED	MAJOR CLINICAL CONDITIONS/PROBLEMS	RESOLVED *(Please check "ô" if resolved)*	RESOLVE DATE

Conservator Name: _____

Primary Phone: _____ Secondary Phone: _____

* Major medical problems considered medical or surgical in nature are identified by Roman numerals, i.e., **I** – Diabetes, **II** – Laminectomy.
* Psychiatric, or serious psychological problems, are identified by capital letters, i.e., **A** – Schizophrenia, **B** – Self-Mutilative Behavior.

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

_____
INSTITUTION

SS# _____ **Sex** _____ **Age** _____ **D.O.B.** _____

Next of Kin: Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: **Area Code** _____ **Number** _____

Date Completed: _____ Month _____ Day _____ Year

Height: _____ Weight: _____ Hair Color: _____ Color of Eyes: _____

Blood Pressure (Sitting): _____ Temp: _____ Pulse _____ Resp. _____

DATE, if done on Admission			
Serology		EKG	
Urinalysis		Chest X-Ray	
CBC		Hemocult	
Chem. Scan			
Td Booster			
Other			

ALLERGIES:

Date or TB Skin Test			
Date Read		Results	
			(Record in MM.)

Visual Acuity (Snellen) **R.** _____ **L.** _____

CURRENT MEDICATIONS: (Specify drug, strength, dosage form and frequency)

_____

_____

_____

_____

_____

_____

_____

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

1. Family History: Have any of your family or relatives had any of the following? If so, specify who:

Heart Disease		Tuberculosis		Cancer	
Sickle Cell		Diabetes		Seizures	
Hypertension		Mental Illness		Other	
Substance Use		Are your parents still alive?			

2. Social History:

Highest Grade Completed _____ Usual Occupation _____ Marital Status _____

Previous Incarcerations _____ Old Number (TN, Other State, Federal) _____

Prior to Incarceration:

Used alcohol: Yes _____ No _____ If yes, Daily ___ Weekly _____ Rarely _____

Other habit forming drug(s): Yes _____ No _____ Name(s) of Drug(s): _____

Ever injected drugs (even once)? Yes _____ No _____

3. When did you last see a doctor? _____

For What Reason: _____

4. Have you ever been told by a doctor that you now have or have had any of the following:
Answer questions by checking **yes** or **no**

NO		YES	COMMENT(S)
☐	a. Rheumatic Fever	☐	
☐	b. Heart trouble	☐	
☐	c. High Blood Pressure	☐	
☐	d. Thyroid trouble or Goiter	☐	
☐	e. Diabetes	☐	
☐	f. Kidney infections or Stones	☐	
☐	g. Jaundice, hepatitis or liver disease	☐	
☐	h. Ulcer	☐	
☐	i. Pneumonia	☐	
☐	j. Tuberculosis	☐	
☐	k. Gallbladder Disease	☐	
☐	l. Sexually Transmitted Infection/Disease (Venereal Disease)	☐	
☐	m. Asthma	☐	
☐	n. Emphysema	☐	
☐	o. Anemia	☐	
☐	p. Hemophilia	☐	
☐	q. Cancer	☐	
☐	r. Epilepsy or Seizure disorder	☐	
☐	s. Allergies, (if yes, what? _____)	☐	
☐	t. Any other serious illness, or injuries, operations or hospitalizations?	☐	
☐	u. Any history of treatment in a Mental Health Clinic or Psychiatric Hospital?	☐	
☐	v. Any history of Substance Use Treatment either in or out patient?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

Hospitalizations

DATE	NAME OF HOSPITAL	LOCATION	REASON

Surgical History

DATE	TYPE OF SURGERY	HOSPITAL/SURGICAL CTR	SURGEON

NO		YES	COMMENT(S)
5.			
☐ a.	Has there been any change in your weight in the past year? 1. Lost ☐ How much? _____ 2. Gain ☐ How much? _____	☐	
☐ b.	Have you ever had excessive anxiety/nervousness, depression or worrying?	☐	
☐ c.	Have you noticed a change in size or color of any wart or mole, or the appearance of a new one?	☐	
☐ d.	Any itching, skin rash or boils?	☐	
☐ e.	Do you use tobacco?	☐	
☐	1. Chew	☐	
☐	2. Pipe	☐	
☐	3. Cigars	☐	
☐	4. Cigarettes	☐	
	5. How many cigars, cigarettes, or pipes do you smoke in 24 hours? _____		
6.	**HEAD AND NECK**		
☐ a.	Do you have dizzy spells?	☐	
☐ b.	Do you have frequent headaches?	☐	
	How often? _____ What medicine helps your headaches? _____		
☐ c.	Do you have any lumps or swelling in your neck, armpits, groin or other areas?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

NO		YES	COMMENT(S)
7.	**EYES**		
☐ a.	Do you wear glasses or contact lens?	☐	
.	For how long? _____		
☐ b.	Do you see double?	☐	
☐ c.	Do you ever see colored halos around lights?	☐	
☐ d.	When your eyes were last examined?	☐	
☐ e.	Do you have trouble seeing objects at a distance or near objects such as a newspaper?	☐	
☐ f.	Do you have vision in both eyes?	☐	
8.	**EARS**		
☐ a.	Do you have difficulty hearing?	☐	
☐ b.	Have you had any earaches lately?	☐	
☐ c.	Do you have repeated buzzing or ringing in your ears?	☐	
☐ d	Do you have a hearing aid(s)?	☐	
9.	**MOUTH, NOSE AND THROAT**		
☐ a.	Do you have any trouble with your teeth or gums?	☐	
☐ b.	When did you last see a dentist?	☐	
☐ c.	Have you ever had sinus problems?	☐	
☐ d.	Does your nose ever bleed for no reason at all?	☐	
☐ e.	Is your voice more hoarse now than in the past?	☐	
10.	**RESPIRATORY**		
☐ a.	Do you have a chronic cough?	☐	
☐ b.	Do you cough up any material?	☐	
☐ c.	Ever have trouble getting your breath after climbing one flight of stairs or walking one city block?	☐	
☐ d.	Do you have frequent colds or influenza attacks?	☐	
☐ e	Do you have sleep apnea?	☐	
☐ f.	Do you use a CPAP/BiPAP Machine?	☐	
11.	**CARDIOVASCULAR**		
☐ a.	Ever get pains or tightness in your chest?	☐	
☐ b.	Ever been bothered by a racing heart?	☐	
☐ c.	Do you have shortness of breath while doing your usual work?	☐	
☐ d.	Need more pillows at night to breathe?	☐	
☐ e.	Do you have swollen feet and ankles?	☐	
☐ f.	Do you use a lot of salt on your food?	☐	
☐ g.	Do you have a pacemaker?	☐	
☐ h.	Do you have a defibrillator?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

NO		YES	COMMENT(S)
12.	**DIGESTIVE**		
☐ a.	Do you suffer discomfort in the pit of your stomach?	☐	
☐	1. Nausea	☐	
☐	2. Vomiting	☐	
☐	3. Indigestion	☐	
☐	4. Heartburn	☐	
☐ b.	Is it painful or difficult for you to swallow liquids or solid foods?	☐	
☐ c.	Do you have trouble with bowel movements?	☐	
☐	1. Hemorrhoids	☐	
☐	2. Bleeding	☐	
☐	3. Constipation	☐	
☐	4. Diarrhea	☐	
☐	5. Bloody or Black Stools	☐	
☐	6. Rectal Pain	☐	
13.	**URINARY**		
☐ a.	Frequently get up at night to urinate?	☐	
☐ b.	Ever had burning or pains when urinating?	☐	
14.	**MUSCULOSKELETAL**		
☐ a.	Have stiff or painful muscles or joints?	☐	
☐ b.	Are your joints ever swollen?	☐	
☐ c.	Have you ever had any broken bones?	☐	
☐ d.	Have difficulty bending or moving?	☐	
15.	***FOR MALES ONLY***		
☐ a.	Is your urine stream very weak and slow?	☐	
☐ b.	Has a doctor ever told you that you have prostate trouble?	☐	
☐ c.	Ever had discharge from your penis?	☐	
☐ d.	Do you have any pain, swelling, sores or lumps on your testicles or penis?	☐	
16.	***FOR FEMALES ONLY***		
☐ a.	Have you had a hysterectomy?	☐	
☐ b.	Are your menstrual periods regular? Date of last menstrual period: _____	☐	
☐ c.	Ever have pain with your periods?	☐	
☐ d.	Do you have excessive bleeding during your period?	☐	
☐	1. Between periods?	☐	
☐	2. After sexual relations?	☐	
☐	3. After going through the “change of life”?	☐	
☐ e.	What type of birth control method are you using? (Check appropriate)	☐	
☐	1. None	☐	
☐	2. Birth control pills	☐	
☐	3. IUD (Loop)	☐	
☐	4. Foam	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC Number

NO		YES	COMMENT(S)
☐	5. Diaphragm	☐	
☐	6. Condoms	☐	
☐	7. Tubes Tied	☐	
☐	8. Other: _____		
☐ f.	Do you have a discharge now?	☐	
☐ g.	When was your last Pap Smear?	☐	
	_____		
☐ h.	Ever had an abnormal Pap smear?	☐	
☐ i.	How many times have you been pregnant? _____		
☐	1. Full term _____	☐	
☐	2. Premature _____	☐	
☐	3. Miscarriages _____	☐	
☐	4. Abortions _____	☐	
☐	5. Are you pregnant now?	☐	
☐ j.	Do you examine you breasts regularly?	☐	
☐ k.	Ever found any lumps in your breasts?	☐	
☐ l.	Ever had discharge from your nipples?	☐	
☐ m.	Have you had the Measles, Mumps, and Rubella Vaccine (MMR) as an adult?	☐	
17.	***SKIN***		
☐	Tattoos, piercings, lesions, ulcers, tags, moles, insect bites, rashes, or infections?	☐	

Do you have an Advanced Directive, Do Not Resuscitate Order or Living Will? (Circle all that apply)

If **NO**, was an Advance Care Plan form and counseling provided? (PH-4194) ☐ Yes ☐ No

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

I certify that the foregoing information supplied by me is true and complete to the best of my knowledge.

Date	Signature of Patient	Signature of Person Reviewing History

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

INSTITUTION: _____

NAME _____ **TOMIS#:** _____ **DATE OF EXAM** _____

Blood Pressure (sitting): _____ Height: _____ Weight: _____ Temp: _____ Pulse: _____ Resp: _____

CLINICAL EVALUATION			
NORMAL	(Check each item in appropriate column; enter ***"NE"*** if not evaluated.)	**ABNORMAL**	**NOTES**: Describe every abnormality in detail. Enter pertinent item number before each comment. Use progress notes for additional information.
	1. GENERAL: Appearance, Nails, Skin, and Identifying Marks, Tattoos, etc.		
	2. EYES: General, Ophthalmoscopic; Pupils, and Ocular Motility		
	3. HEAD AND NECK		
	4. EARS: External and Otoscopic		
	5. MOUTH AND THROAT		
	6. NOSE AND SINUSES		
	7. LUNG AND CHEST		
	8. CARDIOVASCULAR: Heart and Vascular System		
	9. ABDOMEN: Inspection, Auscultation and Palpation		
	10. RECTUM AND ANUS: Hemorrhoids, Fistulae and Prostate, if indicated.		
	11. G.U. SYSTEM a. Genitalia b. Hernia		
	12. PELVIC		
	13. ENDOCRINE		
	14. MUSCULOSKELETAL SYSTEM: Spine, Upper Extremities and Lower Extremities		
	15. NEUROLOGICAL: Cranial Nerves, Motor Functions, Cerebella and DTR's		
	16. PSYCHIATRIC		

Summary of Defects/Conditions and Diagnosis continued on back. ☐

Is there an Advance Directive, DNR order or Living Will on file? ☐ Yes ☐ No

If not, was inmate counseled regarding Advance Directives? ☐ Yes ☐ No Advance Care Plan (PH-4194) Provided? ☐ Yes ☐ No

HEALTH CLASSIFICATION BASED ON PHYSICAL EXAMINATION:

_____ _____

PRINTED NAME OF MEDICAL PROVIDER SIGNATURE OF MEDICAL PROVIDER

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

Summary of Defects/Conditions and Diagnosis

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH CLASSIFICATION SUMMARY

Name: _____ TOMIS#: _____ Date of Birth: _____

Physical Exam Date: _____ Dental Exam Date: _____

Allergies: _____

Health Classification (Code): _____

Code	Description
A	Class A – No Restrictions
B	Class B – Moderate Restrictions
C	Class C – Severe Restrictions

Level of Care (LOC): _____

Based on health record information provided by Mental Health Treatment Team

LOC 1	No Mental Health Services
LOC 2	Outpatient
LOC 3	Supportive Living Services (SLU) Moderate Impairment
LOC 4	Supportive Living Services (SLU) Severe Impairment
LOC 5	None

Clinical Alert: _____ Date: _____ Note: _____

Health Related Restrictions (Codes):_____
(Circle all applicable codes)

Code	Health Conditions
A	Visual Impairment
B	Hearing Impairment
C	Speech Impairment
D	Orthopedic Disease/Disorder ☐ Documented Hx of Back Problems
E	Amputation/Missing Extremity
F	Pregnancy ☐ 1st ☐ 2nd ☐ 3rd (Trimester)
G	Cancer
H	Asthma/Hay Fever
I	Allergies a) Drug _____ b) Other _____
J	Diabetes ☐ BS >300
K	Seizure Disorder
L	Cardiovascular Disease/Disorder
M	Hypertension
N	Pulmonary Disease/Disorder
P	Neurological Disease/Disorder ☐ Dementia
Q	Arthritis
R	Obesity (BMI >40)
S	Aging (>60)
T	Dermatological Disease/Disorder
U	Prosthetic Device Associated with Disability
V	(Specify)
W	Permanently confined to a Wheelchair/Mobility
X	Sleep Apnea
Y	G. U. Disease
Z	Surgery within last 6 months (abdominal, chest, back, or upper extremity)
AA	Other_____
BB	Acute Injury/Serious Medical Condition: Specify

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH CLASSIFICATION SUMMARY

Name: _____ TOMIS#: _____ Date of Birth: _____

Specific Restrictions (Codes): _____
(Circle all applicable codes)

Specific Accommodations (Codes): _____
(Circle all applicable codes)

Code	Restrictions
A	Complete bed rest or limited activity(C)
B	Sedentary work only-lifting 10 lbs. maximum, occasional walking or standing (C)
C	No heavy lifting-20lbs. maximum, able to frequently lift or carry objects up to 10 lbs. (B)
D	Light work only-lifting 50 lbs. maximum, able to frequently lift or carry objects weighing up to 20 lbs.(B)
E	Medium work only-lifting 100 lbs. maximum, able to frequently lift or carry objects weighing up to 50 lbs.(B)
F	Limited strenuous activity for extended periods of time:>1hr (B); 1hr (C); <1hr (C) Note:
G	Continuous standing or walking for extended periods of time:>1hr (B); 1hr (C); <1hr (C) Note:
H	Repetitive stooping or bending (B)
I	Acute need to be housed on first floor/bottom bunk(B)
J	Climbing and balancing (uneven ground) (B)
K	Exposure to loud noises or work detail with prolonged exposure (B)
L	Avoid areas or work details with exposure to skin irritants (B)
M	Participation in weight lifting or strenuous athletics(B)
N	Activity involving potentially dangerous machinery or equipment
O	Operation of motor vehicles (B)
P	Activity involving food preparation/handling (B)
Q	Prolonged exposure to sun or high temperatures (B)
R	Outside work detail during Spring or Summer (B)
S	Exposure to chemicals producing fumes or equipment producing dust (B)

Code	Accommodations
A	Prosthetic Limbs
B	Altered Accommodation (furniture, cell, etc.)
C	Air way assists (Oxygen, CPAP, BiPAP, etc.)
D	Sleeping Accommodation (pillow, blanket, mattress, etc.)
E	Ostomy Supplies
F	Catheter Supplies
G	Assist Devices (cane, crutches, walker, braces, wheel chair)
H	Inmate helper
I	Minimal Assistance for transporting in a van or bus
J	Wheel chair, bus or van required for transport
K	Non-emergency ambulance required for transport
L	Housed on first floor
M	Bottom bunk in housing assignment
N	Special footwear required

Notes:

_____

_____

_____

_____

_____ _____
Medical Practitioner Signature Date

REVIEWED

_____ _____
Medical Practitioner Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

IMMUNIZATION / TB CONTROL RECORD - INMATE

_____
INSTITUTION

NAME _____ TDOC NUMBER _____

IMMUNIZATIONS

DATE	VACCINE	DOSE	SIGNATURE

TUBERCLOSIS SCREENING AND SURVEILLANCE

INITIAL SCREENING: READ AFTER 48 – 72 HOURS

Tuberculin Test Date / Antigen / Method / Initials	Date Read / Initials	Reaction in MM	Chest X-Ray Date / Results	Preventive Treatment Started / Completed

PERIODIC SCREENING: READ AFTER 48 – 72 HOURS IN MM

TUBERCULOSIS SURVEILLANCE: FILL IN IF POSITIVE PPD OR IF DISEASE OCCURS

Bacteriologic Examination Date / Results	Diagnosis Date / Diagnosis	Treatment Started / Completed

TENNESSEE DEPARTMENT OF CORRECTION

CHRONIC DISEASE CLINIC
TREATMENT PLAN

Inmate Name _____

TDOC Number _____ Institution _____

LIST CHRONIC DISEASES

1) _____ 3) _____ 5) _____
2) _____ 4) _____ 6) _____

Either list or refer to pharmacy profile for current medications:

_____

***SUBJECTIVE*:**

Asthma: # attacks in last month? _____
short acting beta agonist canisters in last month? _____
times awakening with asthma symptoms per week? _____
CV/hypertension (Y/N): Chest pain? _____ SOB? _____ Palpitations? _____ Ankle edema? _____
HIV/HCV (Y/N): Nausea/vomiting? _____ Abdominal pain/swelling? _____ Diarrhea? _____ Rashes/lesions? _____

Seizure disorder: # seizures since last visit? _____
Diabetes mellitus: # hypoglycemic reactions since last visit? _____
Weight loss/gain ↑↓ _____ lbs.

For all diseases, since last visit, describe new symptoms:

_____

***OBJECTIVE*:**

Patient adherence (Y/N): with medications? _____ with diet? _____ with exercise? _____
Vital signs: Temp _____ BP _____ Pulse _____ Resp _____ Wt _____ PEFR _____ INR _____
Labs: Hgb A1C _____ HIV VL _____ CD4 _____ Total Chol _____ LDL _____ HDL _____ Trig _____
Range of fingerstick glucose/BP monitoring: _____

Physical Evaluation (PE): _____

HEENT/neck:	Extremities:
Heart:	Neurological:
Lungs:	GU/rectal:
Abdomen:	Other:

Additional Comments: _____

ASSESSMENT:	**Degree of Control***				**Clinical Status***			
	G	**F**	**P**	**NA**	**I**	**S**	**W**	**NA**
1 _____	☐	☐	☐	☐	☐	☐	☐	☐
2 _____	☐	☐	☐	☐	☐	☐	☐	☐
3 _____	☐	☐	☐	☐	☐	☐	☐	☐
4 _____	☐	☐	☐	☐	☐	☐	☐	☐

***Degree of Control**: *G-Good* *F-Fair* *P-Poor* *NA-Not Applicable*
***Clinical Status**: *I-Improved* *S-Same* *W-Worse* *NA-Not Applicable*

PLAN:

Medication changes:

Diagnostics: _____

Labs: _____

Monitoring: BP _____ x day/week/month Glucose _____ x day/week/month Peak flow _____ Other: _____

Education provided: ☐ Nutrition ☐ Exercise ☐ Smoking ☐ Test results ☐ Medication management ☐ Other: _____

Referral (list type): _____ Specialist: _____

days to next visit? ☐ 90 ☐ 60 ☐ 30 ☐ Other: _____ Discharged from Chronic Clinic (specify clinic): _____

Additional Comments: _____

_____ _____
Mid-Level / Physician Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

TEACHING/COUNSELING PLAN

Patient's Name

Subject

ELEMENT	DATES TAUGHT

Note: Each entry must be signed.

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ INMATE NUMBER: _____

DATE	TIME/PLACE	PROB NO.	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

INMATE NAME: _____ TDOC NUMBER _____ DOB _____

RECEIVING INSTITUTION: _____ DATE: ____/____/____ TIME: _____ a.m./p.m.

INITIAL INTAKE: _____ TEMPORARY TRANSFER: _____ PERMANENT TRANSFER: _____

INQUIRE:

1. Have you ever had a positive TB test? ☐ Yes ☐ No If **yes**, describe _____

2. Are you being treated for any illness or health problem (*including dental, venereal disease, or other infectious diseases*)?
   ☐ Yes ☐ No If **yes**, describe: _____

3. Do you have any physical, mental or dental complaints at this time? ☐ Yes ☐ No
   If **yes**, describe: _____

4. Are you currently taking any medication(s)? ☐ Yes ☐ No
   If **yes**, was the medication transferred with the inmate? ☐ Yes ☐ No
   If **yes**, describe (what used, how much, how often, date of last use, and any problems)

5. Have you recently or in the past, used alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No

6. Have you ever been hospitalized for using alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If **yes**, when? _____

7. Do you have any allergies? ☐ Yes ☐ No If **yes**, describe: _____

8. ***(For women)***
   a) LMP _____ b) Are you pregnant? ☐ Yes ☐ No Number of months _____
   c) Have you recently delivered? ☐ Yes ☐ No Date: _____
   d) Are you on birth control pills? ☐ Yes ☐ No
   e) Any gynecological problems? ☐ Yes ☐ No

9. Screening for MRSA Infections:
   a) Do you have any lesions, sores or insect bites? ☐ Yes ☐ No
   If **so**, do you have any open/draining lesions, sores, or insect bites? ☐ Yes ☐ No
   If **yes**, where are these lesions? _____

OBSERVE:

1. Behavior (including state of awareness, mental status, appearance, conduct, tremor and sweating):
   ☐ Normal ☐ Abnormal If **abnormal**, describe: _____

2. Skin Assessment (*including needle marks, trauma markings, bruises, lesions, jaundice, rashes, tattoos, and infestation(s)*
   ☐ Yes ☐ No
   If **yes**, describe: _____

3. Is there evidence of Abuse or Trauma? ☐ Yes ☐ No

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

MENTAL HEALTH:

1. Is the inmate presenting behavior(s) that are considered: ☐ Anxious ☐ Antagonistic/Hostile ☐ Hallucinations ☐ Withdrawn/Avoidant ☐ Depressed/Hopeless
2. Is the inmate presenting disorganized thought? (*Unable to track questions and/or present responses in logical or connected manner*) ☐ Yes ☐ No
3. Have you ever been in a mental hospital? ☐ Yes ☐ No
   If **yes**, when? _____ How often? _____
4. Have you ever been treated for mental health? ☐ Yes ☐ No
   Have you ever been treated for substance use? ☐ Yes ☐ No
5. Have you ever attempted to kill yourself? ☐ Yes ☐ No If **yes**, when? _____
   How? _____ How many times? _____
6. Are you thinking about suicide now? ☐ Yes ☐ No
7. Has a parent, other family member, or close friend committed suicide? ☐ Yes ☐ No If **yes**, who? _____
8.. Do you have a history of past or current head trauma? ☐ Yes ☐ No If **yes**, explain type of injury: _____
9.. As an adult or child, have you personally experienced being: ☐ Sexually abused ☐ Physically abused ☐ Emotionally abused

DISPOSITION:

_____ Intake housing _____ Intake housing with prompt referral appointment *(health, mental health, substance use treatment)*
_____ General housing _____ General housing with prompt/referral appointment
Referred to appropriate health, mental health or substance use provider due to emergency.
Additional comments on Progress Notes (CR-1884): ☐ Yes ☐ No

I have received information regarding the procedure for obtaining routine and emergency health care (*medical, dental, substance use, and/or mental health, and co-pay requirements*). These have been explained to me and I understand how to access healthcare services in the form of:

☐ **Orientation Handbook (i.e. Inmate Handbook)**
☐ **Information Sheet**
☐ **Transient inmate information-describing how to access healthcare**

_____
Inmate Signature

_____
Employee Name Printed

_____
Employee Signature and Title

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
CONSENT FOR TREATMENT

_____
INSTITUTION

Name: _____ Number: _____ Date of Birth: _____
Last First Middle

I hereby authorize _____ and assistants to perform the following operation, procedure,
(Practitioner)
treatment, or psychiatric intervention.

_____
Use Laymans Terms

_____

The nature and extent of the intended operation, procedure, treatment, or psychiatric intervention has been explained to me in detail. I have been advised by _____ of the following
(Practitioner)
alternatives, if any, probable consequences if I remain untreated, risks and possible complications of proposed treatment as indicated:

_____
(Use Layman's Terms)

_____

_____

I acknowledge that no guarantee or assurance has been made as to the result that may be obtained.

If any unforeseen condition arises in the course of the operation calling for the judgment of the practitioner for procedures in addition to or different from those now contemplated, I further request and authorize the practitioner to do whatever is deemed necessary.

I consent to the administration of anesthesia to be applied under the direction and supervision of _____.
(Practitioner)

I have read and fully understand the terms of this consent and acknowledge that the explanations referred to were made and that all blanks have been filled.

Date: _____ Time: _____ _____
(Signature of Patient)

Witness: _____ _____ _____
(Signature of Practitioner and Professional Title) Date

If the patient is a minor or incompetent to consent:

_____ Date: _____ Time: _____ a.m p.m.
(Signature of parent or person authorized to consent for patient)

Witness: _____ Witness: _____

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH TREATMENT PLAN

_____
INSTITUTION

INMATE: _____
NUMBER: _____
DATE OF BIRTH: _____
SEX: _____

DATE OF INITIAL PLAN: _____
TREATMENT PLAN REVIEW DUE ON: _____
☐ VOLUNTARY ☐ INVOLUNTARY ☐ LEVEL OF CARE
☐ INPATIENT ☐ OUTPATIENT
SPECIAL UNIT: SPECIFY: _____

LEVEL OF CARE: ☐ II ☐ III ☐ IV ☐ V

DSM-5 DIAGNOSIS:

TARGET SYMPTOMS/PROBLEMS:

1) _____
2) _____
3) _____
4) _____
5) _____

GOALS ACCORDING TO PROBLEM # ABOVE/INMATE RESPONSIBILITIES:

1) _____
2) _____
3) _____
4) _____
5) _____

TREATMENT MODALITY AND FREQUENCY TO ACHIEVE GOALS:

INMATE SIGNATURE / CONSERVATOR SIGNATURE	DATE
STAFF SIGNATURE TITLE	DATE
STAFF SIGNATURE TITLE	DATE
RECEIVING PROVIDER	DATE

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH TREATMENT REVIEW COMMITTEE
DEBERRY SPECIAL NEEDS FACILITY

INMATE NAME: _____ NUMBER: _____ DATE OF BIRTH: _____ SEX: _____

I. REPORT OF INITIAL PSYCHIATRIST'S MEETING WITH INMATE'S:

Initial Psychiatrist's Recommendation(s):

_____ _____
Inmate's Signature Date

_____ _____
Psychiatrist Signature Date

II. REPORT OF SECOND PSYCHIATRIST'S MEETING WITH INMATE:

Second Psychiatrist's Recommendation(s):

_____ _____
Inmate's Signature Date

_____ _____
Psychiatrist Signature Date

III. REPORT OF TREATMENT TEAM MEETING:

Treatment Team Recommendations(s):

Signature(s) of Treatment Team Member(s):	Date	Comments:
_____ Title		
_____ Title		
_____ Title		
_____ Title		

MENTAL HEALTH TREATMENT REVIEW COMMITTEE
DEBERRY SPECIAL NEEDS FACILITY

IV. REPORT OF TREATMENT REVIEW COMMITTEE:

Signature of Treatment Review Committee:	Date	Comments:
_____ Title	_____	_____
_____ Title	_____	_____
_____ Title	_____	_____

INMATE RIGHTS ADVOCATE COMMENT(S):

_____ Inmate Rights Advocate Signature

_____ Date

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH RECORDS MOVEMENT DOCUMENT

DESTINATION: _____

THIS PACKET CONTAINS HEALTH RECORDS ON THE FOLLOWING INMATE(S):

	Inmate Name	Number	CHECK ALL THAT APPLY: Health Record	Dental Record	Medication	* Purpose (Indicate **A, B, C** or **D**)
1.			☐	☐	☐	
2.			☐	☐	☐	
3.			☐	☐	☐	
4.			☐	☐	☐	
5.			☐	☐	☐	
6.			☐	☐	☐	
7.			☐	☐	☐	
8.			☐	☐	☐	
9.			☐	☐	☐	
10.			☐	☐	☐	

*** PURPOSE OF RECORDS MOVEMENT:**

A. Permanent Transfer **B.** Temporary Transfer for Clinical Services **C.** Record to Archives **D.** Other (*See Comments*)

Comments: _____

Sending Institution: _____ Date: _____

Prepared / Checked by: _____ Date: _____

Transported by: _____ Date: _____

Received by: _____ Date: _____

**** THIS DOCUMENT SHALL NOT CONTAIN PROTECTED HEALTH INFORMATION ****

CR-2176 (Rev. 11-09) RDA

White-Exterior Packet **Canary**-Exterior Packet **Pink**-Inside Records Packet **Goldenrod**-Sending Institution Medical Records Office

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To specify the responsibilities of the dental authority, to outline the range of dental services available to inmates (including intake dental screenings/examinations), to set guidelines in order to determine the dental classification system, and to identify treatment priorities.

III. APPLICATION: Wardens, Associate Wardens, Health Administrators, Dentists, dental care staff, medical contractors, and privately managed institutions.

IV. DEFINITIONS:

A. Adequate Mastication: The ability to chew food, as evidenced by an occlusion score of 16 points or more.

B. Dental Authority: The licensed dentist responsible for dental care to inmates and the supervision of dental staff within the institution.

C. Occlusion Score: The meeting of two opposing tooth surfaces with the total of occlusion points scored as follows:

1. Wisdom teeth = 0 points;
2. Occluding incisors or cuspids = 1 point, (i.e. #7 with #26 = 1 point);
3. Functioning Premolars = 2 points
4. Functional 1st or 2nd molars = 3 points, (i.e., #3 with #30 = 3 points).

V. POLICY: An initial dental examination shall be completed within 14 days of receipt into physical custody of the Tennessee Department of Correction (TDOC). Inmates shall be provided routine and emergency dental care as part of the institutional health care program according to priority of need.

VI. PROCEDURES:

A. Dental Staff:

1. The responsibilities of the dental authority shall include, but not be limited to:

a. Providing dental services in accordance with the Department's policies, OSHA standards, the American Dental Association's infection control guidelines, and regulations of the Tennessee Board of Dentistry.

b. Requesting dental specialty consultations for the appropriate care of the inmate, as needed.

c. Coordinating clinical schedules with the health administrator and institutional staff to ensure the delivery of dental care within the security constraints of the institution.

d. Ensuring continuity of care to all inmates permanently transferred to the facility according to priority of need.

2. The duties of dental assistants and dental hygienists shall be in accordance with the rules and regulations of the Tennessee Board of Dentistry. The dental authority shall supervise the assignment, duties, and clinical training (if necessary) of all dental staff.

B. Intake Dental Services: Dental services available through intake shall include the following:

1. Intake Dental Examination: Each inmate shall receive an examination by a dentist during the period of intake classification. The examination shall consist of a pan-oral x-ray to aid in the detection of abnormalities, and as needed, an intra-oral x-ray to aid in the detection of dental caries and other dental problems which will assist in the development of the treatment plan established by the dentist. The treatment plan is established to inform the inmate of his/her oral condition at the time of intake.

2. Dental treatment during the period of intake classification shall be limited to dental care requiring immediate attention, including instructions on basic oral hygiene and how to access dental services. Dental hygiene education shall initially be provided at intake and then subsequently by the dentist or designee as deemed necessary.

3. In accordance with Policy #113.62, reception centers shall provide dental prosthetics for inmates who require them and are permanently assigned to their institution.

C. General Dental Services:

1. Inmates shall access dental services by signing up for sick call. All dental staff shall provide dental services in accordance with the priorities outlined in Section (D) of this policy.

2. Scheduled Dental Treatment: Treatment shall be based on inmate needs as determined in the dental examination and according to the treatment priorities outlined in Section VI.(D) of this policy. Dental treatment shall include x-rays, restorative procedures, extractions, and dental specialties as defined in Policy #113.62.

3. Dental Sick Call: Dental complaints shall be presented during the regularly scheduled sick call visit and will be conducted by a nurse. The nurse shall refer such complaints to the institutional dentist as appropriate. The dentist will triage the complaints and provide treatment following recognized clinical priorities, making special effort to care for dental emergencies (Category I) during the established dental sick call period. Initial dental sick call visits are generally chargeable co-payment visits. (See Policy #113.15)

4. Emergency: Evaluative treatment of dental emergencies shall be available to inmates on a 24-hour basis. Such treatment may include:

   a. Relief of pain

   b. Emergency extractions

   c. Assessment of a fractured mandible with referral to an oral surgeon within 24 hours

   d. Control of bleeding and acute infection

5. Preventive: Oral hygiene supplies (e.g., toothbrush, toothpaste and dental floss-aids) shall be available to the inmates through the commissary unless prohibited for security and/or safety reasons.

D. Dental Classification System: After an examination by the dentist, each inmate's case shall be placed in a treatment category based on the results of the examination. The treatment category shall be recorded in the "Remarks" section of the Dental Record, CR-1889. Structuring priorities for dental care is not a replacement for professional dental judgment; rather, it is a guide for providing dental care to a specific population whose incarceration may place a time limitation upon available dental services. Every effort should be made to prioritize Category I inmates.

1. Category I. Very Urgent; Requiring Immediate Attention:

   a. Pain or acute infection
   b. Teeth obviously requiring extraction
   c. Suspected neoplasm
   d. Trauma, fractures
   e. Acute periodontal conditions
   f. Uncontrolled bleeding

2. Category II. Moderately Urgent; Requiring Early Treatment:

   a. Dental caries into or near pulp
   b. Extensive penetration of dental caries into dentin
   c. Insufficient teeth to provide adequate mastication
   d. Edentulous oral cavity
   e. Replacement of ill-fitting removable appliances

f. Heavy calculus causing pathology
g. Chronic infections
h. The presence of temporary restorations

3. Category III. Routine Dental Treatment:

a. Incipient dental caries
b. Periodontal treatment

4. Category IV. Maintenance care: No pressing requirement except for routine care and prophylaxis treatment. Category IV services shall only be provided after completion of services for Category I - III patients.

5. Category V. (Exempt conditions): These dental procedures shall not be provided to TDOC patients.

a. Third molars without pathology
b. Fixed prosthodontics (bridges/crowns)
c. Root canals
d. Implants
e. Bone grafts

E. Restorative Materials:

1. The permanent restorative materials of choice shall be silver amalgam and composites.

2. Temporary fillings shall be used for emergency fillings or where advisable due to the condition of the tooth.

3. Precious metals shall not be used.

F. Dental Records: Dental records are considered confidential and shall be maintained for each inmate as follows:

1. Dental staff shall record information gathered during the examination and ~~to~~ document the dental treatment plan on the Dental Record, CR-1889. All dental treatment and orders shall be legible.

2. In accordance with Policy #113.04, when an inmate is transferred to another Tennessee facility, the dental record shall be forwarded as part of the health record.

G. Dental Reports:

1. A daily work/encounter log shall be maintained for the dental clinic showing all dental work accomplished. The inmate's name, number, type of procedure, appointment time, and name of dental staff member(s) providing the service shall be recorded. All dental instruments utilized, including sharps, shall be documented on the encounter log. A separate log shall be maintained for the inventory, accountability and control of all sharps used in the dental clinic.

2. A report of dental activities shall be completed each month, using the Monthly Statistical Report, CR-2124. (See Policy #113.54) The dental authority or designee shall provide the institutional health administrator all data required for institutional or departmental reports.

H. Consent/Refusal of Dental Treatment:

1. Written consent is not required for routine procedures where consent is implied by the inmate presenting himself/herself for treatment.

2. The dentist shall have a Consent for Treatment, CR-1897, signed by the inmate prior to performing extractions or other oral surgical procedures. The consent shall be specific to the procedure to be performed and list alternatives and possible complications to surgery. (See Policy #113.51)

3. If an inmate refuses the treatment recommended by the dentist, he/she may be removed from the dental waiting list and be required to sign up for dental sick call to express his/her desire for dental treatment before being rescheduled. After being advised of the consequences of refusing services, the inmate shall sign a Refusal of Medical Services, CR-1984, which will then be filed with the dental records. (See Policy #113.51) These events shall be documented in the dental record as well as on the daily clinic log.

VII. ACA STANDARDS: 4-4381, 4-4365, and 4-4360.

VIII. EXPIRATION DATE: January 1, 2019.

914-D

STATE OF TENNESSEE

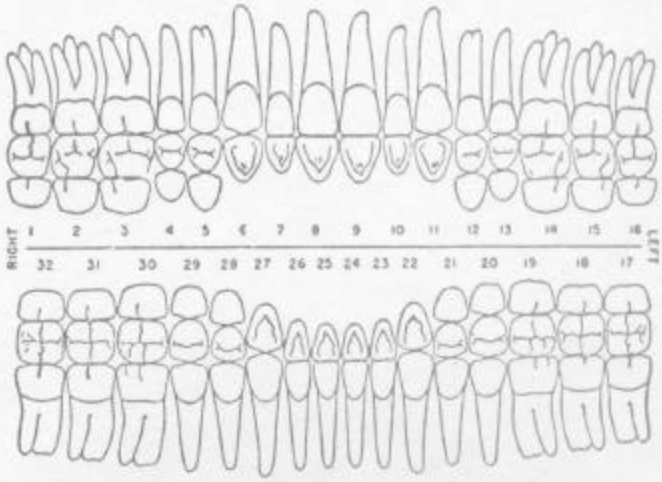
DEPARTMENT OF CORRECTION

DENTAL RECORD

SECTION 1. DENTAL EXAMINATION

PURPOSE OF EXAMINATION

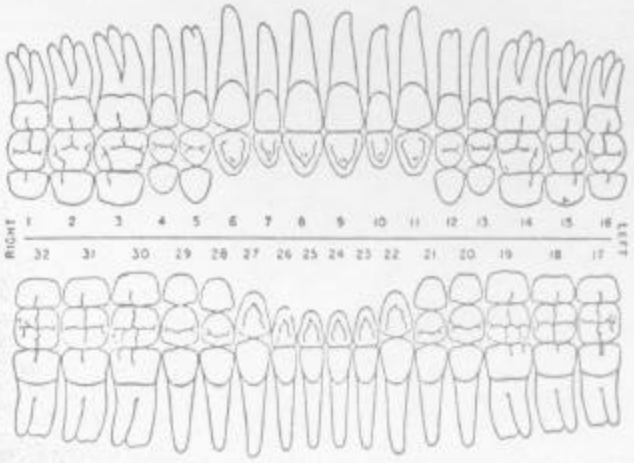
1. MISSING TEETH AND EXISTING RESTORATIONS



REMARKS:

SIGNATURE OF DENTIST COMPLETING THIS SECTION | DATE

2. DISEASES, ABNORMALITIES, AND X-RAYS



A. CALCULUS

	SLIGHT		MODERATE		HEAVY

B. PERIODONTOCLASIA

	LOCAL		GENERAL

	INCIPIENT		MODERATE		SEVERE

C. STOMATITIS (*Specify*)

	GINGIVITIS		VINCENT'S ANGINA

D. DENTURES NEEDED
(*Include dentures needed after indicated extractions*)

FULL		PARTIAL	
U	L	U	L

ABNORMALITIES OF OCCLUSION—REMARKS:

3. INDICATE X-RAYS USED IN THIS EXAMINATION

	FULL MOUTH PERIAPICAL		POSTERIOR BITE-WINGS		OTHER (*Specify*)

SIGNATURE OF DENTIST COMPLETING THIS SECTION | DATE

DATE | NAME OF HOSPITAL

PATIENT'S NAME | REGISTER NO. | WARD

LAST NAME | FIRST NAME | MIDDLE NAME

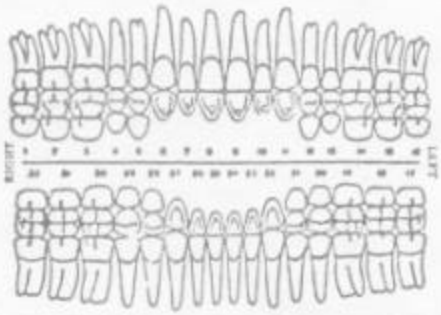
(USE BOTH SIDES)

CR-1889

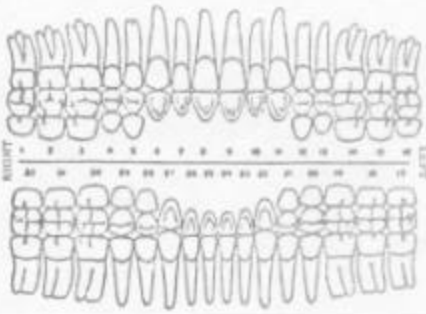
RDA-1458

SECTION II ATTENDANCE RECORD

I. RESTORATIONS AND TREATMENT—Completed during examination



SUBSEQUENT DISEASE AND ABNORMALITIES



REMARKS:

DATE	SERVICES PROVIDED	OPERATOR

5/17/2012

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TENNESSEE DEPARTMENT OF CORRECTION
2012 MONTHLY STATISTICAL REPOR

INSTITUTION -

	Monthly Data:	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL/AVG
2														
3	AVERAGE DAILY POPULATION (ADP):													#DIV/0!
4	PERIODIC HEALTH APPRAISALS AND PHYSICAL EXAMS													
5	Number of intake physical exams completed this month													0
6	Number of periodic health appraisals completed this month													0
7	MRSA/MDRO													
8	(1A1) Number of offenders newly diagnosed with MRSA infection this month													0
9	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
10	TUBERCULOSIS													
11	(1A2) Number of offenders newly diagnosed with active tuberculosis this month	0												0
12	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
13	(1A3) Number of offenders who are new converters on a TB skin test (TST) that indicates newly acquired TB infection	0												0
14	Number of offenders administered skin tests for TB (TST) as part of annual, periodic, or clinically based testing but not intake screening													0
15	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
16	Number of offenders administered skin tests for TB (TST) as part of intake screening only													0
17	Total skin tests for TB (TSTs)													0
18	(1A4) Number of offenders who completed treatment for latent tuberculosis infection													0
19	Number of new offenders treated for latent tuberculosis infection (initiated this month)													0
20	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
21	HEPATITIS													
22	(1A5) Number of offenders diagnosed with Hepatitis C viral infection													#DIV/0!
23	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
24	Number of offenders with Hepatitis C viral infection being treated with antiretroviral treatment													#DIV/0!
25	Number of offenders diagnosed with Hepatitis A viral infection (New cases only)	0												0
26	Number of offenders diagnosed with Hepatitis B viral infection (New cases only)	0												0
27	Number of Hepatitis B vaccines administered													0
28	HIV/AIDS													
29	(1A6) Number of offenders diagnosed with HIV infection (excluding AIDS)													#DIV/0!
30	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
31	(1A7) Number of offenders with HIV infection who are being treated with highly active antiretroviral treatment (HAART)													#DIV/0!
32	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
33	(1A8) Number of selected offenders with HIV infection who have been on antiretroviral therapy for at least six months with a viral load of GREATER than 50 cps/ml													0
34	Total number of treated offenders with HIV infection who were reviewed													0
35	ACA Calculated Outcome Measure								#DIV/0!					#DIV/0!
36	Total number of confirmed cases of AIDS													#DIV/0!
37	Total number of offenders diagnosed with HIV/AIDS	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!

Calculated O.M.= Calculated Outcome Measure

5/17/2012

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TENNESSEE DEPARTMENT OF CORRECTION
2012 MONTHLY STATISTICAL REPOR

INSTITUTION

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1	Monthly Data:	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL/AVG
38	SEXUALLY TRAMSMITTED DISEASES (STDs)													
39	Number of offenders diagnosed with syphilis this month	0												0
40	Number of offenders diagnosed with gonorrhea this month	0												0
41	Number of offenders diagnosed with chlamydia this month	0												0
42	Number of offenders diagnosed with other STDs this month	0												0
43	INFLUENZA													
44	Number of offenders with confirmed diagnosis of influenza (New cases only)	0												0
45	OTHER INFECTIONS													
46	Number of offenders diagnosed with scabies	0												0
47	MENTAL HEALTH													
48	(1A9) Number of offenders diagnosed with an Axis I disorder (excluding sole diagnosis of substance abuse)													#DIV/0!
49	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
50	SICK CALL ENCOUNTERS													
51	Number of NURSE Sick Call encounters													0
52	Nurse encounters per 500 inmate population	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
52	Number of MID-LEVEL Sick Call encounters	0												0
52	Mid-level encounters per 500 inmate population	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
52	Number of PHYSICIAN Sick Call encounters	0												0
52	Physician encounters per 500 inmate population	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
52	Total Sick Call encounters	0	0	0	0	0	0	0	0	0	0	0	0	0
52	Total Sick Call encounters per 500 inmate population	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
52	CHRONIC CARE CLINIC ENCOUNTERS													
52	Number of NURSE Chronic Care Clinic encounters	0												0
52	Nurse encounters per 500 inmate population	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
52	Number of MID-LEVEL Chronic Care Clinic encounters													0
52	Mid-level encounters per 500 inmate population	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
53	Number of PHYSICIAN Chronic Care Clinic encounters													0
54	Physician encounters per 500 inmate population	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
55	Total Chronic Care Clinic encounters	0	0	0	0	0	0	0	0	0	0	0	0	0
55	Total Chronic Care Clinic encounters per 500 inmate population	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
56	CONSULTS													
57	Number of specialty referrals (on-site or off-site)ordered by primary health care practitioners													0
58	(1A12) Number of offender specialty referralscompleted													0
59	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
60	LABORATORY DIAGNOSTIC TESTING													
61	Number of laboratory tests completedonsite (ACA standard 4-4409)													0
62	Number of laboratory tests referred to an off site laboratory (ACA standard 4-4409)													0

Calculated O.M.= Calculated Outcome Measure

TENNESSEE DEPARTMENT OF CORRECTION
2012 MONTHLY STATISTICAL REPOR

INSTITUTION

1	Monthly Data:	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL/AVG
64	HYPERTENSION													
65	(1A13) Number of selected hypertensive offenders with blood pressure reading > 140/> 90 mmHg													0
66	Total number of offenders with hypertension who were reviewed													0
67	ACA Calculated Outcome Measure				#DIV/0!									#DIV/0!
68	DIABETES													
69	(1A14) Number of selected diabetic offenders who are under treatment for at least six months with a hemoglobin A1C level measuring greater than 9 percent													0
70	Total number of diabetic offenders who were reviewed													0
71	ACA Calculated Outcome Measure											#DIV/0!		#DIV/0!
72	DENTAL													
73	(1A14) Number of completed dental treatment plans													0
74	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
75	EMPLOYEE CREDENTIALS													
76	(2A1) Number of health care staff with lapsed licensure or certification	0												0
77	Number of licensed or certified staff													#DIV/0!
78	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
79	(2A2) Number of new health care staff who completed orientation training prior to undertaking their new job													0
80	Number of new health care staff													0
81	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
82	EMPLOYEE BLOOD BORNE PATHOGEN AND TB EXPOSURES													
83	(2A3) Number of occupational (employee) exposures to blood/potentially infectious materials													0
84	Total number of employees													#DIV/0!
85	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
86	(2A4) Number of direct care staff (employees and contractors) with a conversion of a TB skin test (TST) that indicates a newly acquired TB infection	0												0
87	Number of direct care staff tested (TST) for TB infection during periodic or clinically indicated evaluations													0
88	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Calculated O.M.= Calculated Outcome Measure

TENNESSEE DEPARTMENT OF CORRECTION
2012 MONTHLY STATISTICAL REPOR

INSTITUTION

1	Monthly Data:	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL/AVG
89	**GRIEVANCES**													
90	(3A1) Number of offender grievances related to health care services found in favor of the offender	0												0
91	Total number of evaluated offender grievances related to health care services													0
92	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
93	(3A2) Number of offender grievances related to safety or sanitation sustained	0												0
94	Total number of evaluated offender grievances related to safety or sanitation	0												0
95	ACA Calculated Outcome Measure	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
96	(3A3) Number of adjudicated offender lawsuits related to the delivery of heath care found in favor of the offender	0												0
97	Total number of offender adjudicated lawsuits related to health care delivery	0												0
98	ACA Calculated Outcome Measure	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
99	**CQI**													
100	(4A1) Number of problems identified by the CQI program that were corrected	0												0
101	Total number of problems identified by the CQI program													0
102	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
103	(4A2) Number of high-risk events or adverse outcomes identified by the CQI program													0
104	Number of serious injuries or illnesses requiring medical attention (ACA Standard 4409)													0
105	**DEATHS**													
106	(4A3) Number of offender suicide attempts	0												0
107	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
108	(4A4) Number of offender suicides completed	0												0
109	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
110	(4A5) Number of unexpected natural deaths	0												0
111	Number of all other deaths (excluding completed suicides & unexpected natural deaths)	0												0
112	Total number of deaths	0	0	0	0	0	0	0	0	0	0	0	0	0
113	ACA Calculated Outcome Measure	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
114	**PHARMACY**													
115	Number of prescriptions written (ACA Standard 4-4409)													0
116	(4A6) Number of serious medication errors	0												0
117	Number of inmates on prescribed medications													#DIV/0!

Calculated O.M.= Calculated Outcome Measure

TENNESSEE DEPARTMENT OF CORRECTION
2012 MONTHLY STATISTICAL REPOR

INSTITUTION

1	Monthly Data:	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL/AVG
118	**WOMEN'S SPECIALTY SERVICES (TPFW and MLCC ONLY)**													
120	Number of pregnant inmates	0												0
121	Number of live births via vaginal delivery	0												0
122	Number of live births via C-section delivery	0												0
123	Number of miscarriages/spontaneous abortions	0												0
124	Total number of live births	0	0	0	0	0	0	0	0	0	0	0	0	0
125	Number of mamograms completed this month (onsite)	0												0
127	**SPECIALTY CLINICS AND SERVICES (DSNF ONLY)**													
129	Total number of offenders undergoing dialysis	0	0	0	0	0	0	0	0	0	0	0	0	0
130	Males	0												0
131	Females	0												0
132	Number of on-site dialysis treatments this month	0												0
133	Number of physical therapy visits this month	0												0
134	Number of infectious disease consultations this month	0												0
135	Number of oral surgery consultations/procedures this month	0												0
136	Number of podiatry consultations/procedures this month	0												0
	DIAGNOSTIC IMAGING SERVICES (ON-SITE ONLY)													
139	Number of Ultra Sounds completed onsite this month	0												0
141	Number of x-rays completed onsite this month (ACA standard 4-4409)													0
142	**OFF-SITE HOSPITAL ADMISSIONS / ER TRANSPORTS**													
143	(1A11) Number of offenders transported off-site for treatment of emergency health conditions													0
144	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
145	(1A10) Number of offender admissions to off-site hospitals													0
146	ACA Calculated Outcome Measure	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
147	**ON-SITE INFIRMARY ADMISSIONS (Excluding MLCC, CBCX, STSRCF)**													
148	Number of MEDICAL infirmary admissions													0
149	Number of MENTAL HEALTH infirmary admissions													0
150	Number of SECURITY related infirmary admissions													0
151	Total number of infirmary admissions	0	0	0	0	0	0	0	0	0	0	0	0	0
152	Total number of infirmary in-patient days													0
153	Infirmary Average Length of Stay (days)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Calculated O.M.= Calculated Outcome Measure

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
CONSENT FOR TREATMENT

_____
INSTITUTION

Name: _____ Number: _____ Date of Birth: _____
Last First Middle

I hereby authorize _____ and assistants to perform the following operation, procedure,
(Practitioner)
treatment, or psychiatric intervention.

_____
Use Laymans Terms

_____

The nature and extent of the intended operation, procedure, treatment, or psychiatric intervention has been explained to me in detail. I have been advised by _____ of the following
(Practitioner)
alternatives, if any, probable consequences if I remain untreated, risks and possible complications of proposed treatment as indicated:

_____
(Use Layman's Terms)

_____

_____

I acknowledge that no guarantee or assurance has been made as to the result that may be obtained.

If any unforeseen condition arises in the course of the operation calling for the judgment of the practitioner for procedures in addition to or different from those now contemplated, I further request and authorize the practitioner to do whatever is deemed necessary.

I consent to the administration of anesthesia to be applied under the direction and supervision of _____.
(Practitioner)

I have read and fully understand the terms of this consent and acknowledge that the explanations referred to were made and that all blanks have been filled.

Date: _____ Time: _____ _____
(Signature of Patient)

Witness: _____ _____ _____
(Signature of Practitioner and Professional Title) Date

If the patient is a minor or incompetent to consent:

_____ Date: _____ Time: _____ a.m p.m.
(Signature of parent or person authorized to consent for patient)

Witness: _____ Witness: _____

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

REFUSAL OF MEDICAL SERVICES

INSTITUTION _____

Date _____ 20 _____ Time _____ AM/PM

This is to certify that I _____, _____
(Inmate's Name) (TDOC Number)
have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

_____

_____

_____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: _____ _____ _____
(Inmate) (TDOC number) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

The above information has been read and explained to,

_____ _____ but has refused to sign
(Inmate's Name) (TDOC number)
the form.

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.62	Page 1 of 2
	Effective Date: June 15, 2015	
	Distribution: A	
	Supersedes: 113.62 (1/1/12)	
Approved by:		
Subject: DENTAL SPECIALTIES		

I. AUTHORITY: TCA 4-3-603 and TCA-4-3-606.

II. PURPOSE: To provide guidelines for the provision of dental specialty services.

III. APPLICATION: Wardens, Associate Wardens, Health Administrators, Dentists, inmates, the medical contractor, and privately managed institutions.

IV. DEFINITIONS:

A. Dental Authority: The licensed dentist responsible for dental care to inmates and the supervision of dental staff within the institution.

B. Utilization Management Entity (UME): The person(s) or contractor(s) designated by the Tennessee Department of Correction (TDOC) to review, approve, deny, or defer requests for specialty dental consultations.

V. POLICY: Specialty dental consultation, examination, and/or treatment shall be provided when the health of the inmate would otherwise be adversely affected or when the inmate cannot masticate sufficiently to eat a regular diet. Such consultation or treatment shall be based on the recommendation of the dental authority.

VI. PROCEDURES:

A. Fixed Dental Prosthesis: Dentists shall not use precious metals for fixed prosthetic appliances, unless there is no alternative and the inmate's health would otherwise be adversely affected. Before fabrication of a fixed prosthesis or use of a precious metal, the dentist must receive written approval from the UME.

B. Removable Dental Prosthesis:

1. Dental prostheses shall be provided when the health of the inmate would otherwise be adversely affected or when the inmate cannot masticate adequately to eat a regular diet, as determined by the dental authority. (See Policy #113.60 for definition of adequate mastication and occlusion score). Dentures shall only be fabricated if it is determined that the inmate has adequate bone structure to accommodate/support removable dental prostheses.

2. Partial dentures shall be restricted to usage in cases where the number of remaining teeth is insufficient to provide for mastication and the use of a full denture is not indicated. The construction of partial denture(s) shall not be for cosmetic purposes. Removable partial dentures shall not have a metal base.

3. All full dentures made for inmates shall have the name and number of the recipient imprinted for proper identification; partial dentures shall be so imprinted if the partial is large enough.

C. Oral Surgery: Conditions requiring the consultation and treatment of an oral surgeon shall be provided as deemed necessary by the attending dentist upon approval of the UME. Oral surgery for cosmetic purposes shall not be performed.

D. Orthodontics: Orthodontic care is generally considered elective and is not available for inmates. However, if the dentist determines that certain orthodontia is necessary for an inmate's health, it may be provided if approved by the UME.

E. Endodontics: Root canal therapy may be performed when deemed necessary by the dentist. Such procedures shall be limited to anterior teeth crucial to arch integrity, if tooth structure and bony support permits.

F. Periodontics: Periodontal treatment may be performed by the dentist when the prognosis is favorable, the consent of the inmate has been obtained, and the treatment is necessary to prevent significant tooth loss or gum disease.

G. Specialty dental services which are beyond the capability of the institution may be provided at DeBerry Special Needs Facility upon approval by the UME.

VII. ACA STANDARDS: 4-4360, 4-4375, and 4-4398.

VIII. EXPIRATION DATE: June 15, 2018.

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To ensure compliance with state and federal laws governing pharmaceuticals and to promote management of pharmaceuticals in accordance with professional standards of care and sound security practices.

III. APPLICATION: Wardens, Associate Wardens of Treatment (AWT), Health Administrators, all health services staff, medical contractors, and privately managed institutions.

IV. DEFINITIONS:

A. Administer: The direct application of a drug to an inmate by injection, inhalation, ingestion, topical application or any other means.

B. Controlled Substance: A drug, substance, or immediate precursor included in Schedules I through V of the Federal Drug Enforcement Agency's Controlled Substances Act.

C. Discontinued Medication: A medication order stopped by the prescribing provider.

D. Dispensing Medication: The act of packaging a legend drug, either from a bulk container or as a result of compounding, in a container other than the original container of the manufacturer or distributor, and labeling the new container with all the information required by state and federal law.

E. Distribution of Medication: The transfer of prepackaged or labeled medications to an individual for self-administration according to directions provided by the prescribing practitioner.

F. Keep on Person (KOP): Medication approved to be kept in an inmate's possession for the purpose of self-administration.

G. Legend Drug: Any drug or medication which federal law prohibits dispensing without a prescription.

H. Medication Expiration Date: The date that the drug is no longer effective.

I. Mid-Level Provider: A clinical professional with advanced practice training that legally authorizes him/her to treat inmates and prescribe mediation under protocols developed by his/her supervising physician. Mid-level providers may include a physician assistant certified (PA-C), a nurse practitioner, or a clinical nurse specialist (CNS) with a master level of training and a certificate of fitness, or doctorate.

J. Non-Renewed Medications: Medication order that is not re-written upon expiration of the current medication order.

K. Over-the-Counter Medications (OTC) Drug: Any drug or substance which can be legally obtained without a prescription.

L. Par levels: The maximum quantity of emergency medications, stock medications, and medications utilized for nursing protocols authorized by the TDOC Pharmacy and Therapeutics Committee to be stocked at the institution.

M. Perpetual Inventory System: Continuous process for recording the receipt and issuance/ removal of medications and medical supplies. For the purposes of this policy, the essential elements of a perpetual inventory system are an adequate description of the items, the date on which the items are received and placed into inventory, the quantity (units) received, the date items are issued/removed or used, the quantity (units) issued/removed or used, the disposition of the items, and the balance on hand.

N. Stop Date/Discontinue Date: Date the prescribing provider schedules a medication order to be discontinued or renewed.

V. POLICY: All correctional facilities shall manage the medication used within the facility in accordance with professional standards of care, good security practice, and the appropriate state and federal laws and regulations.

VI. PROCEDURES:

A. *Health Services Unit Manual*: Each correctional institution shall maintain a health services unit manual including written procedures describing the management of pharmaceuticals. It shall be approved by the Health Services Administrator, AWT, and the Warden and shall include provisions for the following:

1. Storage: The procedure(s) shall identify and describe the secured storage area provided for pharmaceuticals, and shall provide for safe storage of flammable, toxic, and caustic materials in accordance with Policy #112.09.

2. Keys: The procedure(s) shall restrict the use of keys and identify staff members who have approved access to the secured storage area.

3. Inventory: The procedure(s) shall require an accurate perpetual inventory of items covering the following:

   a. Products containing alcohol
   b. Controlled substances
   c. Emergency medications
   d. Flammables
   e. Stock medications

4. Medication Records: The procedure(s) shall require that medication records, with appropriate dates and signatures, are maintained in accordance with the most current operating procedures manual issued by the pharmacy. Medication records shall include:

    a. Medication order forms
    b. Items received at the institution (manifest reports)
    c. Discontinued medications destruction forms

5. Discontinued Medications: The procedure(s) shall describe the process for the return or disposal of discontinued medications in accordance with the Tennessee Board of Pharmacy laws and regulations. A record shall be maintained of all medication disposals.

6. Controlled Substances: The procedure(s) shall delineate, in detail, management of controlled substances: e.g., the ordering and receiving process; inventory and counting procedures; means for staff accountability when doses are ordered, received, counted, discontinued, wasted, lost, dropped, broken, etc.; and any other institutional specific procedure(s) as identified.

7. Monitoring Audits: The procedure(s) shall describe the auditing system used within the health care unit to ensure compliance with departmental policy.

B. Pharmacy Contractors: The pharmacy contractor shall provide a pharmacist who shall make documented inspections, at least monthly, of all drugs and pharmaceutical materials kept in the institution, in accordance with state laws. This inspection shall include, but not be limited to, a review of opened medications, expiration dates, destruction of discontinued/outdated controlled medications, and other pertinent information and materials. The pharmacist may also review selected Medication Administration Records (MARs) and/or health records to perform a drug utilization review. Inspection records shall be dated, signed, and maintained by the institutional health administrator and pharmacy for at least two years.

C. Prescribing of Medication: Medications shall be administered to inmates only on the order of a licensed physician or dentist. However, a physician may delegate the prescribing of certain medications to a mid-level provider under the following conditions:

1. There exists a joint practice agreement and clinical protocols signed by the preceptor physician which authorizes a mid-level provider to prescribe certain medications. (See Policy #113.11)

2. The joint practice agreement specifies that all drug orders dispensed and administered/distributed according to clinical protocol, from stock medication (non-patient-specific), shall be countersigned and dated by the sponsor physician within a reasonable period of time not to exceed 14 days.

3. Controlled substances may be prescribed by a mid-level provider under the supervision of a licensed physician if the mid-level has a current DEA number.

4. Prior to the prescribing of chronic care, or non-formulary medications the provider must review the MAR.

5. All OTC medications listed on the approved OTC list, and available at the site, shall be obtained by the inmate via commissary, unless the inmate is determined to be indigent by the Health Services Administrator, or their designee.

   When inmates are determined to be indigent, OTC medications shall be written for 30 days, unless written based on clinical practice guidelines for a diagnosed medical condition.

6. Psychotropic medications may be prescribed by a mid-level provider operating under the supervision of a psychiatrist. The prescribing of medications to treat behavioral health disorders may be delegated to a mid-level provider (See Policy #113.11) under the supervision of a Board certified or eligible psychiatrist.

7. Prescriptions for inmates shall be documented on Physician's Orders, CR-1892, or an alternative form as approved by the Director of Clinical Services and/or designee.

8. All prescribed medication orders must include a diagnosis and stop date before being filled by the contractor. The prescribing diagnosis must be documented in the patient record by the ordering provider.

9. Non-formulary approval is required for prescribing more than two psychotropic medications in the same class regardless of the generation.

D. Substitutions of Equivalent Drug Products:

1. No substitutions for the specific medicine mentioned in the provider's prescription are allowed other than therapeutically equivalent drug product(s) containing the same active ingredient(s), dosage form, and strength as provided by state law.

2. All non-formulary requests (approved or denied) shall be maintained with the physician's order in the inmate's health record.

3. Any formularies used for TDOC inmates are subject to the approval of the TDOC Director of Clinical Services in consultation with the State Pharmacy and Therapeutics Committee.

E. Duration of Therapy: Each inmate's prescription(s) shall be periodically reviewed to ensure the appropriate medication therapy. Inmates with long term medication requirements shall have their medication reviewed by a physician, dentist, or mid-level provider at least every six months and the medication(s) reordered, changed, or discontinued as appropriate. All new medication orders shall include a prescription duration not to exceed six months (i.e., the order and up to five refills). If no duration is specified, prior to the nurse transcribing the order, or the contract pharmacy filling the prescription, the ordering provider shall be contacted to clarify the stop date. The stop

date shall be designated by the ordering provider before the medication is administered. Limitations on the quantities of certain specified narcotic pain medications maybe set by the TDOC Pharmacy and Therapeutics Committee. Such limitations will be noted in the approved formulary.

F. Controlled Medication Procedures:

1. Controlled medications shall be administered only on the order of a licensed physician or dentist. A mid-level provider may order only those controlled medications specifically listed in the protocols approved by their supervising physician. All practitioners who prescribe controlled medications must be individually registered under applicable federal and state laws. Practitioners' DEA numbers must be maintained on file at the institution and a signature card bearing the practitioner's full name, specialty, and DEA number shall be maintained by the pharmacy.

2. Controlled medications shall be administered only on a dose-by-dose basis crushed and under water, unless contraindicated, or administration is verified by the provider, and under no circumstances shall an inmate be provided multiple doses for self-administration. Any other medications considered to be of high abuse potential as determined by the Pharmacy & Therapeutics Committee, shall be handled in a similar manner.

3. The CR-2264 or other approved contractor form shall be properly annotated by the responsible licensed nurse each time one or more doses of a controlled drug are removed from the supply or storage location.

4. Controlled medications may only be continued by obtaining a written or phone order from the prescribing provider or an institutional physician. Orders expiring prior to the prescribing provider's scheduled visit may be continued via a telephone order until he/she is able to examine the inmate. Verification of a prescription shall consist of checking the health record for a valid order/prescription for each medication and/or following the procedures outlined in Section VI.(F) of this policy.

5. Perpetual Inventory

   a. A perpetual inventory for controlled medications kept as stock shall be maintained by health services staff on a Control Drug Administration Record, CR-2264 or other approved contractor form.

   b. If a controlled medication is prescribed for a specific inmate, a perpetual inventory shall be initiated and maintained for that medication on the CR-2264 or other approved contractor form.

   c. One licensed nurse going off duty and one licensed nurse coming on duty shall inventory and initial/sign the CR-2264 or other approved contractor form at the change of each shift.

d. Each institution shall have specific procedures for the counts of controlled drugs on each shift. Discrepancies in the controlled drug inventory shall be immediately reported to the Health Administrator, the AWT, and the TDOC Director of Clinical Services or their designee, verbally, followed by a written report to the TDOC Director of Nursing or their designee.

G. Psychotropic Medication Procedures

1. Medications prescribed to treat behavioral health disorders shall be prescribed only by a psychiatrist or mid-level provider after physically examining the inmate and after reviewing the health record and ordering diagnostic testing, if necessary. In emergency psychiatric situations, a phone order may be obtained from the psychiatrist by a licensed nurse.

2. Psychotropic drugs shall be prescribed only when clinically indicated as one facet of a program of treatment or therapy. Under no circumstances shall any medication be prescribed and/or administered for chemical restraints, programmatic control, experimentation, or research.

H. Emergency and Stock Drug Procedures:

1. Each TDOC institution shall maintain the TDOC Universal Stock Medication List, approved annually by the TDOC Pharmacy and Therapeutics Committee.

2. The TDOC Director of Clinical Services in consultation with the State Pharmacy and Therapeutics Committee shall approve a list of medications to be utilized for nursing protocols. Privately managed facilities shall maintain an emergency and stock medications list approved annually by the Director of Clinical Services.

3. Facilities are not required to stock all medications on the TDOC Universal Stock Medication List; nor are the medications required to be stocked at maximum par levels.

4. Emergency medications shall be securely maintained in the health services clinic emergency/treatment area in a mobile crash-cart. The stock medications kept on hand shall be securely maintained in the medication preparation room in a secure cabinet or mobile medication cart.

5. Perpetual inventories shall be maintained by the health care staff for medications utilized for nursing protocols, emergency medications, and stock medications and reconciled at least twice a month. When emergency medication is used, a re-order shall occur within 72 hours. Stock medications shall be signed out when issued (or removed for any reason) and reordered or disposed of per institutional and pharmacy procedures.

6. The nurse shall receive a physician’s order for all administered emergency (including emergency nursing protocol medications) and stock medications within 72 hours (excluding weekends and holidays).

7. Under no circumstances shall a facility procure or maintain bulk stocks of prescription medications. Stock medication shall be appropriately packaged and labeled by the sending pharmacy and ordered from a list approved by the TDOC Pharmacy and Therapeutics Committee.

I. Storage of Medications:

1. There shall be a secure area designated for storage of all medication that is physically separate from other health care areas. The medication storage room shall be located in an area which is not accessible to inmates or unauthorized personnel and which provides for adequate security of the drugs. Access to medications shall be limited to health care personnel, as authorized by the health administrator.

2. The drug storage area must be temperature controlled at 68-77 degrees F. Insulin and other medications requiring refrigeration shall be stored in a locked or secure refrigerator at 36-46 degrees F. The refrigerator used for drug storage shall not be used for food, lab specimens, or other storage. Light sensitive drugs shall be stored in opaque or amber containers.

3. Controlled substances and narcotics must be stored in double locked cabinets in a locked room, to ensure maximum security and control.

4. Over-the-counter drugs and/or prescription medications may be stored in limited supply in examination rooms, emergency rooms, and/or other designated areas as authorized by the Health Administrator, AWT, and the Warden.

5. External preparations shall be stored separately from oral preparations, and ear (otic) preparations shall be stored separately from eye (ophthalmic) preparations. All drugs must be in secure containers and clearly labeled.

J. Conformance with Practitioners' Prescription Medication Orders:

1. The attending physician, dentist, or mid-level provider shall be notified by the medication nurse of an automatic stop order prior to the last dose so that the prescriber may decide if the order/prescription for the drug is to be continued or altered.

2. The provider's verbal/telephone orders for drugs shall be given only to licensed nurse, pharmacist, or mid-level provider, immediately recorded and signed and dated with in 14 days, in the health record on Physician's Orders, CR-1892. Telephone orders for Schedule II drugs are permitted only in the case of an actual emergency situation. Telephone orders for Schedule II drugs shall be signed by the physician and received by the dispensing pharmacist within 72 hours.

3. Medication and Treatment Errors/Omissions, CR-1891, shall be completed in each case of medication administration/distribution error or omission. The nurse responsible for the error or finding the error, or the supervising nurse, shall document the error. The nurse that finds the error shall ensure that the inmate is not in danger of an adverse reaction related to the error, and report the error to the prescriber. The CR-1891 shall not be placed in the health record. The Health Services Administrator or Director of Nursing shall utilize this confidential information for Continuous Quality Improvement (CQI) and risk management.

4. Dispensing or delivery errors shall be documented and the dispensing pharmacy notified. The Health Administrator shall retain a copy of any dispensing and/or delivery error forms for use in CQI studies. A copy of dispensing or delivery error(s) documentation shall be promptly sent to the Statewide Continuous Quality Improvement Coordinator (SCQIC).

5. The contract pharmacy shall be given written notification of adverse reactions. When a medication is obtained from a local pharmacy and a severe adverse reaction occurs, that pharmacy shall be notified in writing. The Health Administrator shall retain a copy of these notifications for use in CQI studies.

K. Disposition of Medications:

1. Intake: Prescription medications brought in with the inmate at intake may be administered upon health professionals' confirmation that:

   a. The drug can be identified by a registered nurse, licensed practical nurse, physician, or pharmacist.

   b. The container is airtight, light resistant (if applicable), and appropriately labeled with the name, strength of the drug, name and address of the dispensing pharmacy or practitioner, dispensing date, stop date, and directions for use. The nurse identifying the medication shall consult with the facility primary care provider and obtain an order prior to administration of the medication.

   c. Prescriptions that have not met their labeled expiration date (i.e., ointments, inhalers, etc.) and/or have a relatively recent dispensing date (six months) give reasonable assurance of stated potency.

   d. The manufacturer's identification codes for oral solids are verified against the labeled drug name and strength prior to administration.

   e Written or telephone orders are obtained from the responsible practitioner for any medication for which appropriateness is doubted.

2. A licensed nurse shall contact the institutional primary care physician or psychiatrist (or designated on-call staff) for clinical direction if an inmate is received at an institution without medication(s) that he/she reports being prescribed, or the transfer form has medication(s) documented but not transferred with the inmate.

3. Non-Renewed, Discontinued, Expired, or Excess Medications:

a. Medications shall be inspected at least monthly for removal of non-renewed, discontinued, expired, and excess medications.

b. All expired medications shall be set aside for destruction or return to the appropriate pharmacy within two months**.**

c. Under no circumstances shall expired medications be administered to an inmate. Such drugs shall be properly removed from stock and disposed of in accordance with Tennessee Board of Pharmacy Laws and Regulations.

d. If the prescribing provider orders discontinued or non-renewed medications restarted, the medication may remain at the institution for up to two months for future use by the same inmate. After two months, all non-renewed, discontinued medications shall be returned to the pharmacy.

e. Each medication to be disposed of or returned to the pharmacy shall be listed by drug name, strength, and quantity on a medication disposal/return form.

f. All refrigerated medication requiring return to the contracting pharmacy shall be returned in accordance with the process established by the contracting pharmacy.

g. Once a multi-dose vial has been opened, or a needle inserted, it shall be dated and properly discarded after 30 days. Insulin shall be discarded after 28 days.

h. A record of the destruction of legend drugs and controlled medications shall be maintained for at least two years.

i. Controlled medications

(1) Controlled medications that are expired, unused, excessive, discontinued, non-renewed, or otherwise unusable shall be destroyed in accordance with Tennessee Board of Pharmacy Laws.

(2) If controlled medications are destroyed onsite, the destruction shall be accomplished by a licensed pharmacist in the presence of a witness and appropriate documentation shall be maintained in accordance with law. If an off site destruction service is employed, all appropriate documentation shall comply with Tennessee law.

L. Inmate Release:

1. When an inmate is transferred**,** either permanently or temporarily, to another TDOC facility or to a non-TDOC facility but is remaining in TDOC custody, the sending institution shall send the unused balance of current medications in their originally labeled containers to the receiving institution. A written notification advising the receiving institution of any prescription renewals required shall be included with the medications.

2. Health Services staff shall package all the inmate's transferring medications in their possession into a manila envelope or other suitable manner for transfer with the inmate's health record and complete the Transfer/Discharge Health Summary, CR-1895 and the Health Record Movement Document, CR-2176.

3. Health services staff shall indicate the prescriptions, along with the quantity of each contained in the package, on the CR-1895.

4. Individuals transporting or receiving the packaged medications shall sign for such so that a "chain of custody" is maintained.

5. At the time of the health screening at the receiving institution, health services staff shall receive the CR-2176 and the contents of the manila envelope to ensure that prescribed medications have been transferred and that the inmate is in possession of all his/her "keep on person" medications. All KOP medications shall be verified during the health screening with current physician orders, counted, examined for expiration dates, and documented on the MAR. Once verified, the appropriate KOP medications may be returned to the inmate.

6. If the prescribed medications in the appropriate remaining amounts as indicated on the MAR are not sent with the inmate, the receiving institution shall contact the sending institution to obtain the medications immediately**.**

7. When an inmate is transferred to another jurisdiction or agency (e.g., a federal agency, another state, or a mental health facility) and the TDOC relinquishes custody of the inmate, the health services staff shall ensure that, at a minimum, a 30 day supply of medications is transferred with the inmate**.**

8. When an inmate is released from TDOC custody and is not being assumed by another agency or jurisdiction, the health services staff shall order a minimum 30 day supply of medication to be transferred with the inmate.

    a. If the release will occur before the receipt of the 30 day minimum supply of medications, nursing staff shall issue the balance of his/her current medications on hand, and notify the contract pharmacy of the amount needed to complete the minimum 30 day supply via a back-up pharmacy order.

    b. The medication shall be sent/called-in to a pharmacy near the inmate's home. The inmate shall be notified where and when to obtain the medication at discharge before leaving the site. If the information of where/when to obtain the medication is not known at the time of discharge, the inmate shall be given a phone number to medical records to determine where the medication was called in, and when/where to pick up the medication.

9. The quantity of medication released with the inmate shall not exceed the number of doses needed to complete the duration of therapy authorized on the original prescription order on the Physician's Order, CR-1892.

10. Inmates shall receive instructions on the use of all medications.

11. All medications shall be packaged in their original labeled containers.

12. The clinician shall review the instructions on the "non-child resistant packaging" statement with the inmate. The inmate shall sign the statement verifying his/her understanding and acceptance of responsibility.

13. All discharge information including disposition, medications and amounts, TST and immunizations, instructions given to the inmate, and contacts made to health care providers at the next level of care shall be documented by the nurse on the Progress Note, CR-1884 and the Discharge/Transfer Health Summary, CR-1895. A copy of the Discharge/Transfer Health Summary, CR-1895 shall be given to the inmate upon release.

14. If an inmate being released is on medication to treat an identified behavioral health disorder and has an established appointment with a community-based behavioral health provider, the health services staff shall obtain sufficient medication for the inmate to take until that appointment date. It is expected that the appointment will occur within the first 30 days after release; therefore, the inmate shall be provided a 30-day supply of medication.

VII. ACA STANDARDS: 4-4378 and 4-4379.

VIII. EXPIRATION DATE: September 1, 2018.

Order Form 1206/4 (If 4-part set) or
Order Form 1206/5 (If 5-part set

PHYSICIAN'S ORDERS

NAME

ROOM NO.
(ADDRESS)

HOSP. NO.

PHYSICIAN

Drug Allergies

Date & Time	Another brand of drug identical in form and content may be dispensed unless checked ☐	DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS → (1)	Nurse's Initials

TENNESSEE DEPARTMENT OF CORRECTION
CONTROL DRUG ADMINISTRATION RECORD

_____

INSTITUTION

DATE _____ Sheet No. _____

DRUG _____ STRENGTH _____

Balance Brought Forward _____ Initials of the Nurse Receiving at Start of Shift

Date	Time	Name	Number	Location	Physician	Administered By	Units Used	Amount Received	Balance	1st	2nd	3rd

TENNESSEE DEPARTMENT OF CORRECTION

MEDICATION AND TREATMENT ERRORS/OMISSIONS

Date Error Discovered _____ Time _____ By Whom _____

Patient's Name _____ Diagnosis _____

Medication or Treatment Involved _____

Description of Error (How discovered, effect on patient, sequence of events and other persons involved)

_____

_____

_____

_____

Physician Notified _____ By Whom _____

Date _____ Time _____ Physician Examined Patient? _____

Medication or Treatment given to counteract error _____

Name of Supervisor Notified _____

Other Person(s) Notified _____

_____

Person(s) Who Made Error _____

Date _____ Time _____ Counseled By _____

Documentation of Counseling, if applicable _____

Cause(s) of Error(s) – Check Below:

1. Failure to follow procedure:
   - A. Identification of patient_____( )
   - B. Didn't check med. Label with ticket_____( )
   - C. Didn't check route of administration_____( )
   - D. Didn't observe patient take medication____( )
   - E. Not charted correctly_____( )
   - F. Not charted promptly_____( )
   - G. Stop order policy not followed_____( )
2. Communication failure:
   - A. Not written correctly_____( )
     - (1) Medication card_____( )
     - (2) Kardex_____( )
   - B. Not read correctly_____( )
   - C. Not heard correctly_____( )
   - D. "Stat" order not given immediately_____( )
3. Wrong Calculation_____( )
4. Drug not available_____( )
5. Other_____( )

TO BE COMPLETED BY CHARGE NURSE OR SUPERVISOR

TYPE OF ERROR – CHECK BELOW

1. Wrong medication_____( )
2. Wrong dosage_____( )
3. Wrong day / time_____( )
4. Wrong patient_____( )
5. Error in transcribing_____( )
6. Omission_____( )
7. Other (explain)_____( )

_____

_____

_____
Signature of Person Who Made Error

_____
Signature of Person Reporting Error

_____
Signature of Charge Nurse or Supervisor

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
TRANSFER / DISCHARGE HEALTH SUMMARY

Name of Inmate: _____ TDOC # _____ DOB: _____
Last First Initial

Current Institution: _____ Transfer Date: _____

Receiving Institution (*if applicable*): _____

Reason for Transfer/Discharge: _____

Requires Chronic Illness Monitoring: ☐ yes ☐ no Last TB Screening/PPD: _____

Requires Mental Health/Psychiatric Monitoring: ☐ yes ☐ no Last Periodic Health Appraisal: _____

HEALTH HISTORY

Check (v) all conditions present

☐ HIV/AIDS	☐ Depression	☐ Hernia	☐ Prosthesis *(specify)* _____
☐ Alcoholism	☐ Diabetes	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Anemia	☐ Emphysema	☐ Hypertension	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Suicide Attempt
☐ Cancer *(specify)* _____	☐ Heart Disease	☐ Liver Disease	☐ Tuberculosis
☐ Chemical Dependency	☐ Hepatitis C	☐ Multiple Sclerosis	☐ Venereal Disease
☐ COPD			☐ Other *(specify)* _____

--- CURRENT PHYSICIAN/DENTIST MEDICATION ORDERS ---

	Name of Drug	Strength/ Route	Frequency	Last Dose Date/Time	Medication Sent (v)	Amounts	KOP
1.					Y ☐ N ☐		☐ Y ☐ N
2.					Y ☐ N ☐		☐ Y ☐ N
3.					Y ☐ N ☐		☐ Y ☐ N
4.					Y ☐ N ☐		☐ Y ☐ N
5.					Y ☐ N ☐		☐ Y ☐ N
6.					Y ☐ N ☐		☐ Y ☐ N
7.					Y ☐ N ☐		☐ Y ☐ N
8.					Y ☐ N ☐		☐ Y ☐ N

Brief Summary of Current Health Problems:

SPECIAL INSTRUCTIONS (e.g., Allergies, Diet, Impairments, Medical Appointments, etc.) :

Referred to Community Resources: ☐ **Yes** ☐ **No** **Specify Below:**

Report Prepared By: _____ Date: _____
Signature/Professional Title

Receiving Institution Review: _____ Date: _____
Signature/Professional Title

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH RECORDS MOVEMENT DOCUMENT

DESTINATION: _____

THIS PACKET CONTAINS HEALTH RECORDS ON THE FOLLOWING INMATE(S):

	Inmate Name	Number	CHECK ALL THAT APPLY: Health Record	Dental Record	Medication	* Purpose (Indicate **A, B, C** or **D**)
1.			☐	☐	☐	
2.			☐	☐	☐	
3.			☐	☐	☐	
4.			☐	☐	☐	
5.			☐	☐	☐	
6.			☐	☐	☐	
7.			☐	☐	☐	
8.			☐	☐	☐	
9.			☐	☐	☐	
10.			☐	☐	☐	

*** PURPOSE OF RECORDS MOVEMENT:**

A. Permanent Transfer **B.** Temporary Transfer for Clinical Services **C.** Record to Archives **D.** Other (*See Comments*)

Comments: _____

Sending Institution: _____ Date: _____

Prepared / Checked by: _____ Date: _____

Transported by: _____ Date: _____

Received by: _____ Date: _____

**** THIS DOCUMENT SHALL NOT CONTAIN PROTECTED HEALTH INFORMATION ****

CR-2176 (Rev. 11-09) RDA

White-Exterior Packet **Canary**-Exterior Packet **Pink**-Inside Records Packet **Goldenrod**-Sending Institution Medical Records Office

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ INMATE NUMBER: _____

DATE	TIME/PLACE	PROB NO.	

Do Not Write on Back

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.71	Page 1 of 8
	Effective Date: September 1, 2015	
	Distribution: A	
	Supersedes: 113.71 (8/15/11) PCN 11-44 (11/1/11)	
Approved by: Derrick D. Schofield		
Subject: ADMINISTRATION/DISTRIBUTION OF MEDICATION		

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To promote the safe management of pharmaceuticals consistent with legal and professional standards of care.

III. APPLICATION: Wardens, Associate Wardens of Treatment (AWT), Health Services Administrators, all clinical services staff, medical contractors, and privately managed institutions.

IV. DEFINITIONS:

A. Administer: The direct application of a drug to an inmate by injection, inhalation, ingestion, topical application or any other means.

B. Controlled Substance: A drug, substance, or immediate precursor, included in Schedules I - V of the *Federal Drug Enforcement Agency's Controlled Substances Act.*

C. Crushed/Whole under Water: A method of medication administration which may involve placing the medication in a small cup of water for several seconds prior to administration. This procedure is used to minimize the possibility of inmates "tonguing" the medication for hoarding, selling, or the act of non-compliance.

D. Directly Observed Therapy (DOT): Face-to-face observation and monitoring by a qualified health professional of an inmate taking their medication.

E. Dispensing Medication: The act of packaging a legend drug, either from a bulk container or as a result of compounding, in a container other than the original container of the manufacturer or distributor, and labeling the new container with all the information required by state and federal law.

F. Distribution of Medication: The transfer of prepackaged or labeled medications to an individual for self-administration according to directions provided by the prescribing practitioner.

G. Keep on Person (KOP): Medication approved to be kept in an inmate's possession for the purpose of self-administration.

H. Medication Administration Record (MAR): A form used by a qualified health care professional to document the administration of prescribed medications.

I. Non-compliance: When an inmate fails to report to a scheduled medication call to obtain his/her prescribed medication or fails to report to a scheduled appointment/assessment.

J. Over-the-Counter Medications (OTC): Non-prescription medications readily available to inmates for self-administration which can be legally obtained from the commissary without a prescription.

K. Parenteral Administration: Administration of medication by a route other than by mouth (e.g., by injection).

L. Qualified Health Professional: For the purpose of this policy, clinical staff who are authorized by licensure, registration, or certification to perform health care services. Examples of qualified health professionals may include but not be limited to physicians, dentists, physician assistants, nurse practitioners, nurses, psychiatrists, psychological examiners, psychologists, clinical social workers, etc.

M. Refusal of Medication: When an inmate asserts that he/she will not take a prescribed medication.

V. POLICY: Medications shall be administered or distributed in a timely manner according to the orders of the prescribing practitioner and in accordance with applicable state and federal laws.

VI. PROCEDURES:

A. Dispensing Medications: Except for licensed physicians, osteopaths, optometrists, or dentists who follow proper record keeping procedures, the act of dispensing is limited strictly to licensed pharmacists and persons working under their immediate supervision.

B. Institutional Unit Procedures: Each institution shall maintain in the health services unit manual a written procedure for the administration/distribution of medications within the facility. The procedure shall be approved by the Warden, or the AWT, and Health Services Administrator and include the following:

1. Times and location of medication administration/distribution.

2. Provisions for furnishing medications to inmates on administrative, punitive, or protective custody; to those inmates participating in work or education programs; and to others who cannot attend the regularly scheduled medication distribution.

3. Administration/distribution procedures for OTC medications in accordance with nursing and clinical treatment protocols.

4. A list of OTC medications available in the commissary reviewed and approved by the State Pharmacy and Therapeutics Committee at least annually. The approved OTC commissary list shall be signed by the Director of Health Services and forwarded to each facility. The approved OTC list shall then be reviewed and signed by the Warden, AWT, and institutional Health Services Administrator. Each Health Services Unit Manual shall contain a current approved list of OTC medications.

5. Other medication procedures unique to the setting.

C. Principles of Medication Administration/Distribution: It is essential that medications be accurately administered in order that the desired therapeutic effect is achieved. Nursing personnel involved in the administration/distribution of medications shall verify the following before administering/distributing a drug or medication:

1. Right Inmate: Verify the full name and TDOC identification number of the inmate receiving the medication. Inmates shall show their ID card.

2. Right Drug: Medications which cannot be properly identified shall never be administered or prepared for distribution.

3. Right Dose: It is important that all medications be administered in the proper dosage as prescribed by the practitioner.

4. Right Time of Administration: It is essential that all medications be given as close to the prescribed time(s) or intervals as possible.

5. Right Route of Administration: It is essential that the medication be given in the route (e.g., oral, intravenous, topically) as prescribed or indicated by the manufacturer.

D. Administration of Medications:

1. All medications shall be administered by licensed nursing personnel.

2. All psychotropic drugs, Controlled medications, TB prophylaxis/treatment medication, and drugs requiring parenteral administration shall be administered only on a dose by dose basis crushed, and under water, unless contraindicated, or administration verified by provider, if contraindicated.

3. Medications ordered to treat mental health disorders shall be prescribed only by a psychiatrist or a psychiatric clinical nurse specialist. TB treatment medication for persons with the active or latent disease shall be administered using directly observed therapy (DOT).

4. The institutional physician may order a month's supply of HIV/AIDS medications to be distributed to the inmate for self-administration after evaluation of regimen and compliance. If there is any evidence the inmate is non-compliant with medications, he/she should immediately be returned to dose-by-dose administration.

5. The institutional physician may order a month's supply of Hepatitis C medications. Once non-formulary approval (if applicable) has been granted for the treatment regimen, re-application is not required for the duration of the treatment regimen. Hepatitis C medications shall be administered using direct observation therapy (DOT).

6. Non-controlled substances which are not subject to abuse and non-psychotropic medications may be distributed in one month's supply as KOP. Old/previously issued cards/bottle/inhalers shall be exchanged prior to issue of new medication.

7. Insulin may be self-administered by the inmate only when a licensed nurse has verified the units and dosage in the insulin syringe, is present to observe and document the inmate's self administration, and observes the inmate**'**s disposal of the used syringe into the sharps/needle container.

8. All medications for inmates in inpatient treatment facilities shall be administered on a dose by dose basis only.

9. Under no circumstances shall a stimulant, tranquilizer, or psychotropic drug be prescribed or administered to an inmate for the purpose of programmatic control, security and management, or for experimentation or research.

10. Institutions preparing medication for distribution to inmates on outside work programs shall ensure that the medication is prepared by licensed nursing personnel and distributed at the proper time by written institutional procedures. Different medications shall not be mixed in one packet or container, and packets shall be properly labeled as follows:

    a. Inmate name and TDOC identification number

    b. Name and strength of drug, quantity, and route of administration

    c. Date and time for distribution

    d. Complete instructions for use

    e. Information necessary for inmate education/precautions

    f. Initials of preparer

11. If medication is not administered **(**based on nursing judgement or a physician's order), the nurse shall enter the appropriate code in accordance with the legend indicated on the approved TDOC MAR(s). The nurse shall document the reason for holding the medication on the inmate's Problem Oriented Progress Record, CR-1884, and notify the prescribing provider if the medication was held due to the nurse's judgment.

E. Documentation: The MAR shall be provided by the pharmacy vendor, as approved by the TDOC Director of Health Services (or designee) and used as a permanent record of medication administered/distributed to an inmate. Upon administration or distribution of a prescribed medication, all pertinent information shall be recorded on the MAR.

1. The inmate's name and number shall be entered in the appropriate space, along with the current month and year.

2. For each medication order, the following information shall be entered in the appropriate block:

   a. Date of order and start/stop date

   b. Name of drug, dose or strength, and dosage form

   c. Route of administration

   d. Time interval or frequency of administration

   e. Duration of order and/or automatic stop order

   f. Attending provider (physician, dentist, etc.)

   g. Initials of the nurse who transcribed the order

3. The hour(s) of medication administration shall be entered beside the medication order.

4. The nurse shall initial the appropriate block as each dose is subsequently administered. When distributing multiple doses of medication, the nurse shall initial and write the number of doses distributed beside the medication order**.**

5. All licensed nursing personnel initialing the MAR shall sign their full signature, professional title, and initials in the designated area.

6. A new MAR shall be initiated the first day of each month for every inmate on medication. All MARs shall be filed in the inmate health record at the end of the month.

7. The MAR shall be used to record one time medication and/or PRN medications.

8. All diabetic medication, including insulin, shall be recorded on the MAR and may also be documented on the Diabetic Record, CR-2006.

9. Blood Glucose results shall be recorded on the Diabetic Record, CR-2006. A review of this document during chronic care visits shall be indicated with the provider signature and date noted in the "Remarks" section of the CR-2006.

F. Non-Compliance/Absent for Medication/Refusal of Medication:

1. If an inmate either refuses or is non-compliant to receive his/ her medications, the qualified health professional administering the medications shall enter the designated code in accordance with the legend indicated on the approved TDOC MAR(s). If at any point in a two week period the inmate has less than a 90 percent compliance rate identified and documented in the medical record, the inmate shall be referred to the prescribing provider with an Institutional Health Services Referral, CR-3431. The referral shall be documented on the Problem Oriented Progress Record, CR-1884, and on the back of the approved TDOC MAR.

2. The prescribing provider shall be notified as soon as possible of the inmate's non-compliance and/or active refusal of medications and the inmate shall be referred to the provider for counseling regarding the possible effects of non-compliance. The counseling session shall be documented on the CR-1884 and shall include an assessment of the inmate's understanding and knowledge of his/her health status, prescribed treatment regimen, and outcome evaluation.

3. In the event the inmate frequently fails to comply with his/her medication regime for medications considered non-critical (i.e., analgesics), the provider may consider discontinuing the medications.

VII. ACA STANDARDS: 4-4402 and 4-4379.

VIII. EXPIRATION DATE: September 1, 2018.

TENNESSEE DEPARTMENT OF CORRECTION
INSTITUTIONAL HEALTH SERVICES REFERRAL

_____
INSTITUTION

☐ MEDICAL

☐ MENTAL HEALTH

INMATE: _____ NUMBER: _____
Last First Middle

PRESENTING PROBLEMS: _____

_____

_____

_____

_____

_____

_____

REFERRED BY: _____ _____ _____
Signature/Title Date Time

SEND REFERRAL FORM TO INSTITUTIONAL HEALTH COORDINATOR

☐ MHA

☐ HSA

RECEIVED BY: _____ _____ _____
Signature/Professional Title Date Time

REFERRAL DISPOSITION (Course of Action): _____

_____

_____

_____

_____

_____

_____

_____ DATE: _____ TIME: _____

_____
Signature/Professional Title

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ INMATE NUMBER: _____

DATE	TIME/PLACE	PROB NO.	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION
DIABETIC RECORD (*by Glucose Monitoring Device)*

_____
INSTITUTION

Patient: _____ Number: _____

Physician _____ Location _____

Current Weight: _____ Height: _____ Age: _____ Diet: _____

Current Medication Order: _____

DATE	TIME	BLOOD GLUCOSE READING	MEDICATION GIV EN	REMARKS	NURSE INTIALS
	HR				
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DIABETIC RECORD (*by Glucose Monitoring Device)*

Patient: _____ Number: _____

DATE	TIME	BLOOD GLUCOSE READING	MEDICATION GIVEN	REMARKS	NURSE INTIALS
	HR				
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I. AUTHORITY: TCA 4-4-103, TCA 4-3-603, TCA 4-3-606, TCA 39-16-201, TCA 50-9-101 et seq., and Tennessee Administrative Compilation (TAC) 0800-2-12.

II. PURPOSE: To enhance professionalism and safety by promoting a drug-free workplace within the Tennessee Department of Correction (TDOC).

III. APPLICATION: To all TDOC employees.

IV. DEFINITIONS:

A. Adulterated Sample: Any sample that appears to have evidence of dilution, contamination, or tampering, before, during, or after the test collection, and the laboratory can confirm what the specific adulterant is.

B. Alcohol: Has the same meaning as in the federal regulations describing procedures for the testing of alcohol by programs operating pursuant to the authority of the United States Department of Transportation as currently compiled at 49 Code of Federal Regulations (C.F.R.) Part 40, as the same may be revised from time to time.

C. Alcohol Testing: The analysis of breath, blood, or any other analysis which determines the presence and level or absence of alcohol as authorized by the U.S. Department of Transportation in its rules and guidelines concerning alcohol testing and drug testing.

D. Applicant: A person who has applied for a safety-sensitive position within the Tennessee Department of Correction and has begun offered employment conditioned upon successfully passing a drug test, and may have begun work pending the results of the drug test.

E. CAP-FUT Program: The College of American Pathologists-Forensic Drug Testing accreditation program.

F. Chain of Custody: The methodology of tracking specified materials or substances for the purpose of maintaining control and accountability from initial collection to final disposition for all such materials or substances, and providing for accountability at each stage in handling, testing, and storing specimens and reporting test results.

G. Confirmation Test: A second analytical procedure to identify the presence of alcohol or a specific drug or its metabolites in a specimen.

H. Conviction: A finding of guilt, including a plea of nolo contendere and/or imposition of sentence, by any judicial body charged with the responsibility to determine violations of the federal or state criminal drug statutes.

I. Drug: Any drug subject to testing pursuant to drug testing regulations adopted by the United States Department of Transportation.

J. Drug-free Workplace: A site for the performance of work done in connection with an employee's job whereby employees are prohibited from engaging in unlawful manufacture, distribution, dispensing, possession, or use of alcohol or drugs.

K. Drug Test or Drug Testing: A chemical, biological or physical instrumental analysis administered by a laboratory authorized to do so pursuant to TCA 50-9-101 et seq., for the purpose of determining the presence or absence of a drug or its metabolites pursuant to regulations governing drug testing adopted by the United States Department of Transportation or such other recognized authority approved by rule by the Commissioner of Labor and Workforce Development.

L. Employee: For purposes of this policy, any person employed full-time or part-time by the Department of Correction.

M. Employee Assistance Program (EAP): An established program capable of providing expert assessment of employee personal concerns; confidential and timely identification services regarding employee drug or alcohol abuse; referrals of employees for appropriate diagnosis, treatment, and assistance; and follow-up services for employees who participate in the program or require monitoring after returning to work.

N. Employee Drug Testing Coordinator (EDTC): Individual appointed by the Commissioner to administer the Department's employee drug testing program.

O. Fit for Duty: For purposes of this policy, Fit for Duty refers to a test performed by a licensed doctor to ensure that individuals are able to perform their duties in a Safety sensitive position.

P. Initial Drug or Alcohol Test: The first alcohol or drug-screening test to determine the presence or absence of alcohol or drugs or their metabolites in a specimen(s).

Q. Invalid Sample: Any sample that appears to have evidence of dilution, contamination, or tampering, before, during, or after the test collection, and the laboratory cannot confirm what the specific adulterant is.

R. Medical Review Officer (MRO): A licensed physician employed by the State contracted vendor who has knowledge of substance abuse disorders, laboratory testing procedures and, chain of custody collection procedures who verifies positive and confirmed test results. This individual possesses medical training to interpret and evaluate positive test results in relation to the individual's medical history or other relevant biomedical information.

S. Metabolite: A substance that takes part in the process of metabolism. Metabolites are produced during metabolism or are constituents of food or substances taken into the body. When screening for drugs, laboratory personnel look for what is left in the urine after the body has broken down a complex drug into smaller pieces, i.e., they will find metabolites of the drug, not the original drug.

T. Prescription or Non-Prescription Medication: A drug prescribed for use by a duly licensed physician, dentist, or other medical practitioner who is licensed to issue prescriptions or a drug that is authorized pursuant to federal or state law for general distribution and use without a prescription in the treatment of human diseases, ailments, and/or injuries.

U. Reasonable Suspicion: A belief based on specific, objective, articulable facts and the reasonable inferences that may be drawn from those facts, or knowledge sufficient under the circumstances, to cause an ordinary prudent and cautious person to believe that an employee used or is using illegal drugs or alcohol.

V. Reconfirmation Test: A third analytical procedure, paid for by the employee, to identify the presence of alcohol or a specific drug or its metabolites in a specimen.

W. Return to Duty Testing: The re-testing of an employee, prior to his/her returning to the workplace, after previously testing positive for the presence of drugs or alcohol.

X. Safety-Sensitive Position: A position in which a drug impairment constitutes an immediate and direct threat to public health or safety, such as a position that requires the employee to carry a firearm, perform life-threatening procedures, work with confidential information or documents pertaining to criminal investigations or work with controlled substances, or a position in which momentary lapse in attention could result in injury or death to another person.

Y. Substance Abuse and Mental Health Services Administration (SAMHSA): A Federal agency within the U.S. Department of Health and Human Services created to focus attention, programs, and funding on improving the lives of people with or who are at risk for mental and substance abuse disorders.

Z. Zero Tolerance: Appropriate employee disciplinary or corrective action, up to or including termination, upon the confirmation of alcohol or drug usage by the employee while in the workplace.

V. POLICY: The TDOC is committed to a drug-free environment and will implement an employee drug testing program to assist in that effort. The Department shall maintain a zero tolerance for the illegal use of drugs on or off the job and the use of alcohol on the job.

VI. PROCEDURES:

A. The Department's Drug-Free Workplace program will conform to the requirements of TCA 50-9-101 through 50-9-114 and the Rules of the Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Drug-Free Workplace Programs, TAC 0800-2-12.

B. Each employee shall be required to certify his/her acknowledgement of this policy and the action to be taken if a violation occurs by using the Acknowledgement of Receipt of TDOC Drug-Free Workplace Policy, CR-3679. The signed acknowledgement shall be maintained in the employee's personnel file. Copies of these acknowledgement forms may be obtained through the Human Resources Division.

C. Employees shall be made aware of the Employee Assistance Program (EAP) and encouraged to seek assistance with any drug or alcohol related problems. All EAP procedures are to follow Policy #305.05.

1. An employee, who believes he or she has a substance abuse issue, may contact his or her supervisor and/or the personnel department for a referral to the EAP program and begin treatment process without penalty.

2. Once the employee enters the EAP program he or she must sign a release of information with the EAP to release information to the TDOC concerning the employee's assessment and progress made with the substance abuse issue. All employees who are offered the EAP program shall submit to follow-up testing as indicated in Section VI. (F)(3).

3. Once an employee is informed of any form of impending drug test, he/she does not have the option of going to supervisors and/or personnel at that time seeking help through EAP to avoid sanctions before the pending drug test is completed. EAP services are available to the employee for all other issues except to avoid drug testing after the employee has been notified of testing requirement.

D. <u>As a condition of employment or continued employment an employee shall not</u>:

1. Use, possess, sell, trade, offer for sale, or offer to buy illegal drugs or otherwise engage in the illegal use of drugs on or off the job.

2. Work or report to work visibly impaired or while possessing in his or her body, blood or urine, illegal drugs in any detectable amount.

3. Report to work under the influence of or impaired by alcohol.

4. Use prescription drugs illegally, including using prescription drugs that have not been legally obtained or using prescription drugs in a manner or for a purpose other than as prescribed.

5. Tamper with a drug test being administered pursuant to this policy.

E. <u>Types of Testing</u>

1. <u>Applicant Drug Testing</u>: All applicants for safety-sensitive positions within the Department will be required to submit voluntarily to a drug test after a conditional offer of employment.

2. <u>Reasonable Suspicion Drug and Alcohol Testing</u>: Reasonable Suspicion Drug Testing: Employees shall be required to submit to drug and alcohol testing as a condition of continued employment to ascertain prohibited drug use in any case in which an individualized "reasonable suspicion" exists that the employee uses and/or is abusing prescription, illegal drugs or is using alcohol on the job. This may be based upon the following reasons:

a. Observable phenomena, such as direct observation of drug or alcohol use or possession or the physical symptoms of being under the influence of a drug or alcohol

b. A pattern of abnormal conduct or erratic behavior

c. The identification of an employee as a suspect in a criminal investigation involving drug possession, use, distribution, or trafficking

d. Information provided by reliable and credible sources or independently corroborated

e. Newly discovered information indicating that the employee may have tampered with a previous drug or alcohol test

3. Follow-up Drug Testing: An employee who, in the course of employment, enters an Employee Assistance Program for a drug or alcohol related problem or enters a drug or alcohol rehabilitation program shall be required to submit to drug and/or alcohol testing, as appropriate, as a follow-up to such program. Such testing shall be scheduled by the Warden, Superintendent, District Director, or designee and shall occur at least quarterly for a two year period after successful completion of the program. No advance notice of a follow-up testing date shall be given to the employee.

4. Post-Accident/Critical Incident Testing:

a. An employee shall be subject to drug and/or alcohol testing if he or she appears to have caused or contributed to a work-site accident resulting in:

(1) Death

(2) Personal injury requiring immediate medical treatment away from the scene of the accident, or

(3) Any type of car accident in which the employee is operating a state vehicle and any form of damage is inflicted on the state and/or another vehicle.

b. An employee who is authorized to carry a firearm shall be required to submit to drug testing after any discharge of the firearm involving death or personal injury.

c. If the accident involved the operation of a qualifying commercial motor vehicle, then post-accident testing may also be required under the authority of the Department of Transportation, Federal Highway Administration (DOT/FHWA).

d. The employee shall be taken to a medical facility for immediate treatment of injury. Specimens shall be obtained at the treating facility or a designated collection site and transported to an approved testing laboratory.

e. No specimens shall be taken prior to the administration of emergency medical care. Once this condition has been satisfied, an injured employee must submit to testing.

5. Random Testing: Employees in safety-sensitive positions shall be subject to mandatory, random drug and alcohol testing.

F. Each employee in a position designated as safety-sensitive shall be notified of such designation and shall be required to certify his/her acknowledgment of the safety-sensitive designation by using Acknowledgment of Receipt of Notice of Designation of Position as Safety-Sensitive, CR-3678.

G. As a condition of continued employment, an employee who is arrested for or charged with any criminal drug offense shall notify the employee's supervisor no later than one working day after such arrest or charge. (See Policy #302.06)

H. If an employee is convicted of violating any criminal drug statute and is found guilty of any disciplinary offense that involves the use of or possession of drugs or alcohol, he/she shall be subject to disciplinary action up to or including termination. If he/she is not terminated, the Department shall also require the employee to successfully complete a drug abuse program sponsored by an approved private or governmental institution.

I. If an employee participating in an activity funded by a federal agency is convicted of violating any criminal drug statute in the workplace, the Department shall notify the appropriate federal agency. Notification shall be within ten days of receipt of notice regarding such conviction.

J. Testing:

1. All testing thresholds shall comply with SAMHSA testing threshold guidelines:

a. All specimens will be tested for the following

(1) Expanded Amphetamines (including MDA and/or MDMA)
(2) Barbiturates
(3) Benzodiazepines
(4) Cannabinoids
(5) Cocaine Metabolite
(6) Methadone
(7) Methamphetamine
(8) Opiates (including Codeine, Morphine and Heroin)
(9) Phencyclidine
(10) Propoxyphene
(11) Oxycodone
(12) Buprenophine

b. Specimens will also be examined for adulteration. The following are the standard, though not the only, indicators of adulteration that will be checked for:

(1) Temperature
(2) Color/Appearance
(3) Nitrates
(4) Oxidants
(5) Specific Gravity
(6) pH Level
(7) Creatinine

2. Contract laboratory staff trained to collect urinalysis specimens shall conduct urine specimen collection. Employees to be tested shall be required to provide positive photograph identification before entering the testing area. A photograph TDOC identification card and/or driver's license may be used for this purpose. Collection procedures shall be in conformance with the procedures compiled at 49 CFR, Part 40, and must be collected in accordance with those procedures using the split sample method. The chain of custody form developed by the Department of Labor for the Tennessee Drug Free Workplace Program shall be utilized.

3. Security of the collection site, chain of custody procedures, privacy of the individual, collection control, integrity, identity, and retention of the specimen, and transportation of the specimen to the laboratory shall be in accordance with the SAMHSA guidelines and United States Department of Transportation regulations (49 CFR, Part 40).

4. A SAMHSA licensed and approved contract laboratory shall conduct an initial drug screening test using an immunoassay testing method. If a positive result is found, the laboratory shall immediately perform a confirmation test using gas chromatography/mass spectrometry (GC/MS).

5. Positive, adulterated, or invalid results attained on both testing methods shall be reported to the MRO who shall proceed as set forth in Section VI.(L).

K. Reporting and Review of Results by MRO

1. The contract laboratory shall report any specimens with evidence of dilution, contamination, tampering or any question normally requiring an MRO opinion to the MRO for disposition. The MRO may determine the need to re-test, re-collect, or otherwise modify the collection procedure to ensure adequate and appropriate testing.

a. Samples which are confirmed as "Adulterated Samples" will be considered positive and will follow the procedures outlined in Section VI.(K)(2-7).

b. Employees whose samples are confirmed as "Invalid Samples" shall be required to do the following:

(1) Submit to an immediate follow up, observed collection.

(2) Should the follow up test produce a second invalid result, the employee will be referred for a Fit for Duty test.

(3) During the Fit for Duty test, employees who have produced invalid results twice will be required to submit to an alternative form of testing (hair, blood, etc.) as determined appropriate by the physician conducting the test and the MRO.

2. The contract laboratory shall report confirmed positive tests to the MRO. After the laboratory has returned a confirmed positive test result to the MRO, he/she shall attempt to contact the employee within 24 hours to privately discuss any issues that might have affected the urine sample.

a. An employee who receives a positive confirmed test result from the MRO may contest or explain the result to the MRO within five working days after receiving such notification. The MRO may require the employee to submit additional evidence to justify a positive drug test result, including, but not limited to, a valid prescription or a letter from the individual's physician verifying a valid prescription.

b. The MRO shall review all medical records made available by the employee, if any, and determine whether a confirmed positive test could have resulted from legally prescribed medication. If an employee's or applicant's explanation or challenge is unsatisfactory to the MRO, or if the employee does not challenge the test result, the tests shall be considered verified. The MRO shall promptly report the verified test result to the Warden or Superintendent/designee for facilities, the District Director for Probation/Parole offices, or the EDTC for central Office Employees.

c. Employees who test positive for legally prescribed drugs or who have produced two invalid tests may be asked to submit to a Fit for Duty test, as determined by the MRO, to determine their ability to function in a safety sensitive position.

(1) Individuals who pass the Fit for Duty test shall be allowed to return to work as scheduled.

(2) Individuals who fail the Fit for Duty test shall have their results and all information leading up to the failure forwarded to the Warden and facility Human Resources Manager. The Warden shall review and decide upon the outcome on a case by case basis.

(3) Should further clarification be needed by the Warden and facility Human Resources Manager, the TDOC Director of Human Resources will be available for consultation.

3. If the MRO is unable to make contact with the employee within 24 hours after a minimum of three reasonably spaced attempts over the 24-hour period, he/she shall contact the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office to contact the employee and inform the employee to contact the MRO. The MRO shall not inform the Warden or Superintendent/designee for facilities and the EDTC for Central Office that the employee has a confirmed positive, adulterated, substituted or invalid test result.

    a. The Warden or Superintendent/Designee for facilities, District Director for probation/parole offices and the EDTC for Central Office shall attempt to contact the employee and instruct him/her to call the MRO. The employee must contact the MRO within 72 hours after the notification by the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office. If the employee does not contact the MRO within 72 hours after being contacted by the Warden or Superintendent/designee for facilities, District Director for Probation/Parole Offices and the EDTC for Central Office, the MRO may verify the test result as positive or refusal to test, as applicable.

    b. If the MRO contacts the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office as authorized above, and the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office is unable after reasonable efforts to contact the employee by telephone or to locate the employee through his/her supervisor, the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office may place the employee on temporary medical leave. The Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office must leave a message for the employee by any practicable means (such as voicemail, e-mail, or letter) to contact the MRO. The Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office inform the MRO of the date and time of the attempted contact. Reasonable efforts include, at a minimum, three attempts, spaced reasonably over a 24-hour period, to reach the employee at the day and evening telephone numbers listed on the chain of custody form.

4. Upon being notified by the MRO of an employee's verified test result, the Warden or Superintendent/designee for facilities District Director for probation/parole offices and the EDTC for Central Office shall notify the employee of his/her positive drug test.

5. Upon notification by the MRO, the employee may request a reconfirmation test using the same specimen sample previously taken.

   a. The reconfirmation test shall be performed by an independent SAMHSA-certified or CAP-FUT program certified laboratory designated by the TDOC contractor.

   b. The reconfirmation test shall be at the employee's expense

6. Results from the analysis of the second test on the split specimen sample shall be evaluated by the MRO and be the final step for determining positive or negative findings.

7. If there is a positive result, the employee shall be subject to disciplinary action up to and including termination.

L. Failure to Provide an Immediate Specimen

1. If the employee fails to provide a specimen immediately, he/she shall remain in the collection area with an escort and may be furnished up to a total of 40 ounces of fluids over a three-hour period.

2. If the employee has not provided a sufficient specimen within three hours of the first unsuccessful attempt, the collection site person shall discontinue the collection and notify the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office employees.

3. Any employee who fails to provide a sufficient urine specimen may have a licensed physician (who has performed an evaluation of the employee) submit to the MRO a brief written statement indicating the physician's conclusion as to the employee's ability to provide an adequate amount of urine and the basis for the conclusion. The MRO shall consider the statement in determining whether the employee has willfully refused to provide the required specimen. After reviewing the physician's statement, the MRO shall report his/her determination to the Warden or Superintendent/designee for facilities, District Director for probation/parole offices, and the EDTC for Central Office employees in writing. For purposes of this paragraph, a medical condition includes an ascertainable physiological condition (e.g., a system dysfunction) or a documented pre-existing psychological disorder, but does not include unsupported assertions of "situational anxiety" or dehydration.

M. Additional Procedures for Random Testing

1. At each facility, probation/parole office, the Training Academy, and Central Office, Human Resources shall maintain a current list of employees who are subject to random testing as the result of being assigned to a safety-sensitive position. All positions in the department shall be reviewed annually to determine whether a change in job functions necessitates a change in a position's designation or non-designation as safety-sensitive.

2. On a schedule established by the Department and using the list of TDOC employees in safety-sensitive positions supplied by TDOC Human Resources, the Contractor will notify the appropriate Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office employees, that an employee has been randomly selected for drug testing. The Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office employees shall notify the employee that he/she has been randomly selected for a drug test and direct the employee to immediately report to the designated test site to provide a specimen. Notification to the employee shall occur during the employee's current shift or, if the employee is not on duty at the time, during the next shift the employee works. Testing shall occur during the period the employee is scheduled to work, and as soon as practicable after the employee is notified of his/her selection.

3. The test shall be at the Department's expense.

N. Additional Procedures for Reasonable Suspicion Drug Testing

1. Employees shall be required to submit to drug and alcohol testing as a condition of continued employment to ascertain prohibited drug use in any case which an individualized "reasonable suspicion" exists that the employee uses or is using drugs or alcohol. This may be based upon the reasons set forth in Section VI.(F)(2).

2. If any employee is suspected of using drugs or of using alcohol, the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office and Office of Investigation and Compliance employees shall gather all information, facts, and circumstances leading to and supporting this suspicion and shall document all the information used in forming the basis for testing. The Warden or Superintendent/designee for facilities, District Director for probation and parole offices, and the EDTC for Central Office employees shall notify the employee through the Reasonable Suspicion of Substance Abuse Testing Notice, CR-3676, which he or she must submit to testing. The written report of the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office employees shall become part of the file and created and maintained by the Director of Human Resources/designee for each reasonable suspicion drug test ordered.

3. An employee shall be escorted to a test site (where the initial test shall be conducted) determined by the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and by the EDTC for Central Office employees. A staff member of the Division of OIC shall provide escort for any Central Office employee who is to be tested due to reasonable suspicion. Wardens (for institutional staff) District Director (for probation/parole staff) the TCA Superintendent (for Academy staff) shall identify staff member(s) who shall provide escort for any employee who is to be tested due to reasonable suspicion. Procedures for the collecting and testing of urine specimens as well as the reporting and reviewing of results shall be in accordance with Sections VI.(J) and VI.(K) above.

4. If the employee fails to provide a specimen immediately, the procedures outlined in Section VI. (L) Above shall be followed. If the employee cannot provide a specimen during the three-hour timeframe, the escorting supervisor shall ensure that contact is made with the Warden or Superintendent/designee for facilities, District Director for probation/parole offices and the EDTC for Central Office employees for further instruction

5. TDOC reserves the right to request observed collection of samples at their discretion. Based on SAMHSA guidelines, all follow up tests due to an initial result will be an observed collection.

O. Confidentiality: Subject to federal and state law, employee drug and alcohol testing results and records shall be maintained under strict confidentiality. The contractor, the MRO, and employees involved in the administration of this policy shall observe strict confidentiality of an employee's test results and treatment. Any employee violating this requirement of confidentiality will be subject to disciplinary action, up to and including termination.

P. Any employee who compromises the integrity of the alcohol and drug testing program or who fails to enforce it shall also be subject to disciplinary action, up to and including termination.

Q. An employee or applicant shall be responsible for notifying the laboratory of any administrative or civil action brought pursuant to TCA 50-9-101 through 114 and/or TAC 0800-2-12.

R. Employees who are confirmed to have a positive drug screen result, or who refuse a required drug screen, or who have a positive drug screen result reconfirmed, or who have altered their specimen or drug screen results are subject to disciplinary action.

VII. ACA STANDARDS: 4-4063.

VIII. EXPIRATION DATE: December 1, 2018.

TENNESSEE DEPARTMENT OF CORRECTION

ACKNOWLEDGMENT OF RECEIPT OF TDOC DRUG-FREE WORKPLACE POLICY (EFFECTIVE DATE 11/1/2006)

By signing this Acknowledgment form, I affirm that I have received a copy of Policy #302.12 Drug-Free Workplace. I understand that it is my obligation to read, understand and comply with the procedures and provisions contained within this policy. I also understand that failure to comply with a drug and/or alcohol testing request or a positive confirmed test for the illegal use of drugs and/or alcohol may lead to disciplinary action up to and including termination of employment and/or loss of workers' compensation benefits.

_____
Employee Name (printed)

_____
Employee Signature

_____
Date

_____
Institution

_____
Witness Signature

TENNESSEE DEPARTMENT OF CORRECTION

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF DESIGNATION OF POSITION AS SAFETY SENSITIVE

(EFFECTIVE DATE 11/1/2006)

By signing this Acknowledgment form, I affirm that I have been notified in writing that my position has been designated as safety sensitive and that I will be subject to random drug/alcohol testing in accordance with Policy #302.12.

_____
Employee Name (printed)

_____
Employee Signature

_____
Date

_____
Institution

_____
Witness Signature

STATE OF TENNESSEE
DEPARTMENT OF CORRECTION
EMPLOYEE SUBSTANCE ABUSE PROGRAM
REASONABLE SUSPICION OF SUBSTANCE ABUSE
TESTING NOTICE

All parts, A through D, must be completed by a trained supervisor and signed by both the supervisor and the Warden/Superintendent (or designee) prior to directing an employee to undergo reasonable suspicion drug testing.

An employee is subject to reasonable suspicion testing when after review of the specific facts and circumstances in a particular employee's case, a trained supervisor concludes that there exists a reasonable suspicion that an employee has engaged or is engaging in conduct prohibited under this policy. A trained supervisor must document the specific facts and circumstances that led to reasonable suspicion.

PART A

Employee: _____Facility: _____

Employee ID # (or SS#) _____ Date(s) of occurrence(s) _____

PART B **Check all that apply.**

1.

PERSONAL APPEARANCE

- ❑ Smells of alcohol
- ❑ Slurred speech
- ❑ Bloodshot eyes, apparent unfocused vision or wearing sunglasses at inappropriate times
- ❑ Deteriorating personal appearance or change in appearance after lunch or breaks
- ❑ Unsteady walk

MENTAL FACTORS

- ❑ Decreased concentration or increased confusion
- ❑ Difficulty understanding and following instruction
- ❑ Repeated mistakes, increased carelessness, errors in judgment
- ❑ Wide mood swings

HEALTH & SAFETY

- ❑ High on-the-job accident rate
- ❑ Numerous accidents off the job that affect work performance
- ❑ Careless handling and maintenance of equipment
- ❑ Needless risk-taking
- ❑ Disregard for others' safety

GENERAL PERFORMANCE

- ❑ Failure to meet deadlines
- ❑ Continuing decrease in work quality and productivity
- ❑ Improbable excuses for poor job performance

PEER RELATIONSHIPS

- ❑ Altercations with others
- ❑ Avoidance of others
- ❑ Excessive co-worker complaints
- ❑ Threatening and intimidating behavior
- ❑ Borrowing money from co-workers

ATTENDANCE

- ❑ Frequent absences for questionable or unexplained reasons or a pattern of absences
- ❑ Unexcused absences
- ❑ Unexplained disappearances from the job
- ❑ Tardiness / leaving work early
- ❑ Long lunches or breaks

Comments made by employee: (Please quote any remarks, admissions, inappropriate language, etc. that may be pertinent to the employee's condition)

_____

_____

_____

****

❑ **2.** Employee observed with drug paraphernalia while on duty or on State of Tennessee property

Reason for believing source is reliable and credible:

_____

_____

_____

****

❑ **3.** Report of prohibited drug and/or alcohol use by employee provided by a reliable and credible source

Reason for believing source is reliable and credible:

_____

_____

_____

Note to Supervisor: Each section of **Part B** will be reviewed independently. An absence of response(s) in any one section does not preclude the ordering of a reasonable suspicion test.

PART C: Provide any additional descriptions of the circumstances, including any facts, inferences drawn from those facts, which constitutes the reasonable suspicion held that the employee has engaged in prohibited drug or alcohol use.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Trained Supervisor Date

_____ _____

Warden/Superintendent (or designee) Date

The signatories are ordering the following reasonable suspicion test (check one):

____ drugs ____ alcohol ____ both

It is required that a copy of this Reasonable Suspicion Form be forwarded to Human Resources.

For purposes of Department of Transportation reporting, please check the following box if this employee is required to maintain a Commercial Drivers License (CDL).

❑ CDL Holder

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index 502.06	Page 1 of 10
	Effective Date: May 15, 2015	
	Distribution: B	
	Supersedes: 502.06 (4/15/13) PCN 14-10 (4/1/14)	
Approved by: Derrick D. Schofield		
Subject: PRISON RAPE ELIMINATION ACT (PREA) IMPLEMENTATION AND COMPLIANCE		

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, TCA 39-13-501, TCA 39-13-503, TCA 39-16-408, TCA 40-39-202, Title 28 CFR Part 115, and the Prison Rape Elimination Act of 2003, 42 USC 15601 through 15609 (PREA).

II. PURPOSE: To prevent sexual abuse of inmates and residents under the jurisdiction of the Tennessee Department of Correction (TDOC).

III. APPLICATION: All TDOC staff, inmates, residents, other employees as defined within this policy, and privately managed institutions.

IV. DEFINITIONS:

A. Employee: For the purpose of this policy, any full-time or part-time staff member, TRICOR employees, volunteer, vendor, intern, contractor, or employee of a contractor.

B. Facility/Site PREA Coordinator (FPC): Associate Wardens of Treatment at TDOC institutions and Assistant Wardens of privately managed institutions who coordinate local PREA programming activities and reporting requirements and oversees the functions of the PREA Compliance Manager. The Director of Community Correction shall serve as the FPC for community confinement centers (residential transitional centers, halfway houses, etc. who are under contract with the TDOC)

C. Potential Sexual Aggressor: Any inmate within TDOC custody who has been identified, utilizing the PREA Screening System Application as an individual who is at risk of sexual abusive tendencies. Any resident in a TDOC contracted confinement or residential facility who has been identified, utilizing the Sexual Aggressor Classification Screening (CR-3737 for females and CR-3638 for males).

D. Potential Sexual Victim: Any inmate within TDOC custody who has been identified, utilizing the PREA Screening System Application as an individual with a past history of victimization. Any resident in a TDOC contracted confinement or residential facility who has been identified, utilizing the Sexual Victim Classification Screening (CR-3737 for females and CR-3638 for males).

E. Prison Rape Elimination Act (PREA): Federal legislation which was enacted and signed by President George W. Bush in 2003 to prevent, detect, and respond to prison rapes, sexual assaults, and sexual harassment within the United States.

F. PREA Compliance Manager (PCM): Individual appointed by the facility PREA coordinator to ensure the facility's compliance with PREA.

G. PREA-Free Walk: A walk (inspection) conducted on a monthly basis at TDOC confinement or residential locations.

H. PREA Screening System Application: Computer application located on the TDOC intranet that is used to screen inmates upon intake and transfer for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. This application replaces the Sexual Aggressor/Victim Classification Screening (CR-3737 for females and CR-3638 for males) NOTE: The CR forms will continue to be used by the residents in contracted facilities supervised by the TDOC Division of Community Supervision.

I. Resident: Any person confined within a community confinement facility, (e.g. halfway houses and residential confinement supervised transitional centers, etc.)

J. Sexual Abuse: Encompasses inmate-on-inmate sexual abuse; inmate-on-inmate sexual harassment; staff-on-inmate sexual abuse; and staff-on-inmate sexual harassment. (These definitions include and are the same for resident-on-resident and staff-on-resident incidents)

1. Inmate-on-inmate sexual abuse: Encompasses all incidents of inmate-on-inmate sexually abusive contact and inmate-on-inmate sexually abusive penetration.

2. Inmate-on-inmate sexually abusive contact: Non-penetrative touching (either directly or through the clothing) of the genitalia, anus, groin, breast, inner thigh, or buttocks without penetration by an inmate of another inmate without the latter's consent, or of an inmate who is coerced into sexual contact by threats of violence, or of an inmate who is unable to consent or refuse.

3. Inmate-on-inmate sexually abusive penetration: Penetration by an inmate of another inmate without the latter's consent, or of an inmate who is coerced into sexually abusive penetration by threats of violence, or of an inmate who is unable to consent or refuse. The sexual acts included are:

   a. Contact between the penis and the vagina or the anus;

   b. Contact between the mouth and the penis, vagina, or anus; or

   c. Penetration of the anal or genital opening of another person by a hand, finger, or other object.

4. Inmate-on-inmate sexual harassment: Repeated and unwelcome sexual advances, requests for sexual favors, verbal comments, or gestures or actions of a derogatory or offensive sexual nature by one inmate directed towards another inmate.

5. Staff-on-inmate sexual abuse: Encompasses all occurrences of staff-on-inmate sexually abusive contact, staff-on-inmate sexually abusive penetration, staff-on-inmate indecent exposure, and staff-on-inmate voyeurism. Staff solicitations of inmates to engage in sexual contact or penetration constitute attempted staff-on-inmate sexual abuse.

6. Staff-on-inmate sexually abusive contact: Non-penetrative touching (either directly or through the clothing) of the genitalia, anus, groin, breast, inner thigh, or buttocks by a staff member of an inmate with or without the latter's consent that is unrelated to official duties.

7. Staff-on-inmate sexually abusive penetration: Penetration by a staff member of an inmate with or without the latter's consent. The sexual acts included are:

   a. Contact between the penis and the vagina or the anus;

b. Contact between the mouth and the penis, vagina, or anus; or

c. Penetration of the anal or genital opening of another person by a hand, finger, or other object.

8. Staff-on-inmate indecent exposure: The display by a staff member of his or her uncovered genitalia, buttocks, or breast in the presence of an inmate.

9. Staff-on-inmate voyeurism: An invasion of an inmate's privacy by an employee for reasons unrelated to official duties or when otherwise not necessary for safety and security reason, such as peering at an inmate who is using a toilet in his or her cell; requiring an inmate to expose his or her buttocks, genitals, or breasts; or taking images of all or part of an inmate's naked body or of an inmate performing bodily functions and distributing or publishing them.

10. Staff-on-inmate sexual harassment: Repeated verbal comments or gestures of a sexual nature to an inmate by a staff member. Such statements include demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

K. Sexual Aggressor: Any inmate within TDOC custody who has been identified, utilizing the PREA Screening System Application as an individual with a past history of institutional sexually aggressive behavior. Also, any resident within a TDOC contracted residential or confinement facility who has been identified, utilizing Sexual Aggressor/Victim Classification Screening (CR-3737 for females and CR-3638 for males).

L. TDOC PREA Coordinator: Individual designated by the Commissioner to oversee, develop, implement, and monitor the Department's PREA programming and reporting responsibilities.

M. Victim: Any inmate within TDOC custody who has been identified, utilizing the PREA Screening System Application as an individual who is a former victim of prison or facility rape or sexual assault. Also, any resident within a TDOC contracted residential or confinement facility who has been identified, utilizing Sexual Aggressor/Victim Classification Screening (CR-3737 for females and CR-3638 for males).

V. POLICY: It is the policy of the TDOC to provide a safe, humane, and appropriately secure environment, free from threat of sexual abuse and sexual harassment for all inmates, by maintaining a program of prevention, detection, response, investigation, and tracking of all alleged and substantiated sexual assaults and sexual harassment. TDOC has zero tolerance for incidences of sexual abuse and sexual harassment within its facilities.

VI. PROCEDURES:

A. The TDOC shall have an absolute zero tolerance towards sexual acts between staff and inmates as well as inmates and inmates. There are no consensual sexual acts in a custodial or supervisory relationship. Any sexual abuse or sexual harassment between employees and inmates is inconsistent with the professional, ethical principles, and polices of the TDOC. There are also no consensual sexual contacts between inmates. All allegations of sexual abuse will be reported and investigated.

B. The Commissioner shall appoint a TDOC PREA Coordinator who will be responsible for implementing, developing, overseeing, and monitoring the Department's PREA activities, policy development and training,

C. The Facility PREA Coordinator (Associate Warden of Treatment/Associate Warden) shall appoint a local PREA Compliance Manager (PCM) who will ensure the facility's compliance with PREA standards. The PCM shall keep the facility PREA coordinator apprised on a monthly basis as to the facility's compliance status. Each facility shall develop internal procedures to document this process.

D. Inmate/Resident Orientation and Education:

1. All inmates entering the TDOC system shall receive verbal and written information concerning sexual abuse within 24 hours of intake at the reception centers. (See Policy #404.05)

2. All contractors housing offenders shall have written policy and procedures providing for resident orientation and education; these policy and procedures shall be approved by the TDOC.

3. Facility staff shall take appropriate steps to ensure that inmates with disabilities (including, inmates who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the staff's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

4. Facility staff shall ensure that written materials are provided in formats or through methods that ensure effective communication with inmates who have disabilities, including inmates who have intellectual disabilities, limited reading skill, or who are blind or have low vision.

5. Staff shall not rely on inmate/resident interpreters, inmate/resident readers, or other types of inmate/resident assistants except in limited circumstances such as an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-responder duties or the investigation of the inmate's claim. TOMIS Contact Note-LCDG shall be posted identifying the name of the assistor and their organization.

6. Facility staff shall take reasonable steps to ensure meaningful access to all aspects of TDOC's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

E. The screening of inmates and residents for sexual aggressor or sexual victim potential and any eventual actual identification as aggressor or victim shall be conducted in accordance with Policy #502.06.1 and the Department's classification processes.

F. Monitoring of sexual abuse or sexual harassment against inmates and residents shall be conducted in accordance with Policy #502.06.1.

G. All allegations of sexual abuse and sexual harassment shall be investigated in accordance with Policy #502.06.2.

H. Each facility shall develop a staffing pattern that provides for the adequate levels of staffing and monitoring to protect inmates and residents against sexual abuse. By July 1st of each calendar year the Warden/AWT shall assess, determine, and document whether adjustments are needed to the facility staffing plan. This review will follow the guidelines of CFR 113.13(a), (b) and (c). A written report shall be provided to the Assistant Commissioner of Prisons and the TDOC PREA Coordinator of the findings of this review. Regardless of any current contractual language between the State and a private residential vendor regarding staffing patterns, these staffing patterns are to be reviewed annually in accordance with PREA required standards upon issuance of this policy.

I. Each PREA site coordinator and/or PREA Compliance Manager shall ensure that an unannounced PREA-free walk (inspection) is conducted on a monthly basis in accordance with PREA Inspection Team Worksheet, CR-3821. This inspection shall be conducted ~~on all shifts~~ to identify and deter staff sexual abuse and sexual harassment.

J. Each Security Shift Supervisor shall conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The unit/program area Log Book shall be annotated with "Unannounced PREA Inspection" by the security shift supervisor when signing into the unit/program area. Additionally, the shift report shall be annotated with the date and time to the unannounced PREA inspection. Any staff member alerting other staff members that these unannounced rounds are occurring will be subject to appropriate disciplinary action.

K. Employee Training:

1. All TDOC employees shall be trained regarding:

   a. TDOC's zero-tolerance policy for sexual abuse and sexual harassment;

   b. How to fulfill their responsibilities under TDOC sexual abuse and sexual harassment prevention, detection, response, and reporting of sexual abuse and sexual harassment. (See Policies #110.01 and #110.05);

   c. Inmates' rights to be free from sexual abuse and sexual harassment;

   d. The right of inmates and employees to be free from retaliation for reporting sexual abuse and sexual harassment;

   e. The dynamics of sexual abuse and sexual harassment in confinement;

   f. The common reactions of sexual abuse and sexual harassment victims;

   g. How to detect and respond to signs of threatened and actual sexual abuse;

   h. How to avoid inappropriate relationships with inmates;

i. How to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates; and

j. How to comply with relevant laws related to mandatory report of sexual abuse to outside authorities.

2. Such training shall be tailored to the gender of the inmates at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only female inmates, or vice versa.

3. Security staff shall be trained how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, in the least intrusive manner possible, consistent with security needs. The Academy shall develop appropriate Lesson Plans for pre-service and in-service security staff.

4. Employees shall document through signature that they have received the training listed in Section VI.(J)(1)(a-j) and that they understand the training they have received.

L. Volunteer and Contractor Training: Each Warden/AWT shall ensure that all volunteers and contractors who have contact with inmates have been trained on their responsibilities under TDOC's sexual abuse and sexual harassment prevention, detection and response policies and procedures. Volunteers shall receive their PREA training in accordance with Policy #115.01. Training acknowledgement for volunteers and contractors shall be documented through signature that they understand the training they have received.

M. Specialized Training for Medical and Mental Health Staff: All full and part-time medical and mental health care practitioners who work regularly in the facility shall be trained in:

a. How to detect and assess signs of sexual abuse and sexual harassment

b. How to preserve physical evidence of sexual abuse

c. How to respond effectively and professionally to victims of sexual abuse and sexual harassment

d. How and to whom to report allegations or suspicions of sexual abuse and sexual harassment

N. Employees of privately managed facilities shall receive PREA training as part of the pre-service and in-service training requirements established by the Contractor and approved by TDOC.

O. The Director of Contracts Administration shall ensure that all new TDOC contracts or contract renewals include language requiring the development of policies and procedures to ensure compliance with PREA standards and training regarding PREA compliance.

P. Any awarded contracts or contract renewals, including Community Supervision contracts, shall be monitored by the Director of Compliance using appropriate inspection instruments during the annual inspection. The inspection instrument shall be developed in conjunction with the TDOC PREA Coordinator to ensure vendor compliance with PREA standards.

Q. Facility staff shall collect accurate uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions, and the PREA Allegation System (PAS). TDOC shall aggregate the incident-based sexual abuse data at least annually. This report shall be prepared by the Decision Support: Research & Planning staff utilizing the DOJ annual reporting format. TDOC shall maintain, review, and collect data via the PAS as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident review.

R. The TDOC PREA Coordinator shall review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:

1. Identifying problem area

2. Taking corrective action on an ongoing basis

3 Preparing an annual report of its finding and corrective action for each facility as well at TDOC as a whole. This report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of TDOC's progress in addressing sexual abuse. This report shall be approved by the Commissioner and made readily available to the public through the Departments website.

S. The TDOC PREA Coordinator shall ensure that data collected is securely retained. TDOC shall make all aggregated sexual abuse data, from TDOC facilities and private facilities with which it contracts, readily available to the public at least annually through the TDOC website. Personal identifiers shall be removed prior to the date being made publicly available.

T. The TDOC PREA Coordinator shall maintain sexual abuse data collected for at least ten years after the date of the initial collection unless federal, state or local law require otherwise.

U. PREA Audit Documentation Retention: Audit documents shall be retained for 12 months following the deadline for any facility audit appeal. Longer document retention may be requested by the U.S Department of Justice.

VII. ACA STANDARDS: 4-4084-1, 4-4281 through 4-4281-8, 4-4282, 4-4371, and 4-4406.

VIII. EXPIRATION DATE: May 15, 2018.

TENNESSEE DEPARTMENT OF CORRECTION
FEMALE SEXUAL AGGRESSOR/SEXUAL VICTIM CLASSIFICATION SCREENING

RESIDENT NAME (*Please Print*) _____ NUMBER _____

STAFF MEMBER(S) (*Please Print*) _____ DATE _____

SEXUAL VICTIM FACTORS

		YES	NO
1.	Prior history of violent offenses	☐	☐
2.	Former victim of Institution (Prison or Jail) rape or sexual assault	☐	☐
3.	Youth age (25 or younger) or Elderly (60 or older)	☐	☐
4.	Small in physical stature (Less than 110 lbs.)	☐	☐
5.	Developmental disability/Mental illness/Medical issues which may contribute to victimization	☐	☐
6.	First incarceration ever (Prison or Jail)	☐	☐
7.	Inmate is or is perceived to be lesbian, bisexual, transgender, intersex or gender non-conforming	☐	☐
8.	History of prior sexual victimization	☐	☐
9.	History of facility consensual sex	☐	☐
10.	Prior history of protective custody (Adult or Juvenile)	☐	☐
11.	Conviction for sex offenses against an adult or child	☐	☐

Is the offender found to be a:

☐ **VICTIM -** If question #2 is answered yes, the offender is classified as a **victim** regardless of the other questions.

☐ **POTENTIAL VICTIM** - If 3 or more of questions #2 – 10 are checked, the offender is classified as a **potential victim**.

☐ **N/A** - If 2 or less of questions # 2-10 are checked, the classification designations are Not Applicable (**N/A**).

Do you recommend another victim finding level? ☐ YES ☐ NO

If yes, which level is recommended? ☐ Potential Victim ☐ N/A ☐ Monitoring ☐ YES ☐ NO

Explanation: _____

FEMALE SEXUAL AGGRESSOR/SEXUAL VICTIM CLASSIFICATION SCREENING
continued

RESIDENT NAME (*Please Print*) _____ NUMBER _____

STAFF MEMBER(S) (*Please Print*) _____ DATE _____

SEXUAL AGGRESSOR FACTORS

		YES	NO
1.	Any history of institutional *(prison or jail)* sexual aggressor behavior	☐	☐
2.	Current or prior rape conviction	☐	☐
3.	Any history of sexual abuse/sexual assault toward others	☐	☐
4.	Any history of physical abuse toward others	☐	☐
5.	Any history of domestic violence toward others	☐	☐
6.	Confirmed gang affiliation	☐	☐

Is the offender found to be a:

☐ **SEXUAL AGGRESSOR** - If question #1 is yes, the offender is classified as a **sexual aggressor** regardless of the other questions.
Any resident classified as SEXUAL AGGRESSOR is to be monitored quarterly for a minimum of one calendar year and is to be re-evaluated for monitoring purposes at annual re-class.

☐ **POTENTIAL SEXUAL AGGRESSOR** - If 2 or more of questions #2 – 6 are checked, the offender is classified as a **potential sexual aggressor**.

☐ **N/A** - If 1 or less of questions # 2-6 are checked, the classification designations are Not Applicable (**N/A**).

Do you recommend another aggressor finding level? ☐ YES ☐ NO

If yes, which level is recommended?

☐ Potential Sexual Aggressor ☐ N/A ☐ Monitoring ☐ YES ☐ NO

☐ **LS/CMI Review (if available)** especially sections 1.8 and sections 2 (perpetrator and victim) and section 4 (other client issues).

Explanation: _____

TENNESSEE DEPARTMENT OF CORRECTION
MALE SEXUAL AGGRESSOR/SEXUAL VICTIM CLASSIFICATION SCREENING

RESIDENT NAME (*Please Print*) _____ NUMBER _____

STAFF MEMBER(S) (*Please Print*) _____ DATE _____

SEXUAL VICTIM FACTORS

		YES	NO
1.	Prior history of violent offenses	☐	☐
2.	Former victim of Institution (Prison or Jail) rape or sexual assault	☐	☐
3.	Youth age (25 or younger) or Elderly (60 or older)	☐	☐
4.	Small in physical stature (Less than 110 lbs.)	☐	☐
5.	Developmental disability/Mental illness/Medical issues which may contribute to victimization	☐	☐
6.	First incarceration ever (Prison or Jail)	☐	☐
7.	Inmate is or is perceived to be gay, bisexual, transgender, intersex or gender non-conforming	☐	☐
8.	History of prior sexual victimization	☐	☐
9.	History of facility consensual sex	☐	☐
10.	Prior history of protective custody (Adult or Juvenile)	☐	☐
11.	Conviction for sex offenses against an adult or child	☐	☐

Is the offender found to be a:

☐ **VICTIM -** If question #2 is answered yes, the offender is classified as a **victim** regardless of the other questions.

☐ **POTENTIAL VICTIM** - If 3 or more of questions #2 – 10 are checked, the offender is classified as a **potential victim**.

☐ **N/A** - If 2 or less of questions # 2-10 are checked, the classification designations are Not Applicable (**N/A**).

Do you recommend another victim finding level? ☐ YES ☐ NO

If yes, which level is recommended? ☐ Potential Victim ☐ N/A ☐ Monitoring ☐ YES ☐ NO

Explanation: _____

MALE SEXUAL AGGRESSOR/SEXUAL VICTIM CLASSIFICATION SCREENING
continued

RESIDENT NAME (*Please Print*) _____ NUMBER _____

STAFF MEMBER(S) (*Please Print*) _____ DATE _____

SEXUAL AGGRESSOR FACTORS

		YES	NO
1.	Any history of institutional *(prison or jail)* sexual aggressor behavior	☐	☐
2.	Current or prior rape conviction	☐	☐
3.	Any history of sexual abuse/sexual assault toward others	☐	☐
4.	Any history of physical abuse toward others	☐	☐
5.	Any history of domestic violence toward others	☐	☐
6.	Confirmed gang affiliation	☐	☐

Is the offender found to be a:

☐ **SEXUAL AGGRESSOR** - If question #1 is yes, the offender is classified as a **sexual aggressor** regardless of the other questions.
Any resident classified as SEXUAL AGGRESSOR is to be monitored quarterly for a minimum of one calendar year and is to be re-evaluated for monitoring purposes at annual re-class.

☐ **POTENTIAL SEXUAL AGGRESSOR** - If 2 or more of questions #2 – 6 are checked, the offender is classified as a **potential sexual aggressor**.

☐ **N/A** - If 1 or less of questions # 2-6 are checked, the classification designations are Not Applicable (**N/A**).

Do you recommend another aggressor finding level? ☐ YES ☐ NO

If yes, which level is recommended?

☐ Potential Sexual Aggressor ☐ N/A ☐ Monitoring ☐ YES ☐ NO

☐ **LS/CMI Review (if available)** especially sections 1.8 and sections 2 (perpetrator and victim) and section 4 (other client issues).

Explanation: _____

TENNESSEE DEPARTMENT OF CORRECTION

INSPECTION TEAM WORKSHEET
PRISON RAPE ELIMINATION ACT (PREA) OF 2003

INSTITUTION

DATE

TEAM LEADER

	POSITION
MEMBERS PRESENT:	
SART COORDINATOR/DESIGNEE:	
SART SECURITY REPRESENTATIVE:	
SART MEDICAL REPRESENTATIVE:	
SART MENTAL HEALTH REPRESENTATIVE:	
OTHER:	
OTHER:	

REVIEW PRIOR MONTH'S REPORT	
Findings: Previous findings corrected?	
Area Toured:	
Findings:	
Staff Quizzed?	
Findings/Comments	
Area Sup. Briefed?	
Comments	
PREA Drill Conducted	
Findings/Comments	
Cameras working?	
Additional comments	

I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To provide a descriptive summary of institutional counseling staff responsibilities.

III. APPLICATION: To all institutional employees and inmates of the Tennessee Department of Correction (TDOC) and privately managed institutions.

IV. DEFINITIONS:

A. Career Development Plan: A detailed plan that the offender will develop with the assistance of Career Development Facilitator that includes occupational and educational short-term goals, long-term goals, and action steps for the individual to follow through while incarcerated and once released. Career development plans will be based on the results of career exploration tools.

B. Career Development Services: Services provided to assist offenders in employment readiness, career development, and workforce development.

C. Career Exploration Tool: An evidence-based tool, such as the O*Net Interest Profiler, that measure an individual's interests and skills in occupational areas and provide direction to the individual in possible career paths.

D. Counseling Services: Supportive consultation services provided by correctional counselors and other correctional staff to provide effective guidance, to promote an inmate's adjustment within the correctional environment, and to aid in coping with various issues of incarceration and transition from prison to community.

E. Employment Portfolio: Comprehensive packet of employment search and career development tools for the offender that includes, but is not limited to: master resume, master application, career development plan, employment readiness hand-outs, vital document applications, copies of earned certifications, etc.

F. Employment Readiness Assessment: An evidence-based assessment tool that certifies offenders as employment ready.

G. Employment Readiness Workshops: Workshops, facilitated by a career development facilitator on employment readiness subject matters to include interviewing skills, resume writing, dress for success, basic math skills, how to keep a job, etc.

H. Level of Service/Case Management Inventory (LS/CMI): A validated risk/needs assessment tool (adopted by both TDOC and the Board of Parole) that utilizes motivational interaction and interview techniques to collect offender-specific information to more accurately identify crime-producing attributes of each inmate and to make more appropriate and productive recommendations for the inmate's level of programming.

I. Reentry Services: Services provided to assist offender transitioning from prison to community i.e., identification, housing, employment, education, substance abuse, mental health, medical, behavioral programming, Veteran's benefits, transportation, disability benefits and service providers.

J. Social Service Staff: Correctional counselors, substance abuse counselors, and mental health professionals.

K. Specialized Counseling: Individual and/or group oriented mental health services provided by licensed/qualified professional staff in order to meet the needs of an inmate.

L. Transitional Assessment Plan (TAP): A document that identifies an inmate's assets and liabilities; prioritizes the inmate's programmatic needs; establishes meaningful goals; and includes action plans to aid the inmate in successfully meeting the stated goals.

M. Transitional Assessment Plan-Behavioral Intervention Goals (TAP-BIG): Information derived from each inmate's LS/CMI scores that identify his/her strengths and weaknesses, prioritizes his/her programmatic needs, establishes meaningful goals, and includes action plans to aid inmates in successfully meeting the stated goals. TAP-BIG information shall be stored on LCLX.

N. Transitional Zone: Period of time in which an inmate is within one to six years of his/her release eligibility date (RED), expiration date, or future action date.

V. POLICY: The Warden/designee shall develop, supervise, and maintain counseling services designed to address the needs of the inmates assigned to the facility.

VI. PROCEDURES:

A. Counseling Services

1. In order to support the process of offender reentry, it is imperative that counseling staff begin the reentry process when an offender is sentenced to TDOC. Each facility shall provide the following counseling services to the offender population:

a. Reentry Services counselors shall assist with offender release planning, TAP-BIG, family reunification, housing, Veteran's Affairs, Social Security, etc.

b. Career Development Services counselors shall assist offenders in obtaining identification, administering career exploration and employment readiness assessments, creating career development plan and employment portfolio, conduct job readiness workshops, etc.

c. Program Facilitators shall facilitate evidence-based programming as approved by the Department.

d. Case managers shall assist offenders by reviewing, updating, and documenting an offender's program status, case plans, and providing information and clarification regarding an offender's inmate's inquiries to include, but not limited to, trust funds, sentence management questions, classification, etc.

B. Staff Availability

1. Institutional policy shall cover procedures for counselor assignments, inmate access to counselors, and provision of crisis intervention services. Such policy shall be submitted to the Assistant Commissioner of Rehabilitative Services for review and approval. Counselors are responsible for ensuring that TOMIS conversation LCD3, Staff Assignment, is kept current.

2. Social service staff to inmate ratio shall not exceed 1:50 unless approved by the Assistant Commissioner of Rehabilitative Services.

3. Work schedules of counselors and unit team staff shall be flexible and include evenings and weekends.

C. Provisions for Services

1. TAP-BIG recommendations for inmates will be recorded on e-TOMIS LCLX or on TOMIS LCLX, Option 2, per Policy #513.04.1 and, if necessary, continued under LCLF (NA) by staff at reception centers at the conclusion of the classification process. (See Policy #401.08)

   a. Within 14 days of the inmate's arrival at the permanently assigned institution, the counselor shall meet with the inmate to review classification and TAP/TAP-BIG recommendations. Inmates will be placed on registers according to Policy #513.04.1

   b. Staff shall also request the assistance of mental health and educational specialists for recommendations as needed. The use of community resources which augment institutional social services shall be encouraged.

2. Program Plan Summary: Following the TAP/TAP-BIG review, a program plan summary or update is to be entered on TOMIS-LCDG, Contact Type TAPR (Transitional Assessment Review Plan) by a member of counseling services. The summary should include a brief statement concerning the inmate's needs background.

   Emphasis should be placed on areas which appear to be significant. Needs should include, but not be limited to, the following:

   a. LS/CMI Domains
   b. Mental health
   c. Sex offender treatment (SOTP)
   d. Violence intervention and anger management
   e. Victimization
   f. Predatory conduct
   g. Security threat group (STG)
   h. ID/Driver's License (See Policy #511.05)

3. Monitoring/Progress Notes: During the period of incarceration, the inmate's progress will be monitored by the counseling services staff. Program progress notes and other significant contacts shall be entered under LCDG, Contact Type TAPR. During scheduled annual or special classification hearings, the counselor shall summarize the inmate's total progress to date.

4. Notes shall be made if significant events occur at any time between these intervals, or if there is a substantive contact between the inmate and the counselor, including but not limited to, the following events:

   a. Treatment program/class terminations
   b. New LS/CMITAP-BIG recommendations
   c. Significant misconduct
   d. Segregation
   e. Social Issues

   Counseling services staff may determine if there is a need for additional or updated evaluations, e.g., mental health. In this case, the counselor shall make the referral to the appropriate program coordinator or supervisor.

5. Inmates who are in the transition zone will be seen quarterly to review program status and documentation recorded on TAPR by the assigned case manager.

6. The process of program review and monitoring will be suspended during periods of administrative segregation except for obvious needs, e.g., health, mental health, and conduct. Appropriate attention will be given to such needs and notes will be made during required reviews.

7. Protective custody unit programmatic resources may be limited, thereby resulting in suspended program activity. However, there may be issues of need to be addressed and noted, e.g., significant protection issues including victimization, which may necessitate further attention.

D. The chief counselor and correctional counselors shall serve on various institutional committees and boards, as institutional coordinators of inmate organizations.

E. Any staff member with documented qualifications may provide specialized group counseling and other appropriate services which address LS/CMI domains and are within their areas of expertise (i.e., substance abuse programs, etc.). Classroom training and monitoring by the mental health staff also allows for non-clinical group counseling to be conducted by unit teams or individual counselors (AA, NA, anger management, self-esteem, etc.).

VII. ACA STANDARDS: 4-4428, 4-4433, 4-4434, 4-4435, 4-4437, and 4-4442.

VIII. EXPIRATION DATE: September 15, 2016.

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 508.04	Page 1 of 1
	Effective Date: October 1, 2013	
	Distribution: B	
	Supersedes: N/A	
Approved by: Derrick D. Schofield		
Subject: COUNSELING SERVICES		

POLICY CHANGE NOTICE 13-40

INSTRUCTIONS:

Please change Section VI.(B)(2) to read as follows:

"2. Case Management Correctional Counselor staff to inmate ratio shall not exceed 1:150 unless approved by the Assistant Commissioner of Rehabilitative Services."

ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 508.04	Page 1 of 1
	Effective Date: March 15, 2015	
	Distribution: B	
	Supersedes: N/A	
Approved by: Derrick D. Schofield		
Subject: COUNSELING SERVICES		

POLICY CHANGE NOTICE 15-3

INSTRUCTIONS:

Please add new Sections VI.(B)(4) and VI.(B)(5) to read as follows:

"4. The Associate Warden of Treatment/Designee shall notify the Statewide Correctional Counselor Program Manager at TDOC Central Office of any reassignment of specialty counselors within three business days of the reassignment. Specialty counselors include the following:

a. Reentry Specialists

b. Career Development Specialists

c. Program Facilitators for Group Therapy, Therapeutic Community, and Pro-Social Life Skills.

5. The Associate Warden of Treatment/Designee shall notify the Statewide Correctional Counselor Program Manager at TDOC Central Office in writing of any correctional counselor who is on extended leave within three business days of notification from correctional counselor. The Associate Warden of Treatment/Designee shall also provide a contingency plan in writing on how to ensure the correctional counselors duties will be covered during his or her absence to ensure the facility is operating within policies."