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

II. PURPOSE: To ensure the availability of laboratory services necessary to provide health care to inmates.

III. APPLICATION: Wardens/Superintendents, Associate Wardens of Treatment/Deputy Superintendents, health administrators, medical contractors, privately managed facilities, and health care staff.

IV. DEFINITIONS:

A. Clinical Laboratory Improvement Amendments (CLIA): Establishes quality for all laboratory testing to ensure patient test results' accuracy, reliability, and timeliness.

B. CLIA Certificate for Provider-Performed Microscopy Procedures (PPMP): Certification to perform laboratory procedures that have been specified as provider-performed and, if applicable, examinations or processes that have been approved as waived laboratory tests by the U.S. Department of Health and Human Services.

C. CLIA Certificate of Waiver: Certification for a laboratory to perform examinations or procedures approved as waived laboratory tests by the U.S. Department of Health and Human Services.

V. POLICY: Each facility shall provide the necessary laboratory services to support health care.

VI. PROCEDURES:

A. *The Health Services Unit Manual* at each facility shall include written procedures for acquiring necessary laboratory services. The facility may use the contract laboratory's guidelines and instructions.

B. All CLIA guidelines shall be adhered to by privately managed institutions and medically contracted facilities in obtaining appropriate certification and/or certificate of waiver for its laboratories. Deberry Special Needs Facility shall obtain a CLIA Certificate for provider-performed microscopy procedures (PPMP).

C. Each facility’s health service unit shall perform essential laboratory services consistent with the inmate population and the accessibility of health care resources.

1. On-site laboratory tests with immediate results shall include multiple-test dipstick urinalysis, finger-stick blood glucose, fecal occult blood, and peak flow.

2. Facilities housing female inmates shall possess slides with slipcovers and microscopes so that vaginal wet preps can be accomplished.

D. Each facility shall be capable of adequately collecting, safeguarding, storing, and transporting laboratory specimens. Specific specimen requirements from the institution's contract laboratory shall be contained in the institution's Health Service Unit Manual.

E. A laboratory log shall be maintained for all laboratory procedures performed in-house and through contract services. The log shall include the date, time, inmate number, name of the laboratory procedure, provider name, date the specimen was sent, and the date the results were received. Each facility's health administrator shall provide laboratory data on the Monthly Statistical Report.

F. Each facility shall maintain data in accordance with CLIA guidelines. Basic requirements include:

1. Immunohematology reports and data are to be kept for five years.

2. Pathology reports and data are to be kept for ten years.

3. All other reports and logbooks must be kept for at least two years.

G. All laboratory services shall require the order of the physician or mid-level provider. Appropriate laboratory forms shall be fully completed when requesting services. All laboratory results shall be reviewed, initialed, and dated by the physician or mid-level provider within five business days of receiving the results at the institution and then filed in the health record~~s~~ as appropriate.

H. Documentation:

1. Nurses shall document a narrative note indicating the date, time, and type of laboratory specimen collected on the Problem Oriented Progress Note, CR-1884.

2. For venipunctures, the nurse shall additionally document the size of the needle used, the number of needle sticks occurring to collect the specimen, the part of the body where the venipuncture occurred, and how the patient tolerated the procedure.

3. The following CR forms shall be used to document the respective on-site testing and filed in Section II of the health record:

a. Diabetic Record, CR-2006

b. Prothrombin Time: International Ratio (PT/INR) Result Sheet, (Non-Coumadin Patient), CR-4211

c. Coumadin Patient Flow Sheet, CR-4212

d. Urine Dipstick Results, CR-4186

e. Fecal Occult Blood/Hemoccult Card Results, CR-4268

VII. APPLICABLE FORMS: CR-1884 (Rev. 8/19), CR-2006 (Rev. 9/19), CR-4186 (Rev. 2/21), CR-4211, CR-4212, and CR-4268.

VIII. ACA STANDARDS: 5-ACI-6D-05.

IX. EXPIRATION DATE: February 1, 2026

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

_____

INSTITUTION

INMATE NAME: _____ TDOC ID: _____

DATE	TIME	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION
DIABETIC RECORD (*by Glucose Monitoring Device)*

_____
INSTITUTION

Patient: _____ TDOC ID: _____

Physician _____ Location _____

Current Weight: _____ Height: _____ Age: _____ Diet: _____

Current Medication Order: _____

DATE	TIME	BLOOD GLUCOSE READING	MEDICATION GIVEN	REMARKS	NURSE INTIALS
	HR				
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Provider Review: _____ Date: _____

DIABETIC RECORD (*by Glucose Monitoring Device*)

Patient: ______________________________ TDOC ID ______________

DATE	TIME	BLOOD GLUCOSE READING	MEDICATION GIVEN	REMARKS	NURSE INTIALS
	HR				
	HR				
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Provider Review: ______________________________ Date: ______________

TENNESSEE DEPARTMENT OF CORRECTION

URINALYSIS DIPSTICK RESULTS

_____

INSTITUTION

NAME: _____ TDOC ID: _____

Brand/Type of Dipstick:_____**Time:**_____

TEST RESULTS

**Results-Circle Appropriate Reading*

Appearance: Clear Cloudy Sediment

Color: Yellow Amber Pink Orange Blue Green Brown Red

Leukocytes: NEG 15+ 70+ 125++ 500+++

Nitrite: NEGATIVE POSITIVE (Any degree of pinkish color) **See Strip Bottle

Urobilinogen: NEG Trace 0.2(3.5) 1 (17) 2(35) 4(70) 8(140) 12(200)

Protein: NEG 15(0.15) 30(0.3)$^{+}$ 100(1.0)$^{++}$ 300(3.0)$^{+++}$ 2000(20)$^{++++}$

PH: 5.0 6.0 6.5 7.0 7.5 8.0 9.0

Blood: NEG TRACE (+/-) $^{+}$ $^{++}$ $^{+++}$ 5-10 50

Specific Gravity: 1.000 1.005 1.010 1.015 1.020 1.025 1.030

Ketone: NEG 5(0.5)$^{+}$ 15(1.5) $^{++}$ 40(4.0)$^{++}$ 80(8.0) $^{+++}$ 160(16)$^{++++}$

Bilirubin: NEG 1(17)$^{+}$ 2(35)$^{++}$ 4(70)$^{+++}$

Glucose: NEG 100(5)+/- 250(15)$^{+}$ 500(30)$^{++}$ 1000(60)$^{+++}$ 2000 or more (110) $^{++++}$

Nurse completing reading: _____Date:_____

Provider reviewing results: _____Date:_____

TENNESSEE DEPARTMENT OF CORRECTION

Prothrombin Time: International Ratio (PT/INR)

Result Sheet

(Non-Coumadin Patient)

Patient Name_____ **TDOC ID:** _____

Date	Time	PT Result	INR Result	Nurse Signature

Provider Signature_____ **Date**_____ **Time**_____

TENNESSEE DEPARTMENT OF CORRECTION

Coumadin Patient Flow Sheet

DEMOGRAPHICS	
Facility Name:	TDOC ID:
Patient Name:	DOB:
Location:	Gender: ☐ Male ☐ Female
Clinical Indication*:	INR Therapeutic Range: ☐2-3 ☐2.5-3.5 ☐_____

Cautions:

☐ Coumadin fact sheet reviewed with patient ☐ Master Problem List Populated

Date Of INR Result	Current Dose	INR Result	Complications	List Dose Change	Next INR Date	Practitioner's Signature

Guideline for Adjusting Coumadin Dosages:

INR less than lower limit of therapeutic range (2) – increase weekly Coumadin dose by 5 – 20%;
INR above therapeutic range by 0.1 - 0.5 – decrease weekly Coumadin dose by 5 – 10%;
INR 0.6 – 2 above therapeutic range – consider withholding one dose, and decrease weekly dose by 10 -15%;
**INR 2-7 above therapeutic range – withhold 2 doses, decrease weekly dose by 15-20% and administer a single dose of Vitamin K 1-2.5 mg p.o.
INR > 7 above the therapeutic range – hold Coumadin **and administer a single dose of Vitamin K 3-5 mg p.o.; the provider should anticipate significant reduction in INR within 24-48 hours

Monitoring:

INRs are to be monitored at least twice a week when Coumadin is initiated; Then weekly for at least 4 consecutive weeks of therapeutic values, then monthly; The monitoring cycle restarts from the beginning whenever an INR is non-therapeutic.

****Supra-therapeutic INRs Require Emergent Attention with a Provider**

In the case of significant bleeding, patients must be referred to hospital for parenteral Vitamin K and fresh frozen plasma (FFP) infusion.

***Indication and INR Range**

1. Acute Myocardial Infarction with risk 2-3
2. Recurrent Myocardial Infarction 2.5 – 3.5
3. Atrial Fibrillation (moderate to high-risk patients) 2-3
4. Valvular Heart Disease 2-3
5. Tissue Heart Valves 2 -3
6. Prevention of Venous Thromboembolism (High risk surgery) 2-3
7. Treatment of Venous Thrombosis 2-3
8. Bi-leaflet Mechanical Heart Valve 2-3
9. Mechanical Heart Valve (caged ball, caged disk) 2.5 -3.5
10. Other:

TENNESSEE DEPARTMENT OF CORRECTION

HEMOCCULT CARD RESULTS

_____
INSTITUTION

INMATE NAME: _____ TDOC ID: _____

#1 Hemoccult Card Result (circle one): positive / negative

_____
Date Nurse Signature Completing Test

#2 Hemoccult Card Result (circle one): positive / negative

_____
Date Nurse Signature Completing Test

#3 Hemoccult Card Result (circle one): positive / negative

_____
Date Nurse Signature Completing Test

Results Reviewed by: _____
Provider Signature Date