Health Care Services

Manual

Adult Custody Division
Corrections Branch
Ministry of Justice

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1. Health Care Services

Health care services, provided by qualified personnel, are available to all inmates.

1.1. Purpose

The primary purpose of health care services is to treat illness, injury and disease to restore or improve the health of the inmate, recognizing differences in gender, age and culture.

1.2. Levels of health care

The following levels of care will be provided within the Adult Custody Division:

- First aid;
- Emergency care;
- Primary care;
- Provisions for 24-hour nursing care, if required; and
- Isolation care capability.

1.3. Emergency health care

1. Around-the-clock emergency health care is available to all inmates.
2. Plans to achieve this goal are developed by the warden or designate, and contain, at minimum, the following elements:
    - Emergency on-call physician services;
    - Emergency evacuation of patient from the facility;
    - Access to emergency vehicle(s); and
    - Use of designated hospital emergency departments or other health facilities, as needed.

1.4. Manuals of policies and procedures (revised: Sep-12)

Manuals of policies and procedures are developed for the delivery of health care services. Contents are recommended by the director, Health Services and/or the director, Mental Health Services in consultation with the Health Care Committee and approved by the provincial director, Adult Custody. They are:

- B.C. Corrections Health Care Reference Manual (HCRM);
- B.C. Corrections Health Care Records User's Manual;
- B.C. Corrections Drug Formulary;
- Lippincott Manual of Nursing Practice; and
- Occupational Health and Safety Regulations.

1.5. Health care space

1. The Adult Custody Division provides adequate health care space, equipment, supplies and materials to meet the needs of each centre.

2. Space is designed to allow for private examination and treatment of patients.

1.6. Management of health services (revised: Sep-12)

1. Administration of health services is the responsibility of the warden or designate.

2. Daily planning and organization is the responsibility of the health care manager, in consultation with the warden or designate.

3. The director, Health Services and/or the director, Mental Health Services are responsible for overseeing matters of clinical practice.

1.7. Registration and certification (revised: Mar-13)

1. Provincial licensing, registration or certification requirements and restrictions apply to health care personnel who provide services to patients.

2. When health care professionals are employees or are on a direct service contract, verification of credentials is the responsibility of the warden or designate.

3. When a contractor employs health care professionals, the contractor is responsible for verification of credentials.

4. Registration required:

    - Physicians – College of Physicians and Surgeons of British Columbia;
    - Dentists – College of Dental Surgeons of British Columbia;
    - Psychologists – College of Psychologists of British Columbia;
    - Nurse Practitioners – College of Registered Nurses of British Columbia;
    - Nurses – College of Registered Nurses of British Columbia;
    - Psychiatric Nurses – College of Registered Psychiatric Nurses of British Columbia;
    - Licensed Practical Nurse – College of Licensed Practical Nurses British Columbia; and
    - Physiotherapists – Association of Physiotherapists and Massage Practitioners.

5. Certification required:

    - Pharmacy technicians must graduate and hold a certificate from a recognized pharmacy training program;
    - Medical office assistants must graduate and hold a certificate from a recognized medical office assistant program or have equivalent experience;
    - Occupational first aid attendants must be certified by WorkSafe BC; and
    - Persons, other than nurses, nurse practitioners, physicians and pharmacists, whose job description requires them to distribute medication, must be certified through the *Medication Distribution Handbook* training.
    - All health care professionals receive training and certification in the Primary Assessment and Care (PAC) inmate health information system and, as required, in CORNET, the Corrections Branch offender management system.

1.8. Orientation

1. The warden or designate ensures that health professionals receive orientation before they work on their own.

2. Orientation includes:

    - Security and control procedures;
    - Local procedures and routines;
    - Personal safety matters;
    - Adult Custody Division operating policies;
    - ADM directives;
    - Emergency procedures, including response requirements to medical emergencies, fire and evacuation; and
    - An overview of the structure and organization of the Corrections Branch and the justice system.

1.9. Health care records (revised: Sep-12)

1. Health care records are established and maintained in the prescribed format outlined in the *Health Care Record User's Manual*.

2. Only approved B.C. Corrections Branch health care forms are used.

3. Health care records are maintained for each patient in the Primary Assessment and Care (PAC) inmate health information system. Only health care forms that require a patient's signature (e.g. request, contract, or consent forms) or other paper forms and documents from external sources (e.g. diagnostic results from a laboratory) are maintained in a patient's physical file. These paper documents are also accounted for in PAC.

4. Health care records are maintained separately from correctional records.

5. Subject to the exceptions outlined below in section 1.10(2), Adult Custody Division health care professionals have sole access to PAC, health care files, and their contents.

6. Health care professionals ensure that a summary of pertinent information from active physical health care records is documented in PAC by direct data entry. A notation is made in PAC of this file review.

7. Reference is made in PAC regarding the location of active physical health care records if information from those files is not entered in the system in a timely manner.

8. Historical and non-active physical health care records that have been entered in PAC are subject to archiving in accordance with records management legislation and policy. Documentation is not removed from a file forwarded for archiving.

9. Health care professionals ensure PAC business continuity by saving data to a designated computer hard drive at the close of every day prior to midnight.

10. Only the medical director, Corrections Branch, the director, Health Services and the director, Mental Health Services have unrestricted access to information contained within PAC for the purpose of conducting investigations, as authorized by the provincial director or the deputy provincial director. Requests for PAC help desk actions are approved by the director, Health Services and the director, Mental Health Services. The director, Health Services and the director, Mental Health Services are responsible for reviewing and responding to approved agents who request information from PAC.

1.10. Confidentiality (revised: Jan-13)

1. Health care staff maintain the confidentiality of personal information in accordance with the *Freedom of Information and Protection of Privacy Act* (FOIPPA).

2. Information obtained during health care assessment and treatment is confidential.

3. Exceptions are:

    - The duty to warn of serious impending danger;
    - Information necessary for the safe management of the patient and security of staff. This information is communicated through the CORNET Alerts screen and CORNET Client Log updates. Specific diagnostic information must be excluded;
    - Investigations conducted by the Office of Ombudsman, the Investigation and Standards Office, and the Office of the Coroner;
    - Preparing a defence when court actions are brought against the Adult Custody Division or the health care service provider;
    - A request/demand pursuant to section 96(1) *Child, Family and Community Services Act* for child protection purposes;
    - Upon receipt of an access to information request, personal medical records are reviewed and severed by approved personnel as authorized in section 33.2(c) FOIPPA;
    - Written consent given by the inmate to disclose to a third party;

- A legal search warrant;
- Health care professionals subpoenaed by the court; and
- For mental health information from the health care record necessary for dangerous offender applications, contact the director, Health Services and director, Mental Health Services.

4. Requests received from the police, Crown counsel, defence counsel or other third party for medical/health data without written consent, search warrant or a subpoena, must not be disclosed, either verbally or by access to written documentation, to protect confidentiality.

5. Discarded paper from health care that includes the names of patients and/or other confidential information is shredded.

1.11. Health assessment (revised: May-13)

1. New admissions: Within 24 hours of intake, all inmates have a health assessment performed by a physician, nurse practitioner or a nurse acting under the direction of a physician, regardless of the date of their last admission. Assessments are done in private. The Initial Health Assessment form is completed in the Primary Assessment and Care (PAC) inmate health information system.

2. A search and review is conducted of any historical health care file to ensure that all known information concerning the inmate is referenced.

3. All onsite files are located and retrieved. For clinical reasons, the health care manager and/or physician may request retrieval of offsite files. A summary of pertinent data from these files is entered in PAC.

4. Transfers:

    - When an inmate is transferred within the provincial correctional system, a review of the health care record is completed, including the Initial Health Assessment form, New Mental Health Screening form, and significant changes in health or mental health status.
    - Prior to transfer, a notation is made in the Primary Assessment and Care (PAC) inmate health information system, and includes current health and mental health status, and treatment plan.
    - The receiving centre reviews the health care record within 24 hours of admission, documents the review in PAC, and ensures that arrangements are made to continue

the patient's treatment plan and address any outstanding health or mental health needs.

- For patients with mental health needs, a referral is made to the mental health co-ordinator to ensure that arrangements are made to continue the patient's mental health treatment plan.

5. When an inmate is received from a mental health facility (e.g. Forensic Psychiatric Hospital following a temporary absence or assessment), a new initial health assessment is completed.

1.12. Placement (revised: Mar-13)

1. Health care staff complete an initial health assessment for all inmates within 24 hours of intake and prior to classification decisions regarding work, education and recreation. Information from the assessment is conveyed to correctional staff as follows:

    - Information critical to the immediate health and safety of an inmate is entered in the CORNET Alerts screen.

    - Relevant information that is required for case management of the inmate and operation of the correctional centre is entered on the CORNET Client Log. Specific diagnostic information must not be included.

    - Alerts are added and expired in CORNET as necessary to maintain current information.

    - Changes are communicated on the CORNET Client Log.

2. Placement needs for health reasons are communicated on the CORNET Client Log.

3. A patient requiring health care beyond the resources available in the facility is transferred to another correctional centre where such care is available, or placed in hospital.

4. A patient cannot choose to be treated outside of a correctional centre if in the opinion of the treating physician or nurse practitioner appropriate treatment is available onsite. Health care staff maintain a record of all reasonable efforts made to minimize the likelihood of an inmate suffering significant and avoidable health consequences if treatment is refused in a correctional centre. Legal advice is sought when an inmate, having been advised of the consequences, absolutely refuses available medical treatment.

1.13. Special diets (revised: Mar-13)

1. The physician or nurse practitioner may recommend a special diet to accommodate a life-threatening allergy or to manage a medical condition. When a physician or nurse

practitioner is unavailable, a registered nurse may recommend a special diet for up to seven days.

2. Health care staff advise correctional staff that an inmate requires a special diet by:

    - Sending an email to the food services manager and deputy warden of programs or designate; and

    - Entering a medical alert on CORNET using the code Special Diet.

3. When health care staff recommend a diet to manage a medical condition, the need for the special diet is reviewed periodically by the physician or nurse practitioner. The special diet alert in CORNET is updated or expired if necessary and changes are communicated to the food services manager and deputy warden of programs or designate.

4. Correctional managers may request confirmation from health care staff that the special diet is medically necessary.

5. Correctional staff address other non-medical concerns regarding diet. The patient avoids food that causes intolerance or is disliked.

1.14. Informed consent

1. Examinations, treatments and procedures affected by informed consent standards in the community are observed by B.C. Corrections Branch.

2. Patients are informed of the nature, consequences, risks and alternatives concerning the proposed treatment, examination or procedure. Patients have the right to refuse treatment and must be informed of the consequences of this refusal. Refer to the *Health Care Record User's Manual* for information and instruction for completing a Refusal for Treatment (HS 021) form.

3. General hospitals have a method for proceeding with emergency treatments when informed consent cannot be obtained. Procedures used by the local hospital apply to individuals in custody of the Adult Custody Division.

1.15. Health care requests (revised: Jul-08)

1. Inmates' completed Health Service Request (HS 020B) forms are forwarded confidentially and daily to health care professionals.

2. All Health Service Request forms are recorded in PAC using the Health Service Request Details screen.

3. The nurse(s) screens Health Service Request forms, provides treatment, and prioritizes referrals to health care professionals.

1.16. Consultations with on or off-site specialists (revised: Mar-13)

1. The correctional centre's physician or nurse practitioner determines whether a consultation with the specialist is required. The physician or nurse practitioner refers the patient to the specialist to request an opinion and treatment recommendations.

2. Before seeing a consulting specialist, patients are informed by health care staff that the physician or nurse practitioner will plan and prescribe treatment after consulting with the specialist.

3. A specialist does not write prescriptions and refrains from making representations to the patient regarding what medications may be prescribed.

4. The specialist prepares a consultation report and recommended treatment plan that are reviewed during the next scheduled clinic by any attending physician or nurse practitioner. Any physician or nurse practitioner authorized to provide service at the correctional centre may review the report and recommendations, and initiate the treatment plan.

5. If the physician or nurse practitioner concurs with the recommendations provided in the specialist's report and is able to make a determination following a review of the patient's health care record, the recommended treatment is prescribed. Any reasons for deviation in treatment from the specialist's recommendations are outlined clearly in the Primary Assessment and Care (PAC) inmate health information system by the physician or nurse practitioner. Examples may include:

    - Medical contraindications;
    - Medication interactions;
    - Questionable efficacy based on past experience; or
    - History of medication diversion in the past.

6. When the physician or nurse practitioner who is responsible for implementing the treatment plan requires an additional or updated patient assessment before prescribing medication, this physician or nurse practitioner sees the patient as soon as possible so as not to delay treatment.

7. When there is substantial disagreement between the recommendations of the specialist and the physician or nurse practitioner's intended treatment plan, the physician or nurse

practitioner is required to contact the specialist to discuss the case. Examples of substantial disagreement may include:

- Physician or nurse practitioner declines to prescribe a medication recommended by the specialist;
- Physician or nurse practitioner declines to prescribe a medication at the dosage recommended by the specialist; or
- Physician or nurse practitioner disagrees with a surgery or procedure recommended by the specialist.

8. Physicians and nurse practitioners consult with each other regarding challenging cases.

9. The final decision regarding the patient's treatment plan rests exclusively with the centre's physician or nurse practitioner.

1.17. Specialist appointments – maternity (revised: Sep-12)

1. Pregnant women at Alouette Correctional Centre for Women (ACCW) are referred to the Ridge Meadows Maternity Clinic (RMMC) when the delivery date is during their incarceration at the centre. Such referrals are consistent with patients in the Maple Ridge catchment area.

2. RMMC referral forms are used, and protocols between RMMC and ACCW are followed.

3. RMMC physicians monitor the patient and determine the level of health risk. They also make decisions regarding referrals to obstetricians at the Ridge Meadows Hospital (RMH) when necessary. ACCW patients are expected to receive the range of RMH delivery and perinatal care services onsite at the Ridge Meadow Hospital.

4. If physicians at RMMC and/or RMH believe the patient requires referral to a tertiary centre for labour, delivery and perinatal care, the hospital of choice is the Royal Columbian Hospital (RCH). Referral to RCH is consistent with practices in the Maple Ridge area.

5. The director, Health Services is advised when a tertiary referral is initiated.

1.18. Medical diagnostic reports (revised: Mar-13)

1. As soon as medical diagnostic results are received, they are date-stamped.

2. The nurse reviews the results and immediately advises the physician or nurse practitioner of urgent abnormal results and prepares test results for review by the physician or nurse practitioner at the next doctor's clinic.

3. The physician or nurse practitioner reviews and initials test results, documenting the disposition of the case in the Primary Assessment and Care (PAC) inmate health information system before the report(s) is filed on the patient's health care record.

1.19. Clinical reassessment (revised: Mar-13)

1. Referrals or requests for reassessment between clinicians must be entered in the patient's health care record in the Primary Assessment and Care (PAC) inmate health information system.

2. Referrals include the reason for requesting a reassessment.

1.20. Frequent monitoring medical conditions[1] (revised: Mar-13)

1. Patients with acute or evolving medical conditions are monitored at least daily and more often if clinical circumstances warrant. Patients housed in segregation or observation with such conditions are monitored at least every shift or more often if clinical circumstances warrant. A Frequent Monitoring Record is also completed. Refer to the *Health Care Record User's Manual* for information and instructions in completing the Frequent Monitoring Record.

2. Implementation of a frequent monitoring protocol is mandatory for all patients who are housed in segregation or observation for medical reasons. Frequency and type of examinations required for each patient will be specified in the medical record. A Frequent Monitoring Record form will be completed on all such patients.

3. Recommendations for placement in segregation for medical observation are reviewed and approved, in consultation with correctional staff, by the health care manager or designate, or the physician or nurse practitioner, prior to placement being effected. A nursing plan is developed.

4. When patients are housed in segregation or observation for medical reasons, health care professionals advise the correctional supervisor and segregation staff, verbally and in writing through the CORNET Client Log, about the reasons for the confinement, the supervision level, and the patient's conditions and needs. Supervising correctional staff is similarly advised of the medical conditions and needs of inmates housed in segregation for disciplinary reasons.

[1] Relates to both physical and mental health conditions.

5. Health care professionals review on a daily basis CORNET Client Log entries for patients housed in segregation or observation for medical reasons.

1.21. Health care professional visits to segregation inmates (revised: Jul-08)

Inmates housed in segregation are seen by health care professionals and have the opportunity to speak with them at least once in every 24-hour period.

1.22. Education materials

Adult Custody Division provides health information and education to patients.

1.23. Health equipment given to patients

1. Precautions related to security, health, safety and self-harm must be taken when health equipment is given to patients.

2. Health equipment issued to patients must be monitored and retrieved when no longer needed.

1.24. Research (revised: Sep-12)

Research involving inmate health care is approved only by the assistant deputy minister, Corrections, in consultation with the director, Health Services and the director, Mental Health Services.

1.25. Review process

The Adult Custody Division must ensure a review process is in place to monitor health care services.

1.26. Critical incident investigation (issued: Sep-12)

1. The health care contractor does not commence any investigation or review until the Corrections Branch, Investigation and Standards Office, and/or Office of the Coroner have completed their investigations. The health care contractor receives written confirmation of the completed investigations from the Corrections Branch prior to commencing its own investigation or review.

2. The health care contractor immediately provides all medical records requested by the chair of a critical incident review team.

3. Only the director, Health Services and the director, Mental Health Services may access health care records as members of a critical incident review team.

2. Mental Health Services

Mental health services, provided by qualified personnel, are available to all inmates.

2.1. Purpose (revised: Jul-08)

1. The primary purpose of mental health services is to treat mental illness to restore or improve the health and functioning of the patient, recognizing differences in gender, age, and culture. Mental health professionals work in consultation with the health care team and are bound by health care policies in chapter 1, Health Care Services.

2. Mental health screening identifies inmates who require mental health services and special care or attention in the institution. Mental health screening may help identify inmates who are at risk of self-harm or harm to others.

3. Relevant information obtained from the mental health screening must be recorded in the New Mental Health Screening section of the Primary Assessment and Care (PAC) inmate health information system. Information necessary for corrections staff to safely house the inmate in the centre is shared with corrections staff as required.

4. A psycho-diagnostic assessment includes an evaluation of the patient's mental health history, current mental status, treatment needs, risk of self-harm, and other psychological or psychiatric needs that may arise. Whenever possible, the psychologist or psychiatrist seeks to obtain previous health care records pertaining to the patient's history of mental illness.

5. Mental health assessments focus on obtaining information needed to make decisions about classification and treatment services. Mental health treatment focuses on restoring the patient's mental health and assisting the patient to receive services when released to the community. When possible, the services of a forensic liaison or a mental health worker are enlisted to arrange post-release community services.

2.2. Levels of mental health care

The following levels of care are provided:

- Mental health screening;
- Crisis intervention; and
- Basic mental health care and treatment.

2.3. Management of mental health care (revised: Sep-12)

1. Psychologists, psychiatrists and other mental health professionals are responsible for providing mental health services to inmates.

2. Administration of mental health services is the responsibility of the warden.

3. The director, Mental Health Services, and/or the director, Health Services are responsible for overseeing matters of clinical practice.

2.4. *Mental health services provided (revised: May-13)*

1. Mental health services provided include:

    - Intake screening;
    - Monitoring/screening of inmates;
    - Psycho-diagnostic assessment when indicated;
    - Basic mental health care and treatment; and
    - Planning for post-release mental health care.

2. Mental health intake screening:

    - New admissions: A mental health intake screener interviews all inmates within 24 hours after admission. The New Mental Health Screening form is completed in the Primary Assessment and Care (PAC) inmate health information system and referrals are made to health care and mental health care professionals. Urgent information is promptly shared with corrections staff.
    - Transfers:
        - When an inmate is transferred within the provincial correctional system, a review of the health care record is completed, including the Initial Health Assessment form, New Mental Health Screening form, and significant changes in health or mental health status.
        - Prior to transfer, a notation is made in the Primary Assessment and Care (PAC) inmate health information system, and includes current health and mental health status, and treatment plan.

- The receiving centre reviews the health care record within 24 hours of admission, documents the review in PAC, and ensures that arrangements are made to continue the patient's treatment plan and address any outstanding assessment or treatment needs.

- For patients with mental health needs, a referral is made to the mental health co-ordinator to ensure that arrangements are made to continue the patient's mental health treatment plan.

3. When an inmate is received from a mental health facility (e.g. Forensic Psychiatric Hospital following a temporary absence or assessment), a new mental health screening is completed.

4. Ongoing monitoring/screening of inmates:

    - When an inmate has a mental illness, mental status must be monitored by a mental health professional to ensure that proper care is administered. Inmates may be referred for subsequent mental health assessment.

    - At the request of the warden or designate, a mental health professional reviews the impact of separate confinement during every 30-day period that an inmate is on separate confinement status. The warden or designate, in consultation with the mental health professional, considers the results of the review in determining whether separate confinement status must continue. Refer to section 1.22.9, *Adult Custody Policy*.

5. Psycho-diagnostic assessments:

    - Psycho-diagnostic assessments are conducted on sentenced inmates who are identified as likely being mentally ill following the screening and monitoring process. When an assessment is indicated, a psychologist or psychiatrist must conduct the assessment.

    - If the psychologist or psychiatrist determines that the inmate does not require a mental health assessment, the assessment is not completed. However, the inmate is monitored to determine whether the inmate's mental status deteriorates.

6. Mental health treatment

    - Once an inmate is assessed with a mental illness that requires treatment, a referral is made to a psychologist, physician or nurse practitioner. The physician or nurse practitioner may refer the patient to a psychiatrist for treatment consultation or treatment. If available, the patient is referred to a treatment program within the correctional facility or within the Adult Custody Division.

7. Planning for post-release mental health care

- Staff plan for post-release mental health care for patients who receive treatment for mental illness.

2.5. *Psychiatric and psychological reports (revised: Mar-13)*

Psychiatric and psychological reports may be made available to authorized persons upon request, including Crown counsel, members of the National Parole Board, and probation officers, when the author of the report:

- Gives consent; and

- Is not available and the centre's physician or nurse practitioner believes that authorities should be advised of information contained in the report to protect the public or patient.

2.6. *Inmate mental health transfers and hospital admissions*

When it is necessary to transfer an inmate to a provincial mental health facility the warden or designate in consultation with a clinician, may affect the transfer as follows:

1. Sentenced inmates:

    - By preparing the following documents and sending them to the director of a provincial mental health facility:

    - Two certificates (pink slips) completed by two physicians in accordance with section 22 (3) of the *Mental Health Act*.

    - An application for admission in the form prescribed in section 29 (4) of the *Mental Health Act.*

    - Upon receipt of the above documents, the director of the mental health facility may admit the patient to the facility for treatment. Once admitted, the length of the inmate's stay is in accordance with section 29 (6) of the *Mental Health Act*.

    - When application is made directly to the director of a provincial mental health facility, and the patient is accepted for admission, the correctional centre making the application releases the inmate with an emergency or non-emergency medical temporary absence authorization permit (refer to "Types of Temporary Absences" in the *Adult Custody Policy*).

    - When the patient is not well by the time the sentence expires, the director of the provincial mental health facility re-certifies and retains the patient under the *Mental Health Act*. The patient is released directly from the mental health facility as provided

for in the *Mental Health Act*. For this reason, personal effects must always accompany an inmate transferred to a mental health facility.

2. Remanded inmates:

    - When a remanded inmate appears to be mentally ill, a clinical opinion is obtained. If psychiatric care is needed, Crown counsel is notified to initiate follow-up. Depending on the circumstances, Crown counsel may decide to return the inmate to court:

    - (a) To enter a stay of proceedings and have the inmate committed under section 22 of the *Mental Health Act*; or

    - (b) To seek a 30-day remand for a psychiatric assessment, in reference to section 672.11 and 672.12 of the *Criminal Code*; or

    - (c) For a finding of unfit to stand trial, in reference to section 672.11(a) of the *Criminal Code*.

    - In the event of (a) occurring, the patient is escorted to a designated mental health facility for hospitalization in accordance with the *Mental Health Act*. In the event of (b) or (c) occurring, the inmate is escorted to the Forensic Psychiatric Hospital, Port Coquitlam, under warrant by the court.

    - If Crown counsel does not enter a stay of proceedings, the patient who is certified is transferred to a designated mental health facility or the Forensic Psychiatric Hospital. When the patient is not well by the time the custody warrant expires or is revoked, the director of the provincial mental health facility retains the patient under the *Mental Health Act*. The patient is released directly from the mental health facility as provided for in the *Mental Health Act*.

3. Treatment of patients/residents prior to transfer:

    - When documentation under sections 22 and 29 of the *Mental Health Act* is complete for the transfer of an patient to a provincial mental health facility (section 29 of the *Mental Health Act*) and the provincial mental health facility cannot accommodate the patient, the attending physician may order treatment to commence, if such treatment is essential to preserve the life or health of the patient prior to transfer. The patient must consent to the treatment prescribed, as indicated by completion of form 005.

3. Suicide Prevention

1. A primary responsibility of the Adult Custody Division is to provide safe custody for inmates in correctional centres.

2. This policy assists correctional centre staff in preventing inmates from attempting and committing suicide by providing guidelines and procedures for:

    - Authority identification of suicidal inmates;
    - Assigning responsibilities to staff; and
    - Preventative measures.

3.1. Authority

1. Section 215 (1) (c) of the *Criminal Code* places a legal duty on everyone to provide "the necessities of life" to a person under their charge if that person is unable to do so because of detention, age, illness or insanity.

2. Section 215 (2) makes it an offence for failing, without lawful excuse, to perform that duty, if failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be injured permanently.

3. Section 241 makes it an offence to counsel, procure, aid or abet a person to commit suicide.

3.2. General responsibility

1. Staff must be continually alert to behaviour or information suggesting that an inmate is at risk for suicidal behaviour or self-harm.

2. Such behaviour or information must be promptly reported to a supervisor.

3. Immediate intervention is necessary to prevent a suicide attempt or act of self-harm.

3.3. Information sources (revised: Jul-08)

1. It is important to identify suicidal inmates as soon as possible through Adult Custody Division information systems and coordinated staff communication.

2. The following sources of information identify potentially suicidal inmates:

s.15

3.4. Inmates at risk factors

The following factors, singly or in combination, are a cause for concern and may identify potentially at risk inmates:

s.15

s.15

3.5. Inmates at risk criteria (revised: Mar-13)

1. Taking into account the risk factors described above and other relevant information, an inmate who presents a risk of self-harm or suicide may be recommended for at risk status.

2. An inmate can only be declared to be at risk by a health care professional, a warden or designate.

3. The designation of at risk status is reviewed at the next clinic of a psychologist, physician, nurse practitioner or psychiatrist.

4. Removal of at risk status is done only by the warden or designate in consultation with a psychologist, physician, nurse practitioner or psychiatrist.

5. A decision regarding the declaration of at risk or removal of at risk status is recorded in the PAC health care record and CORNET Client Log. Names and positions are noted of individuals involved in the decision.

3.6. Record and report observations (revised: Jul-08)

1. Staff members report concerns regarding an inmate they believe to be self-destructive, or information regarding self-destructive or unusual behaviour, to the warden or designate with a copy to the health care centre. These observations and discussions are entered on the inmate's CORNET Client Log.

2. When an inmate is identified as at risk, monitoring by correctional staff occurs as outlined in the At Risk Inmate Surveillance Policy and Procedure (refer to *Adult Custody Policy*.)

3.7. Preventative action

1. Once an inmate is brought to the attention of staff members as being at risk, efforts are made to increase communication with the inmate. Increased surveillance may not solve the problem or prevent suicide.

2. Reliance on mechanical surveillance, e.g. video monitoring and removal of materials that could be utilized in suicide attempts, is not as effective as personal contact and professional care.

3. In consultation with a clinician, staff may consider placing the inmate in a dormitory setting to increase contact with other inmates who might provide support.

4. Moving the at risk inmate to a special observation, if available, may be appropriate if other strategies are ruled out or deemed ineffective.

3.8. Access to media reports

1. At risk inmates are often charged with offences reported in the media.

2. Due to the negative potential raised by exposure to media coverage of these events, at risk inmates should not be permitted access to media reports related to their case.

3. This prohibition includes newspapers, news magazines, radio and television. Access to media unrelated to the incident may be provided.

3.9. Transfer of at risk inmates (revised: Jul-08)

When an at-risk inmate is transferred within the corrections system, the warden or designate ensures that:

1. The receiving institution is informed in advance with as much detail as possible, and adequate CORNET information is provided upon arrival;

2. The appropriate VISEN plus coding is applied to the transfer documents;

3. A Classification Alert (C.A.) is added to CORNET; and

4. The comment screen on CORNET system indicates “suicide alert” and advises the receiving institution of the inmate’s at risk status.

5. Health care and mental health professionals ensure that the Primary Assessment and Care (PAC) inmate health information system reflects the patient’s at risk status prior to transfer.

3.10. Release procedures for suicidal inmates

1. When an inmate has been declared at risk during the period of incarceration and particularly if the inmate still remains at risk upon discharge, forensic liaison staff, should alert community resources.

2. If a forensic liaison is not available, health care and mental health care staff undertake this responsibility.

3.11. B.C. crisis lines

Most cities have a B.C. crisis line. Health care staff have the telephone number for the local B.C. crisis line for reference and use.

4. Dental Care and Dentures

4.1. Dental services

The Adult Custody Division provides essential dental services to inmates when there is:

1. Evidence of serious disease or injury that is curable or can be substantially alleviated; and

2. Substantial potential for harm to the inmate if care is delayed or denied.

4.2. Management of dental care

Dentists are responsible for the management of the dental health care program and delivery of services to inmates.

4.3. Services provided (revised: Jul-08)

1. When dental care is considered essential, Corrections Branch provides service at no cost to the inmate. This includes treatment for acute pain or infection, major trauma or fractures. Treatment is provided when failure to treat in a timely manner would result in serious medical ill effect.

2. An inmate's projected release date is a factor in determining whether to provide treatment, and the nature of treatment. Corrections Branch will not undertake accelerated or extensive dental services prior to release for a condition that can be safely addressed by the inmate after release.

3. Corrections Branch does not provide elective, non-acute dental care, elective oral surgery, orthodontic, restorative or cosmetic services. Exceptions include non-acute conditions. These conditions may be addressed as non-emergencies if a dentist believes that they could become medical problems if left untreated during incarceration.

4. Impacted teeth, including third molars, are extracted only if there is a history of serious problems or serious infection that cannot be managed with more conservative treatment. If extraction is necessary, only the symptomatic tooth is removed. An exception is inmates with long remaining periods of incarceration when there is a danger of soft tissue disease associated with the impacted tooth. When conditions that existed prior to incarceration have been neglected by the inmate, the inmate may be required to bear a portion of the cost of treatment.

5. A warden must authorize referral to a specialist and a cost estimate must be obtained prior to commencing treatment.

4.4. Dentures or partials

1. Corrections will not provide prostheses for pre-existing conditions except when it is medically essential during incarceration.

2. The inmate must demonstrate that existing teeth are inadequate to consume a prison diet. Inmates who have functioned adequately in that condition prior to incarceration will not be provided prostheses.

3. When a health care professional judges that the health of an inmate would be harmed if not provided with necessary dentures or partials, and the inmate is on a long-term remand or has a long period remaining on the sentence, they may be purchased.

4. An inmate who has the funds will be required to pay, in whole or in part, for the dentures or partials. When the inmate is capable of paying only part of the cost, the remainder is the responsibility of the Adult Custody Division.

5. When the inmate is without funds or resources to purchase dentures or partials, the entire cost is the responsibility of the Adult Custody Division.

6. An agreement representing a mutually acceptable financial responsibility between the inmate and correctional centre regarding identified costs must be completed and signed prior to commencement of dental work or fabrication of a dental prosthesis to replace missing or extracted teeth.

7. When loss or damage of dentures or partials is judged the fault of the inmate, the entire cost of replacement is the responsibility of the inmate.

8. Inmates may purchase dentures or partials at their own expense if the purchase is approved by the appropriate health care professional.

5. Prosthetic Devices

1. When an appropriate specialist (e.g. optometrist, dentist, orthopaedic surgeon) judges that an inmate who is on long-term remand or has a long period of sentence remaining requires a prosthetic device (e.g. eyeglasses, hearing aids, knee brace), either to function normally or to participate in a program, the following provisions apply:

    - An inmate who has the funds is required to pay from those funds, or in whole or in part, for the prosthetic device. When the inmate is capable of paying only part of the cost, the remainder is the responsibility of the Adult Custody Division;

    - When the inmate is without funds or resources to purchase the prosthetic device, the entire cost is the responsibility of the Adult Custody Division; and

    - An agreement representing a mutually acceptable financial responsibility between the inmate and correctional centre regarding costs must be completed and signed before the prosthetic device is made or purchased.

2. When the inmate's prosthetic device(s) is lost or damaged, through no fault of the inmate, and in the absence of negligence on behalf of the inmate or other inmates, the cost of replacement is the responsibility of the Adult Custody Division. The replaced prosthetic device(s) must be of similar quality to those lost or damaged.

3. When a prosthetic device is purchased entirely or partially with Adult Custody Division funds, it is constructed with standard quality issue (e.g. standard frames and lenses).

4. Inmates may purchase with their own funds prosthetic devices when an appropriate specialist determines the need.

6. Emergency Medical Equipment

6.1. Emergency medical equipment (revised: Jan-13)

1. Emergency medical equipment includes the ER jump bag, as detailed in the emergency medical equipment checklist, the automated external defibrillator and portable oxygen.

2. Emergency medical equipment is used by health care professionals. In areas where care is provided by OFA attendants that are non-health care professionals, these locations must stock OFA kits according to WCB regulations.

3. The emergency medical equipment checklist is periodically reviewed, revised and distributed by the director, Health Services.

4. The current emergency medical equipment list and checklist is kept on a clipboard with pen beside the emergency equipment.

5. Equipment is checked weekly and immediately after use. The purpose for checking equipment is to:

    - Ensure that health care staff are familiar with where items are located;

    - Ensure that the equipment is fully stocked and prepared for potential emergencies; and

    - Replace items prior to their expiry date (e.g. medications and normal saline).

6. Sign and date the checklist and keep it for future auditing purposes.

7. Place masking tape, with the date and initials across equipment bag, or use a healthlok numbered closure on bag zippers, recording the date the healthlok was applied, initials and healthlok number on the checklist.

8. Equipment must be rechecked whenever tape or healthlok closure is broken. If the tape or closure is broken when the nurse comes to check the equipment, it is noted on the checklist.

7. Medication

7.1. Medication distribution (revised: Apr-13)

1. Qualified personnel must distribute medication. This includes nurses, physicians, nurse practitioners and pharmacists. Other persons, whose job description requires them to distribute medication, must be certified as having completed the required training.

2. A pharmacist, physician, nurse practitioner or a nurse using the Medication Distribution Handbook conducts this training.

3. Prior to the patient receiving medication, corrections staff and health care staff independently verify the inmate's identity.

7.2. Priority medication (revised: Sep-12)

1. Priority medications are those used in the treatment of acute or serious medical conditions where a missed dose may result in significant harm to the patient. In consultation with the Medication and Therapeutics Committee and the health care contractor, the director, Health Services determines periodically which medications are deemed to be priority medication.

2. Health care staff make direct contact with a patient who is scheduled to receive priority medication to ensure proper administration. When a patient does not attend the health care unit to obtain priority medication, health care staff see the patient in person to determine why the medication is being refused. The reason for refusal is documented. Correctional staff facilitate requests by health care staff to make direct in-person contact with the patient regarding the administration of priority medication. Refer to section 9.6.1, *Adult Custody Policy*.

7.3. Medications with overdose potential

1. The Adult Custody Division recognizes that certain medications such as narcotics and psychiatric medications carry a serious risk of injury and death in overdose situations.

2. To minimize this risk:

    - Solid dosage forms of these medications must be crushed or opened unless contraindicated, or medications provided in liquid form if the cost of the liquid is equivalent or less than the solid form; and

- Inspect the patient's mouth and ask the person to talk to ensure that medication has been swallowed.

7.4. Medication labelling

1. Medication prescribed by a practitioner must be labelled.

2. The prescription label must be machine printed or typed and include the following information:

    - Name, address and phone number of the pharmacy;
    - Prescription number;
    - Dispensing date;
    - Name and C.S. number of patient for whom the drug is dispensed;
    - Name of the practitioner;
    - Brand name or generic name of the drug, followed by the drug identification number;
    - Quantity and strength of the drug;
    - Dispensing pharmacist's initials;
    - Practitioner's directions for use; and
    - Other information required by good pharmacy practice.

3. Labels must not be altered after medication has been dispensed. If changes in dosage or administration times are required, a new prescription must be ordered.

7.5. Contingency medication (revised: Mar-13)

1. Contingency medications are limited to the current Contingency Medication List as approved by the Medication and Therapeutics Committee.

2. Only health care professionals may utilize contingency medications to commence therapy until the prescription supply arrives from the pharmacy.

3. These contingency medications must be stored in a locked cabinet in the health care centre.

4. Entire prescriptions are not to be filled from contingency supplies.

5. The health care manager or designate ensures that:

    - The amount of medications administered matches the contingency medication records;
    - There are no expired medications;
    - Cards are being used for contingency doses only and not for an entire regimen;
    - Health care staff are aware of the purpose and use of the contingency supply, and that all doses must be administered only on the authorization of a centre's medical or dental prescription; and
    - Prescriptions for HIV/AIDS medications and their dosages must be checked and confirmed by the P.D.C. Pharmacy before initiating treatment with contingency medications.

6. Use of contingency medications must be charted on the contingency medication records. This record is kept with the corresponding contingency medication and must include:

    - A label from the pharmacy, including name of the correctional centre, pharmacy, medication name, strength, quantity, lot number and expiry date;
    - Date and time the medication was used for a particular patient;
    - Name of the patient for whom it was prescribed;
    - Name of the physician, nurse practitioner or dentist who prescribes the medication;
    - Dosage of medication given; and
    - Signature of health care professional who administered the medication.

7.6. New admissions: Recording and storage of medications upon admission (issued: Jan-09)

1. Records staff ensure that all medications belonging to a newly admitted inmate are forwarded immediately to the intake nurse during the admission process.

2. The intake nurse records the inmate's medications in the Primary Assessment and Care (PAC) inmate health information system. Once documented, the medications are returned to records staff who place them in the inmate's personal effects.

3. Health care personnel ensure that procedures regarding priority medications are followed.

7.7. New admissions: Acute and chronic conditions and medications (revised: Mar-13)

1. Within 24 hours of admission to a correctional centre, patients who have acute or chronic conditions that require medical attention as well as those who are on prescribed medication are reviewed either by the centre physician or nurse practitioner or the on-call physician. Orders are received from the physician or nurse practitioner regarding initiating, continuing or discontinuing medications, as appropriate. Patient's disposition and associated orders are clearly documented in the Primary Assessment and Care (PAC) inmate health information system.

2. Prescriptions from Vancouver Jail physicians whose credentials have been reviewed and recognized by B.C. Corrections are accepted and directly administered to patients by health care staff at Alouette Correctional Centre for Women, North Fraser Pretrial Centre or Surrey Pretrial Services Centre. At the earliest opportunity, the physician or nurse practitioner at the receiving centre or the on-call physician reviews the case, and endorses and adjusts the existing prescriptions.

3. An Information Access Consent (HS 024C) form must be signed by the newly admitted patient authorizing Adult Custody Division, Health Services to access PharmaNet.

4. If the centre does not have access to PharmaNet and requires the P.D.C. Pharmacy to access information, this signed form must be faxed to the P.D.C. Pharmacy.

7.8. Physician standing orders (revised: Mar-13)

1. Centre physician(s) has standing orders including, but not limited, to emergency and withdrawal medications.

2. Physician standing orders must be reviewed and updated annually.

7.9. Drug Formulary (revised: Mar-13)

1. The B.C. Corrections Medication and Therapeutics Committee compiles a *B.C. Corrections Drug Formulary*.

2. The *Drug Formulary* is used to:

    - Ensure the consistency of medications used in correctional centres of the B.C. Corrections Branch;

    - Maintain a high quality of drug therapy; and

- Reduce medication costs.

3. Drugs must be ordered from the *Drug Formulary* by generic name to ensure that the pharmacist supplies the least expensive brand.

4. Physicians and dentists may order medications listed in the *Drug Formulary*, except in circumstances described below.

5. A physician, nurse practitioner or dentist may order medication not listed in the *Drug Formulary* only when the physician, nurse practitioner or dentist believes there is a compelling reason to do so and there is no acceptable alternative in the Drug Identification Number (DIN). In these circumstances, a Non-Formulary Medication Order form must be completed. A copy of the form must be sent to the Medication and Therapeutics Committee c/o P.D.C. Pharmacy.

6. Approved additions or deletions of medications in the *Drug Formulary* are published in the annual *B.C. Corrections Medication and Therapeutics Committee Report*. Formulary updates are sent to all *Drug Formulary* holders.

7.10. Medication ordering and receiving

1. Orders must be forwarded to the P.D.C. Pharmacy by fax. To ensure that the P.D.C. Pharmacy receives faxed prescriptions, the cover page provided by the P.D.C. Pharmacy must be used. All sections of the cover page must be fully completed and faxed to the P.D.C. Pharmacy along with the prescriptions.

2. A copy of faxed prescriptions is kept by health care. After they have been faxed, original prescriptions are put into an envelope and sent to the P.D.C. Pharmacy.

3. Medications from the P.D.C. Pharmacy are checked by comparing the blister card with the copy of the faxed prescription, medication record and billing report as soon as the medication arrives. Discrepancies are promptly reported to the P.D.C. Pharmacy.

7.11. Medication record (revised: Jul-08)

1. All medications, including contingency and over-the-counter medications, must be accounted for in the Primary Assessment and Care (PAC) Medication Record Set.

2. Health care professionals must account personally for medications they administer.

3. Other qualified personnel must sign for medications that they distribute. In addition, the patient must co-sign.

4. Medication charting errors are retained as a record in PAC.

7.12. Medication errors (revised: Mar-13)

1. A medication error occurs when:

    - An individual receives medication ordered for another patient (wrong patient);
    - The drug administered is not the drug prescribed, is a contraindicated drug or is the wrong form of the ordered drug (wrong medication);
    - The amount of the drug administered is not the prescribed dose (wrong dosage);
    - Administration of the drug is greater than 30 minutes prior to or following the scheduled times (wrong time);
    - The drug is administered via an incorrect route (wrong route); and
    - An ordered dose is not given (omission). Exceptions are if the patient does not attend for or refuses medications.

2. Patient safety is the primary concern for the nurse in the event of a drug error or suspected drug error. After completing a nursing assessment, the nurse – in consultation with the physician or nurse practitioner – provides medical treatment if required. Assessment and intervention must be documented in the Encounters section in the Primary Assessment and Care (PAC) inmate health information system.

3. A Report of Medication Error must be completed and submitted to the centre's health care manager the same day of the error. Reports concerning medication errors involving controlled drugs or narcotics must be faxed to the P.D.C. The report includes:

    - Name and title of the nurse who made the error;
    - Name and title of the person discovering the error;
    - Date, time, place and patient's name;
    - Original medication order written by physician or nurse practitioner;
    - Identification of type of error transcribing, dispensing, administering or documenting;
    - Characteristics of error – wrong patient, dose, drug, time, route;
    - Factors contributing to error and brief explanation of the facts;
    - Nursing assessment data, including evaluation of the patient's response/condition following the error;

- Names and titles of personnel or individuals involved in the error; and
- Immediate action taken to safeguard the patient, with patient responses.

4. The health care manager must communicate to the warden or designate the type of error, medication, consequence and remedies without disclosing the identity of the patient.

7.13. Drug control count (revised: Jul-08)

1. The P.D.C. Pharmacy supplies the Narcotic and Controlled Drug Administration Record booklet.

2. Each dose of narcotic, controlled drugs and potential drugs of abuse administered to a patient must be recorded on the Narcotic and Controlled Drug Administration Record, and patient's PAC Medication Record Set.

3. The Narcotic and Controlled Drug Administration Record must be completed for:

   - Counting Required Drugs at least s.15
   - In larger centres, the count is completed by two health care staff s.15
   - In centres that have only one nurse regularly working, at least s.15 two people count and sign the Narcotic and Controlled Drug Administration Record. The nurse and medical office assistant (MOA) could accomplish this task; and
   - Counting Recommended Drugs at least s.15

4. Discrepancies in the count of the Narcotic and Controlled Drug Administration Record must be reported to the health care manager and the P.D.C. Pharmacy.

5. Drugs not listed in the Narcotic and Controlled Drug Administration Record that should be counted must be added in the space provided.

6. The health care manager checks the charting, sign and date on the front page of the booklet before returning the completed Narcotic and Controlled Drug Administration Record to the P.D.C. Pharmacy.

7.14. Theft of controlled substance (issued: Jul-10)

1. Any loss, theft, or forgery of a controlled substance as defined in the *Controlled Drugs and Substances Act* is reported to the deputy warden of programs.

2. In accordance with Health Canada guidelines, loss, theft, or forgery of a controlled substance as defined in the *Controlled Drugs and Substances Act* is reported to the:

    - Local police immediately; and
    - Health Canada, Office of Controlled Substances no later than 10 days after its discovery.

3. The deputy warden of programs notifies the authorities identified in paragraph 2 above.

7.15. Medication storage (revised: Jul-08)

1. Medications are kept in a secure locked area accessible only to health care professionals and other personnel designated to distribute medication.

2. Medications that need to be kept cool are stored in a secure refrigerator only accessible to health care professionals or qualified personnel designated to distribute medication.

7.16. Medications upon release (revised: Dec-12)

1. When the date of discharge of the inmate is known in advance, a s.15 of medications is provided.

2. Exceptions include:

    - Self-administered medications in the patient's possession may accompany them, as these medications cannot be recycled;
    - Judgement must be used in circumstances when an inmate may be considered at risk of self-harm;
    - Essential medications, e.g. for HIV, endocarditis, diabetes and osteomyelitis, must be provided in quantities sufficient to last until the earliest possible scheduled physician's appointment;
    - If no followup appointment date is known for continuation of antiretroviral medications, up to s.15 and
    - If no followup appointment date is known for psychiatric medications, up to s.15 s.15

7.17. Return unused medications to the P.D.C. Pharmacy

1. Unused blister-carded medication must be returned to the P.D.C. Pharmacy.

2. This includes:

    - Medication no longer required is to be returned to the P.D.C. Pharmacy for recycling;

    - Self-administered medications can only be recycled if they have not been in the patient's possession. "Not Given" must be entered on the blister card of any self-administration medication being returned for recycling. If it is not entered, the medication must be returned to the P.D.C. Pharmacy for disposal; and

    - Expired medications or expired medications in the patient's possession must be returned to the P.D.C. Pharmacy for disposal.

7.18. Discontinuation due to diversion (revised: Mar-13)

1. Individuals who are permitted to distribute medication in a correctional centre are outlined in section 7.1. Diversion occurs when medication that is prescribed to a patient is redirected by the patient to another inmate or individual.

2. Diversion of medication is an indication for the physician or nurse practitioner to consider a change in the patient's treatment plan, up to and including the discontinuation of prescribed medication. When possible, the patient is seen by a physician or nurse practitioner prior to any change in the treatment plan.

3. Documented proof of diversion by the patient is established before medication is discontinued.

4. Only physicians or nurse practitioners may change or discontinue medication. If a physician or nurse practitioner is not available onsite then the on-call physician is consulted.

5. If a decision to discontinue medication or change the treatment plan is made by the physician on the basis of a telephone consultation, the patient is seen by a physician or nurse practitioner for follow-up during the next doctor's clinic.

6. The following must be considered when medication is discontinued:

    - Scope, composition and appropriateness of the patient's treatment plan, including medication dosage;

    - Suitability of the patient for the particular program;

- Safety of the patient involved;
- Safety of other inmates who may be receiving the diverted medication; and
- Violation of a patient treatment agreement (e.g. methadone).

8. Self-Administration of Medication

8.1. Objectives

The objectives of the self-administration of medication are to:

- Enhance inmate responsibility and accountability for their own health care;
- Advance the goal of a stable environment within adult correctional centres; and
- Reduce staff workload with respect to distributing medication to inmates.

8.2. Approved medications (revised: Sep-12)

1. Only medications approved by the Medication and Therapeutics Committee may be self-administered by inmates.
2. The director, Health Services:
    - Maintains and distributes a list of approved medications and dosage forms for self-administration; and
    - Is responsible for revising the list as necessary in consultation with the Medication and Therapeutics Committee.

8.3. Blister pack procedures (revised: Mar-13)

1. Medication for self-administration is only ordered by a physician or nurse practitioner and dispensed by a pharmacist in the form of a blister pack except when dosage form prohibits such packaging. Blister packs have instructions for self-administration on the label.
2. The prescribing physician or nurse practitioner is responsible for advising patients on potential side effects of medication and providing instructions for self-administration.
3. Medication is administered in solid dosage form, when possible. Such medication must be packaged in blister packs with paper foil backing.
4. The pharmacist identifies blister packs that are self-administered with a green “For Self-Administration” label. Blister packs without this green label must not be self-administered.

8.4. Non-compliance by patient

1. A health care professional may prohibit a patient from self-administering medication if there is evidence of non-compliance or abuse.

2. Correctional staff may also prohibit inmate self-administration, subject to review by a nurse. In such cases, medication is still administered according to procedures for distributing non-self-administered medication.

8.5. Contraband

1. Loose, non-issued, tampered or expired medications are contraband.

2. Patients must return empty or unfinished blister packages to health care staff by the medication stop date.

3. Correctional staff who seize medication past the stop date must ensure they are returned to the health care staff.

8.6. Inmate on temporary absence

Inmates on temporary absence must take their issued medication and present the packages for inspection upon return to the centre.

8.7. Expensive medication

1. Prescriptions for expensive medication may be only partially filled, at the discretion of the pharmacist, to reduce costs for patients who are in custody only a few days or who may be unable to finish the medication due to uncomfortable side effects.

2. Partially filled prescriptions are identified with a red dot on the blister pack.

8.8. Refilling prescriptions

Patients on self-administration medications are advised that it is their responsibility to alert health care staff one week before a prescription requires refilling.

8.9. Record keeping

The patient signs the Drug Profile (HS 011) form for self-administration medications indicating that the medication was received and instructions are understood.

8.10. Transfer procedures

1. Upon transfer to another centre, the patient is responsible for ensuring that self-administered medication is included with personal effects.

2. If medication is lost in transit, the patient is responsible for advising the nurse at the receiving centre.

9. Over-the-Counter Medication

9.1. Objectives

The objectives of this policy are to:

1. Enhance inmate responsibility and accountability for their own health care. Inmates bear the cost of these preparations, just as they would in the community, even when medication is recommended by a health care professional;

2. Advance the goal of a stable environment within adult correctional centres. Inmates do not require health care approval to purchase these medications; and

3. Reduce staff workload with respect to distributing medication to inmates.

9.2. Approved list

1. The list of approved over-the-counter medications and preparations for purchase through canteen is updated by the Medication and Therapeutics Committee and distributed through Corrections Branch Headquarters.

2. Possession of these items does not constitute contraband.

3. Correctional or health care staff no longer distribute items on the list.

9.3. Cautions

1. The purchase of some medications, such as Tylenol and Motrin, is restricted according to directives issued periodically from Corrections Branch Headquarters.

2. Canteen access to over-the-counter medications must not be given to persons at known current risk of self-harm or when health care or correctional staff believe that the inmate cannot safely self-administer over-the-counter medications.

3. Inmates found hoarding medications, such as Tylenol, are denied access. In these cases, correctional staff consult health care and alternatives are arranged.

10. Methadone

10.1. Methadone maintenance treatment (revised: Dec-12)

1. The Adult Custody Division makes methadone available to inmates who are admitted to a centre on a recognized methadone maintenance treatment program.

2. Health care staff working in correctional centres of the Corrections Branch are expected to be familiar with, and adhere to, the principles and procedures described in the most recent version of the *Methadone Maintenance Handbook*, which is published by the College of Physicians and Surgeons of B.C.

3. Patients on methadone are housed in centres that offer a daily nursing presence.

4. Inmates who qualify for admission to the B.C. Methadone Maintenance Program and express a desire to participate should be considered according to the criteria outlined in section 10.4

10.2. Physician communication (revised: Dec-12)

Patients verified to be on a methadone program at the time of admission are eligible for continued methadone treatment while incarcerated. Verification of current methadone treatment is confirmed by contacting the College of Physicians and Surgeons of BC or the patient's community methadone prescriber. When these options are not readily available, a review of the patient's PharmaNet profile is used as verification. Whenever possible, methadone treatment is not interrupted or delayed.

10.3. Methadone orders and documentation (revised: Dec-12)

1. Methadone is ordered by a physician who has a current authorization to prescribe methadone from the College of Physicians and Surgeons of BC. It is the responsibility of physicians providing contracted services to the Corrections Branch to ensure they have the necessary authorization. To facilitate continuity of care, methadone prescriptions written by Vancouver Jail physicians are accepted, as written, until reviewed by the receiving centre physician.

2. Methadone orders are written on the BC Duplicate Prescription forms.

3. Methadone, s.15 is counted s.15 with other controlled drugs. Discrepancies are immediately reported to the P.D.C. Pharmacy.

10.4. Methadone initiation (revised: Dec-12)

The medical director, Corrections Branch, is consulted before treatment with methadone is initiated. Methadone initiation takes place according to the following criteria and procedures:

1. The patient qualifies for the methadone maintenance treatment program (MMP) according to the criteria outlined in the most recent version of the College of Physicians and Surgeons of B.C. *Methadone Maintenance Handbook.*

2. The patient indicates an interest in participating in the methadone program. Once accepted, the patient consents to following the rules of the program and signs a Methadone Maintenance Treatment Patient Agreement before starting methadone.

3. Remanded individuals or inmates with short sentences are eligible for methadone initiation subject to the opinion of the treating centre physician and after discussion with the medical director, Corrections Branch. The anticipated length of stay in custody must be long enough to incrementally dispense a medically safe dose and stabilize the maintenance dose.

4. Before an inmate starts methadone treatment, a methadone physician in the community commits, in writing, to undertake the care of the patient upon release.

5. Anyone with a history of cardiovascular disease, currently on drugs that prolong the QT interval, or other indications for electrocardiogram (ECG) monitoring should have an electrocardiography study completed prior to commencing methadone treatment, and at appropriate intervals thereafter. For patients with no other risk factors for cardiac arrhythmia, it is recommended that an ECG be recorded if the dose of methadone exceeds 150 mg and that this be repeated as clinically indicated.

6. The treating centre physician is trained and experienced in the practice of methadone induction and prepares a written treatment plan using the Corrections Branch Methadone Maintenance Treatment Initiation Plan. The completed form is sent to the medical director, Corrections Branch, for discussion prior to initiating methadone. This plan outlines, among other important treatment components, the:

    • Starting dose;

    • Frequency and type of patient monitoring to be carried out;

    • Anticipated benefits of methadone for the patient; and

    • Frequency of physician followup during initiation.

7. Once methadone is initiated, a medical practitioner may declare the patient medically unfit for transfer as detailed in section 4.13, *Adult Custody Policy*, until his/her condition is stable and the maintenance dose of methadone is established. In the rare instance when transfer to

another centre is contemplated, the receiving centre is consulted in advance and the treatment plan is discussed with the receiving physician. Before patient transfer can take place, the receiving physician must agree to undertake the care of the patient and continue methadone initiation. The medical director, Corrections Branch, is notified of the transfer of a patient undergoing methadone initiation.

8. Prior to starting methadone, the pharmacist is consulted regarding any possible interactions between methadone and other medications currently prescribed for the patient.

9. A urine drug screen is completed prior to starting methadone and includes testing for opiates, cocaine, amphetamine, benzodiazepines and methadone metabolites to verify recent or current drug abuse. The absence of opioids in the urine during assessment does not preclude admission to the MMP if the assessment confirms that methadone maintenance treatment is appropriate.

10. During the methadone initiation phase, a random urine drug screen is completed weekly until the maintenance dose is reached. Following this phase, frequency of urine drug screens are determined by the treating centre physician and written into the treatment plan. All drug screen results are recorded in the Primary Assessment and Care (PAC) inmate health information system.

11. A Frequent Monitoring Record is completed in PAC for all patients undergoing methadone initiation. A nurse reviews and records vital signs and evidence of methadone side effects daily in PAC. This record includes respiratory rate, level of alertness and pupillary size, and ideally occurs at four hours post-ingestion of a methadone dose (peak serum methadone level). Any concerns regarding decreased level of consciousness or respiratory rate are reported to the on-call or treating centre physician immediately. Frequent monitoring is discontinued when the patient has reached an effective maintenance dose, and there have been no dose adjustments within the last seven days.

12. As in the case of methadone maintenance, the methadone dose is withheld from any patient exhibiting signs of somnolence or intoxication. When the dose is withheld, the treating centre physician is notified as soon as practical. The treating centre physician reviews and adjusts the treatment plan accordingly. All changes are recorded in the health care record in PAC.

13. Regular consultations with the medical director, Corrections Branch, are mandatory for all complex cases.

14. The treating centre physician reviews and examines the patient prior to any dose increases. Advance prescriptions for methadone dose increases are not written.

15. The co-ordination of urine testing and treatment, follow-up appointments and progress of new methadone patients are reviewed at least weekly by the health care manager at the centre.

10.5. Methadone distribution (revised: Dec-12)

1. Methadone is not administered without first consulting the patient's photograph to ensure correct identity prior to each methadone dose. In centres utilizing identification bar codes, the bar code is scanned and matched to the bar code on the medication.

2. Administration of methadone occurs in the morning and is undertaken by a health care professional. The methadone dose is followed by one full glass of water (8oz/250ml), inspection of the patient's mouth to ensure swallowing of the entire dose, and then direct observation by correctional staff for a minimum of 20 minutes to reduce the risk of diversion.

3. Each dose of methadone administered is charted on the patient's PAC Medication Record Set and Methadone Drug Control forms. Completed Methadone Drug Control form(s) are faxed to the P.D.C. Pharmacy for stock monitoring.

4. When methadone patients are unable to receive the prescribed methadone dose in the morning due to a court appearance or transfer, arrangements within each centre are made for them to receive the methadone in the evening of the same day when possible. When methadone patients reach health care prior to 6 p.m. and it is verified that the methadone dose was not given that morning, they receive the full prescribed dose. When methadone patients reach health care between 6 p.m. and 10 p.m. and it is verified that the methadone dose was not given that morning, half of the prescribed dose is given to them. A methadone dose is not given after 10 p.m. A return to usual dosing the next morning occurs when possible. When methadone patients do not receive any methadone doses for three days, they are seen by a physician to have their methadone dose reviewed.

10.6. Addiction counselling (revised: Dec-12)

All patients on methadone are referred for addiction therapy and counselling.

10.7. Withdrawal (revised: Dec-12)

1. Patients who wish to decline methadone treatment or have been discharged from the methadone maintenance treatment program (MMP) are placed on a methadone withdrawal protocol. The College of Physicians and Surgeons of B.C. indicates that "the maximum weekly reduction of methadone should be no more than five percent of the total dose in order to minimize withdrawal symptoms and the risk of relapse. Tapered dosages should be undertaken as a trial of weaning off methadone. Patients who relapse to opioids or decompensate in other aspects of their lives during or after the trial of weaning should be offered re-entry to MMP and re-stabilized. Patients should not be penalized for unsuccessful weaning from MMP."

2. When involuntary withdrawal of methadone is considered, the Corrections Branch medical director is consulted regarding a tapering schedule.

10.8. Disposal (revised: Dec-12)

Expired or unused methadone is sent to the P.D.C. Pharmacy for disposal.

10.9. Discharge from Corrections (revised: Dec-12)

1. To ensure methadone therapy continues after the patient is discharged from a correctional centre, an individualised discharge plan is formulated.

2. When informed of a patient's planned discharge date, the health care professional contacts the patient's community methadone physician and arranges an appointment, preferably for the actual date of discharge. If this is not feasible, the correctional centre physician writes a methadone prescription and faxes it to the patient's designated community pharmacy. The prescription covers the time period up to and including the day the patient is able to see his/her community methadone physician (i.e. no longer than seven days).

3. Patients are not given methadone to take with them upon discharge.

4. Discharge methadone prescriptions are faxed directly to the patient's designated pharmacy. The original is mailed, not given to the patient.

5. A methadone transfer form is completed and faxed to both the College of Physicians and Surgeons of B.C. and the community methadone physician.

11. Suboxone (issued: Dec-12)

11.1. Introduction

Suboxone does not replace methadone for the treatment of opioid dependency, but there are situations when this treatment modality is considered. Suboxone sublingual tablets are only prescribed by physicians who have experience in substitution treatment of opioid drug dependence. Suboxone is only prescribed under the following circumstances:

- The physician must have a methadone maintenance exemption. Intrinsic in obtaining and maintaining a methadone maintenance exemption is education and experience in substitution treatment of opioid drug dependence.

- Physicians must have completed the online education module by Schering-Plough Canada available at *www.suboxonecme.ca*. Completion of this module is based on an honour system, and is not verified except in unusual circumstances.

11.2. Suboxone maintenance treatment

1. The Adult Custody Division makes Suboxone available to inmates who are admitted to a centre on a recognized Suboxone maintenance treatment program.

2. Health care staff working in correctional centres are familiar with, and adhere to the principles and procedures described in, the most recent version of the *Methadone Maintenance Handbook* that is published by the College of Physicians and Surgeons of B.C.

3. Patients on Suboxone are housed in centres that offer a daily nursing presence.

4. Patients on Suboxone sign a Suboxone Maintenance Treatment Patient Agreement.

11.3. Suboxone initiation

1. There are some clinical circumstances when the physician may wish to initiate Suboxone treatment, or convert a patient from methadone to Suboxone, as in the case of a patient with a prolonged QT interval or a patient at high risk of a prolonged QT interval.

2. Suboxone initiation follows the same process as outlined in section 10.4 (with the exception of subsection 10.4(5)) and is completed in consultation with the medical director, Corrections Branch.

11.4. Physician communication

A patient on Suboxone at the time of admission continues on this medication, provided the treating physician in the community (i.e. the patient's primary Suboxone prescriber) or a review of the patient's current PharmaNet profile confirms the patient's treatment status. Whenever possible, Suboxone treatment is not interrupted or delayed.

11.5. Suboxone orders and documentation

1. Suboxone is ordered by a physician who is contracted through the current health services provider and authorized by the College of Physicians and Surgeons of B.C. to prescribe Suboxone.

2. Suboxone orders are written on BC Duplicate Prescription forms.

3. Suboxone,[s.15] is counted[s.15] with other controlled drugs. Discrepancies are immediately reported to the P.D.C. Pharmacy.

11.6. Suboxone monitoring

1. A urine drug screen for methadone or methadone metabolite (EDDP), buprenorphine, cocaine, opiates, amphetamines and benzodiazepines is completed prior to continuation of Suboxone maintenance treatment.

2. A Frequent Monitoring Record is completed in the Primary Assessment and Care (PAC) inmate health information system for all patients continuing on Suboxone maintenance treatment. A nurse reviews and records vital signs and evidence of Suboxone side effects daily in PAC. This record includes respiratory rate, level of alertness and pupillary size, and ideally occurs at three hours post-Suboxone dose (peak serum Suboxone level). Any concerns regarding decreased level of consciousness or respiratory rate are reported to the on-call or treating centre physician immediately. Frequent monitoring is discontinued when the patient has reached an effective maintenance dose, and there has been no dose adjustment within the last seven days.

3. Random urine drug screens are performed, at minimum, every four weeks during the period of incarceration. Any screens positive for illicit substances other than buprenorphine require review and discussion with the treating centre physician before distribution of more Suboxone dosing.

4. The Suboxone dose is withheld from any patient exhibiting signs of somnolence or intoxication. When the dose is withheld, the treating centre physician is notified as soon as practical. The treating centre physician reviews and adjusts the treatment plan accordingly. All changes are recorded in the health care record in PAC.

11.7. Suboxone distribution

1. Suboxone is not administered without first consulting the patient's photograph to ensure correct identity prior to each dose. In centres utilizing identification bar codes, the bar code is scanned and matched to the bar code on the medication.

2. Administration of Suboxone occurs in the morning and is undertaken by a health care professional. The dose of Suboxone is preceded by one full glass of water (8oz/250ml). In direct view of the health care professional, the patient places the Suboxone under the tongue and allows it to dissolve. Direct observation by correctional staff occurs for a minimum of 10 minutes to reduce the risk of diversion. Inspection of the patient's mouth occurs following this period, to ensure the medication has completely dissolved.

3. Each administered dose of Suboxone is charted on the patient's Primary Assessment and Care (PAC) Medication Record Set and Suboxone Drug Control forms. Completed Suboxone Drug Control forms are faxed to the P.D.C. Pharmacy for stock monitoring.

11.8. Addiction counselling

All patients on Suboxone are referred for addiction therapy and counselling.

11.9. Withdrawal

1. All patients who voluntarily or involuntarily discontinue a Suboxone maintenance program are offered the opportunity of a graduated withdrawal from the program.

2. If abrupt discontinuation of Suboxone maintenance treatment is considered, the medical director, Corrections Branch is consulted.

11.10. Disposal

Expired or unused Suboxone is sent to the P.D.C. Pharmacy for disposal.

11.11. Discharge from correctional centre

1. To ensure Suboxone maintenance treatment continues after the patient is discharged from a correctional centre, a discharge plan is formulated on an individual basis.

2. When informed of a patient's planned discharge date, the health care professional contacts the patient's community Suboxone physician and arranges an appointment, preferably for the actual date of discharge. If this is not feasible, the correctional centre physician writes a Suboxone prescription and faxes it to the patient's designated community pharmacy. The

prescription covers the time period up to and including the day patients are able to see their community Suboxone physician (i.e. no longer than seven days).

3. Patients are not given Suboxone to take with them upon discharge.

4. Discharge Suboxone prescriptions are faxed directly to the patient's designated pharmacy. The original is mailed, not given to the patient.

11.12. Suboxone for rapid opiate detoxification

Suboxone can be used as a short-acting opioid medical detoxification. It is used to minimize withdrawal symptoms from short-acting opioids, reduce the risk of medical complications, reduce transfers to hospital, and improve patient outcomes on admission to a provincial correctional centre.

1. A comprehensive patient assessment is performed by nursing staff during the admission process when the initial health assessment (IHA) is completed.

2. If there is a potential for alcohol and/or opiate withdrawal, a Clinical Institute Withdrawal Assessment of Alcohol – revised Scale (CIWA-Ar) form and a Clinical Opiate Withdrawal Scale (COWS) form is completed. Chart the CIWA-Ar and COWS scale results in the IHA in Primary Assessment and Care (PAC) inmate health information system.

If the CIWA – Ar (Alcohol) scale is:

- greater than 8, call the physician for an Alcohol Withdrawal Protocol; or
- greater than 15, contact the physician URGENTLY.

If the COWS (opiate) score is:

- greater than 12, call the physician for a Suboxone Withdrawal Protocol;
- equal to 5 for the GI section, call the physician for a Suboxone Withdrawal Protocol; or
- greater than 24, contact the physician URGENTLY.

3. The Suboxone Withdrawal Protocol is not prescribed concurrently with the Alcohol Withdrawal Protocol.

4. A urine drug screen (UDS) is completed. Chart the UDS result in PAC.

5. The patient must be free from short-acting opioids for at least 12 hours.

6. Discuss the patient's condition with the physician and obtain orders to start on the Suboxone Withdrawal Protocol.

7. Obtain the patient's informed consent.

8. Educate the patient about Suboxone and give them the Suboxone patient information sheets.

Explain that:

- The tablet must completely dissolve under the tongue
- They will be observed for a minimum period of 10 minutes to ensure the risk of diversion is reduced
- Withdrawal symptoms will improve in 20-30 minutes.

9. After obtaining a physician's order, initiate the 3 day withdrawal protocol:

- Day 1: 8 mg Suboxone sublingually
- Day 2: 8 mg Suboxone sublingually
- Day 3: 8 mg Suboxone sublingually

10. Suboxone distribution occurs in the morning. Follow the process as described in section 11.7.

11. If the first dose is given stat, continue with the second dose the next morning.

12. A Frequent Monitoring Record is completed in PAC for all patients undergoing rapid opiate detoxification using Suboxone. A nurse reviews and records vital signs and evidence of withdrawal symptoms daily in PAC for each of the three days duration of the protocol.

13. A withdrawal episode is created in PAC.

14. Ensure the patient remains hydrated for the duration of the protocol.

15. Refer patient to the treating centre physician on the third day as needed.

16. Repeat the COWS on the third day and the seventh day, and document in PAC.

17. Contact the on-call or treating centre physician for any urgent problems.

12. Marijuana

1. Marijuana and particularly its active ingredient, THC, are alleged to have pharmacological properties as an anti-nauseant, analgesic and appetite stimulant.

2. The College of Physicians and Surgeons of British Columbia advises physicians against recommending smoked marijuana because of a lack of research evidence concerning benefits and potential side-effects.

3. The Canadian Medical Protective Association states that physicians "would have difficulty determining the recommended dosage of marijuana and the recommended form and route of its administration, given the lack of research in this area." Given this statement, and the availability of safer and more effective treatments for all conditions for which marijuana has been proposed, the B.C. Corrections Branch does not provide marijuana to inmates, regardless of whether they accessed this substance prior to incarceration.

13. Testing – Communicable Diseases

13.1. Introduction

Upon admission to a correctional centre, the intake nurse offers testing for communicable diseases to each inmate. Testing is made available on request to each inmate at intake and during custody.

13.2. Testing – inmates (revised: Mar-13)

All testing is voluntary. Inmates wishing to be tested for a communicable disease must make their requests known to the health centre nurse, physician or nurse practitioner.

13.3. Testing – staff

Staff wishing to be tested must consult their family physician or local health unit. If the test is the result of an on-the-job incident, WorkSafe BC forms must be submitted.

13.4. Counselling

1. Pre and post-test counselling are given to inmates requesting HIV and hepatitis C testing.

2. Counselling, treatment and support are provided at the health centre for individuals testing positive for HIV and/or hepatitis C.

14. Infection Control and Prevention

1. Staff and inmates in correctional institutions are recognized as being at risk for the transmission of certain infectious diseases including tuberculosis, hepatitis and HIV.

2. For this reason, all persons are considered potentially infectious.

14.1. Infection control information and educational program

1. Understanding and action are possible primarily through information and education.

2. A comprehensive educational program for staff and inmates is developed in all centres.

3. Wardens or designates implement the program in conjunction with local health professionals.

4. As part of recruit training, the Corrections and Community Justice Division (JIBC) provides complementary information on transmission control and preventive measures.

5. Educational programs are developed that discuss communicable diseases generally and individual diseases specifically (i.e. AIDS and hepatitis).

6. At the minimum, the Adult Custody Division provides for:

    - The availability of information on transmission control and precautions to minimize transmission of infectious disease for inmates and correctional staff;

    - Instruction on the proper usage of items for infection control (i.e. condoms, lubricants and bleach); and

    - Opportunities for updates to ensure staff and inmates are aware of current information.

14.2. Placement/ classification (revised: Mar-13)

1. Housing assignments are consistent with normal security and/or special needs classification.

2. A physician, nurse practitioner or nurse only considers special/separate housing related to infectious disease following a recommendation.

3. Although the standard approach is to employ universal precautions, there may be an occasional need for specific handling information.

4. When a health care professional advises the warden or designate that an inmate presents a medical risk, information that does not reveal the specific diagnosis may be shared with staff in direct contact with the inmate. This information is communicated on the CORNET Alerts screen or CORNET Client Log.

14.3. Vaccinations

1. Vaccinations are provided to inmates in accordance with the standards set for the community by the Centre for Disease Control (CDC).

2. Inmates meeting the criteria for vaccination, established by the CDC, receive vaccination on a voluntary basis.

3. Staff members wishing to participate in the hepatitis B vaccine program consult with the warden or designate.

4. Staff (or their immediate family members) wishing to receive post-exposure vaccinations consult with their family physician.

5. A determination regarding pregnancy is made on all female inmates prior to vaccination.

15. Blood and Body Fluid Borne Pathogens

15.1. Overview (revised: Dec-12)

1. Body fluids are treated as potentially infectious.

2. Persons trained in safe techniques – either by officers or inmates directly supervised by officers – must clean up blood and spills of body fluids.

3. When handling body fluids, the following precautions are taken:

    - Wear disposable examination gloves;
    - Cover cuts and open wounds with clean bandages;
    - Wear coveralls when exposure is extreme (e.g. copious bleeding);
    - Wear surgical masks in cases of extensive contamination by body fluids;
    - Wash hands thoroughly with soap and water after removal of gloves;
    - Clean up spills of blood or body fluids promptly and thoroughly, using readily available materials; and
    - Place potentially contaminated clothing and other items in clearly identified, impenetrable plastic bags for disposal or separate cleaning. Hazardous waste bags are clearly marked “BIOHAZARDOUS”.

15.2. Response to exposure to blood or other potentially infectious material (revised: Dec-12)

For the initial management of an exposure incident involving blood or other potentially infectious materials, the affected individual:

- Immediately seeks first aid from the on-site occupational first aid attendant; and
- Reports the incident to a supervisor and then goes to the nearest hospital emergency department within two hours of the incident for a medical evaluation. (Note: Reporting must not cause a delay in seeking medical attention.)

15.3. Use of starter kit for management of accidental exposure to HIV (revised: Dec-12)

1. When it is not possible to attend the hospital according to section 15.2, the starter kit is used for the employees, contractors and inmates of the B.C. Corrections Branch who have accidental exposure to Human Immunodeficiency Virus (HIV).

2. In consultation with health care personnel, the starter kit should be initiated within two hours of exposure to offer the best chance of preventing HIV transmission.

3. To initiate the starter kit, follow the *Guidelines for Blood and Body Fluids Exposure Management for Staff and Inmates at B.C. Correctional Centres*, and *The Management of Accidental Exposure to HIV* provided by the B.C. Centre for Excellence in HIV/AIDS.

4. s.15
s.15 The Ambulatory Pharmacy at St. Paul's Hospital in Vancouver sends the kit directly to the centres.

5. The starter kit provides enough medications for five-day anti-retroviral therapy. The exposed person should see a physician as soon as possible to determine the need for full 28-day therapy. The physician should contact the Ambulatory Pharmacy at St. Paul's Hospital (1-888-511-6222), if the full therapy is needed.

6. Each kit has a reorder form attached to the front. The form must be completed in full to receive a replacement kit. Fax the completed reorder form to the Ambulatory Pharmacy at St. Paul's Hospital (604-806-8675) to receive the replacement starter kit directly at the centre. Forms received before 11 a.m. on business weekdays are processed and sent out the same day.

7. Because the starter kit contains prescription drugs, a written or verbal prescription from the centre physician is required to initiate the starter kit.

8. There is no charge for the starter kits if the reorder form is completed and faxed.

9. Loss or misuse of the kit results in a $200 charge to the B.C. Corrections Branch.

10. To avoid unnecessary wastage of medication, kits are reordered when a minimum of two months remains on the prescription.

15.4. Protective equipment – infection control kits (revised: Dec-12)

1. Correctional officers are issued and carry, while on duty, disposable examination gloves and one-way anti-reflux valves (Microshields) in a belt-worn pouch.

2. When available, one-way bag valve facemasks are used whenever mouth-to-mouth resuscitation is required.

3. The following currently approved items, identified as an infection control kit, are available in centres:

    - Surgical masks;
    - Eye shields;
    - Standard issue coveralls;
    - Cleaning materials;
    - Disposable examination gloves; and
    - N95 respirator.

15.5. Exposure Control Plan (revised: Dec-12)

Correctional centres maintain an exposure control plan for the prevention and control of infectious diseases in the workplace.

15.6. Condoms

15.6.1 General

1. The Adult Custody Division recognizes a duty to reduce the risk of sexually transmitted diseases among inmates.

2. To meet this responsibility, adult correctional centres ensure that condoms are made available to inmates.

15.6.2 Purpose

This policy provides guidelines for the distribution of condoms in adult correctional centres.

15.6.3 Definition

1. A condom is a prophylactic used to prevent the transmission of infectious disease.

2. The term condom includes latex rubber condoms for male inmates or latex dental dams or condoms for female inmates.

15.6.4 Confidentiality

Staff ensure that confidentiality is maintained to respect the privacy of inmates who access or possess condoms.

15.6.5 Costs

Condoms are distributed to inmates free of charge.

15.6.6 Types

Latex condoms are distributed because medical research indicates this is the most effective material to prevent transmission of infectious disease.

15.6.7 Lubricant

One-time use packages of water-soluble lubricants (i.e. K.Y. Jelly or Lubafax) are supplied with condoms to ensure maximum protection for users.

15.6.8 Instructions on use

Printed material regarding the use of condoms is available at the point of access.

15.6.9 Supply maintenance

1. Correctional staff must maintain supplies of condoms, water-based lubricant and printed instructions regarding correct use.

2. Distribution methods are based on the following principles:

    - Freely available – in secure centres, condoms are available in the living units and may be available through health care. Replacement supplies in living units are checked on a daily basis by correctional staff and restocked as required. In open centres, condoms must be in central, easily accessible locations;

    - Readily accessible – a designated access point is in each secure living unit or open custody centre (e.g. washrooms or clean-up areas, laundry, kitchen) where replacement supplies are kept; and

    - Ensures anonymity – the access point must allow maximum anonymity and not require inmates to approach a correctional officer.

15.6.10 Contraband

1. Staff who discover unopened condoms or lubricant packages in an inmate's possession do not confiscate these articles.

2. Inmates suspected of using condoms to smuggle contraband, are dealt with through the normal disciplinary process.

15.7. Bleach

15.7.1 General

Consistent with Adult Custody Division policies regarding the control of infectious diseases, adult correctional centres ensure that filtered household bleach is available and accessible for inmate use.

15.7.2 Purpose

This policy provides guidelines for the distribution of filtered bleach in adult correctional centres.

15.7.3 Strength

To be fully effective in reducing the spread of infectious disease, bleach used as a disinfecting agent must be full strength filtered household bleach (6% sodium hypochlorite).

15.7.4 Instructions on use

1. Printed material regarding use of bleach is available at the point of access.

2. Health care staff must provide and post in each unit information regarding proper methods of using filtered bleach as a disinfectant.

15.7.5 Distribution

1. Filtered bleach is distributed to inmates in secure centres in 30-60 ml bottles.

2. Correctional staff maintain supplies of bleach.

3. Each centre establishes a policy that details the method of bleach distribution based on the following principles:

    - Freely available – in secure centres, filtered bleach is available in the living units and may be available through health care. Replacement supplies in living units are checked on a daily basis by correctional staff and restocked as required. A minimum of five bottles are available in each living unit at all times;

    - Readily accessible – a designated location is in each secure living unit or open custody centre (e.g. clean-up areas, laundry, kitchen) where replacement supplies are kept for exchange;

- Replacement basis – filtered bleach is available in designated access areas where inmates can return empties and obtain full bottles;

- Ensures anonymity – the point of access and exchange must afford maximum anonymity and not require inmates to approach a correctional officer to obtain bleach; and

- Minimizes risk of injury – filtered bleach for distribution to inmates in secure is in prescribed 30-60 ml bottles. Bottles are labelled to indicate the date of decanting and that they contain filtered bleach. If self-decanting is used in open centres, eye protection, funnels and proper pouring decanters must be employed to minimize spills. Rubber gloves are provided to protect against skin contact.

15.7.6 Contraband

1. A single 30-60 ml bottle of filtered bleach is not considered contraband. Inmates who possess larger quantities are considered to be in possession of contraband.

2. Although items commonly subject to disinfecting with bleach are contraband (i.e. hypo-dermic needles, syringes, tattoo kits) an inmate's use of bleach does not provide a case to establish drug usage or other unacceptable activity.

15.7.7 First Aid

1. The following First Aid steps should be used in the event that anyone is splashed with bleach:

    - Skin – remove contaminated clothing and thoroughly wash contacted areas;

    - Eyes – flush thoroughly with water for 15 minutes while holding eyelids open; and

    - If ingested – have victim drink warm water. Do not induce vomiting.

2. Health care staff are immediately advised of incidents involving injuries related to bleach.

15.7.8 Central supply

1. Filtered bleach for distribution to inmates in secure centres is obtained from the designated central supplier. This ensures province-wide consistency in concentration, bottle size and style, as well as labelling.

2. Each bottle of bleach must clearly indicate that bleach is corrosive and caution should be taken to avoid contact with eyes and skin. The bottle label also indicates that bleach should not be ingested or mixed with other substances except water.

3. The style of bottles and caps reduce the ability to squirt the contents by squeezing the bottle.

16. Airborne Pathogens

16.1. Tuberculosis (revised: Sep-12)

16.1.1 Background

1. A significant proportion of individuals in correctional centres are at high risk of becoming infected with tuberculosis (TB) or having active disease. For this reason, it is necessary to screen all admissions for symptoms of TB and test symptomatic and high-risk individuals upon arrival in a correctional centre.

2. The potential for unrecognized cases of TB and transmission to susceptible individuals in correctional settings results primarily from delayed diagnosis and failure to isolate and treat cases of TB.

3. Currently, there are no resources to individually screen each inmate with a tuberculin skin test upon arrival. In addition, testing for TB is not routinely done on all asymptomatic individuals with no risk factors for TB. Therefore, intervention is necessary to ensure, at a minimum, that all known high-risk inmates receive a thorough assessment for TB as soon as possible after admission.

4. Inmates found to have tuberculosis are managed according to the advice and protocols of the B.C. Centre for Disease Control (BCCDC), Division of TB Control.

16.1.2 Procedure

1. All inmates receive an initial health assessment by a nurse upon admission to a correctional centre. As part of this initial health assessment, inmates are closely questioned regarding history, signs, symptoms or exposure to TB, and history of HIV or HIV risk factors, as follows:

    - Previous diagnosis of TB, with dates and treatment;
    - Contact with a person with confirmed TB (name of source and date of exposure);
    - Cough, weight loss, night sweats or fever;
    - Recent arrival from China, Africa, South America and South East Asia, where TB is endemic;
    - HIV status;

- Risk factors for HIV infection, (e.g. IV drug user or partner, homosexual/bisexual, sex-trade worker);
- Use of steroids or other immunosuppressors; and
- Previous tuberculin testing, dates and results.

2. Due to the potential for the spread of tuberculosis among susceptible inmates and staff, a high index of suspicion is maintained when interviewing and assessing persons in high-risk groups.

3. At a minimum, all persons receive a TB skin test no later than the next nurse's clinic following admission, if they are expected to remain in Corrections Branch custody long enough for the TB skin test to be interpreted (48 hours after Mantoux is applied), and are:

    - Symptomatic for TB;
    - Reporting contact with a known TB case; or
    - Persons with HIV, regardless of symptoms or contact, who have not been tested during the previous six months.

4. Symptomatic patients are referred to the physician for additional medical assessment and recommendations.

5. Non-symptomatic, HIV-negative individuals with no history of TB contact who are in lower risk categories or request TB testing and have not received a TB skin test within the previous six months, are tested when staff time and resources permit.

6. Positive skin tests are reported to the Division of TB Control for immediate instructions regarding follow-up, testing and treatment of the patient, as indicated.

7. Patients with documented positive TB skin tests in the past receive an annual chest x-ray.

8. The warden, director of Health Services, and health care contractor are notified immediately of a suspected or confirmed case of TB at a correctional centre.

17. Inmate Fasting

17.1. Definition (revised: Jul-10)

A "fast" is a complete and voluntary abstinence from nourishment by an inmate using unimpaired and rational judgment concerning the consequences.

17.2. Right to fast (revised: Jul-10)

1. Even though correctional staff are charged with providing "necessaries of life" (section 215 of the *Criminal Code*) and the safekeeping of inmates within the correctional centre, inmates have the right to fast.

2. Staff do not interfere with an inmate's exercise of this right, provided the inmate is:

    - Old enough to consent to medical treatment;
    - Mentally competent; and
    - Conscious.

17.3. Authority (revised: Jul-10)

1. The World Medical Association's Declaration of Tokyo (1975): *Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* provides as follows:

    > "Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner."

2. Courts in Canada and elsewhere have not made definitive decisions concerning the right of an inmate to voluntarily starve to the point of serious health consequences or death.

3. Accordingly, the Corrections Branch takes the steps necessary to protect the life and health of a fasting inmate.

17.4. Notification (revised: Mar-13)

1. When it becomes known that an inmate is fasting, corrections staff must notify:

    - The health care professional, either immediately if the inmate has been fasting for 24 hours or more, or within 24 hours if the inmate has just commenced fasting; and

    - The warden or designate who in turn informs the director, Health Services.

2. When health care staff are informed that an inmate is fasting, a referral is made to a mental health professional.

3. Within 24 hours of receiving notification, the director, Health Services, in consultation with the director, Mental Health Services and health care manager, determines whether compelling circumstances exist to warrant notifying the inmate's next of kin. If compelling circumstances do not exist, informed consent may be sought from the inmate to initiate such contact. The warden or designate notifies the inmate's next of kin upon the recommendation of the director, Health Services.

4. The assistant deputy minister, Corrections Branch, is notified of a fasting inmate as soon as one of the following occurs. The fast:

    - Becomes public information;

    - Seriously disrupts management of the correctional centre; or

    - Reaches the tenth day.

5. Continuous updates are provided to the assistant deputy minister on the inmate's health condition.

6. Regular meetings occur among Corrections Branch management, the Health Services director, the Mental Health Services director, treating physicians, nurse practitioners and Legal Services Branch counsel to review the fasting inmate's progress.

17.5. Health care staff surveillance and documentation (revised: Jul-10)

While the inmate continues to fast, health care staff monitor daily the patient's condition, including vital signs, weight and mental status.

17.6. Medical temporary absence (revised: Jul-10)

When an inmate becomes unconscious or the clinician determines an imminent threat to the life and health of an inmate, the warden or designate, on the advice of the clinician, transfers the inmate to a hospital facility through an emergency medical absence (refer to "Types of Temporary Absences" in *Adult Custody Policy*).

18. Private Clinicians Visiting Inmates

18.1. Interviews

1. An inmate in a correctional centre may be visited and interviewed by a private medical, psychiatric, or psychological clinician not on staff or retained by the Corrections Branch, Adult Custody Division.

2. When an interview is requested, the clinician is referred to the correctional centre's health care manager and asked to provide the following information:

    - Name of person conducting the interview;
    - Name of inmate being interviewed;
    - Purpose of interview; and
    - Preferred time and expected length of interview.

18.2. Security clearance

The warden or designate is also contacted to:

- Confirm that the inmate is in the correctional centre and available at the requested time; and
- Authorize clearance for the clinician to enter the correctional centre at the specified time.

18.3. Expenses and costs

1. Fees and expenses of a private clinician are the responsibility of the inmate, not the Adult Custody Division.

2. The Adult Custody Division may bill private clinicians for extraordinary costs incurred by the Corrections Branch.

18.4. Treatment (revised: Mar-13)

A patient treatment plan recommended by a private clinician is not undertaken until:

- The treatment plan is approved by the correctional centre's physician or nurse practitioner regarding medical issues, or psychologist regarding non-medical, mental health issues;
- Consent in writing has been given by the inmate; and
- The treatment plan is documented in the Primary Assessment and Care (PAC) inmate health information system.

19. No Cardiopulmonary Resuscitation (Issued: Nov-04)

19.1. Background

1. When patients are diagnosed with a terminal illness and recovery is unlikely, health care staff are required to discuss with them their wishes regarding resuscitation in the event of respiratory or cardiac arrest.

2. Given that patients have the right to choose the level of therapeutic intervention in foreseeable circumstances, staff make every effort to have dying patients declare their wishes regarding resuscitation.

3. Patients who know they have a terminal illness or are at the end of their lives may request that no active resuscitation be started on their behalf. This request is made with the agreement of the centre physician who issues a No Cardiopulmonary Resuscitation order (No CPR).

4. Refusal of resuscitation for competent patients with a terminal illness is acceptable in correctional settings.

5. A No CPR order does not imply withholding or withdrawing any therapy except CPR, artificial ventilation and assisted circulation.

6. At all times, the mental and physical comfort of dying patients must be managed actively, regardless of their decision concerning resuscitation.

19.2. Procedure (revised: Jul-08)

1. The centre physician reviews with all terminal patients at the centre the benefits and consequences of accepting and refusing resuscitation.

2. If there is doubt or disagreement regarding the decision, a second opinion is obtained from another physician.

3. According to the wishes of the terminal patient, a family member or patient representative may be included in the decision.

4. When a terminal patient makes the decision to not be resuscitated, a No CPR order must be documented in the Primary Assessment and Care (PAC) inmate health information system by the centre physician.

5. Reasons for the No CPR order—as well as the expressed views of the patient, patient's representatives (family or guardian) and health care providers—are documented in PAC.

6. When a terminal patient is incompetent, this status is documented in PAC. If available, the patient's representative (family or guardian) is consulted. Refusal of resuscitation on its own is not evidence of mental incompetence.

7. A physician reviews the No CPR order at intervals, especially prior to and following inter-facility transfers and whenever there is a change in the mental or physical condition of the terminal patient. Review intervals must not exceed six months.

8. A no CPR order may be cancelled at any time if the dying patient requests a change. All changes must be clearly documented by the centre physician in PAC.

19.3. Signed Documentation (revised: Jun-09)

1. When there is a decision to proceed with a No CPR order, the centre physician completes a No CPR (HLTH 302.1) form from the Ministry of Health.

2. A copy of a completed HLTH 302.1 form, signed by the centre physician, is kept in a suitably labeled file and provided to paramedics upon arrival by the nurse on duty.

3. When a No CPR order is issued, health care staff send an email to inform the centre's deputy warden of programs that a No CPR (HLTH 302.1) form for paramedics regarding a particular inmate has been placed in the shift supervisor's office.

19.4. Relationship with Paramedics

The No CPR Orders section of the BC Ambulance Service Policy and Procedure Manual is summarized as follows:

- Paramedics follow a No CPR order provided to them that is signed by a physician;
- Paramedics comply with a No CPR order from a physician when verbally communicated by a physician or a nurse; and
- If there is no verifiable No CPR order, paramedics proceed with resuscitation.

19.5. No Nurse on Duty

1. Centre physicians may provide No CPR orders to health care providers, but not to correctional officers.

2. When no nurse or physician is on duty at the centre, correctional officers follow procedures detailed in section 9.22 of *Adult Custody Policy*.

3. To maintain patient confidentiality and ensure access by paramedics to No CPR orders, the shift supervisor retains a copy of a HLTH 302.1 form that is signed by the centre physician and placed in a sealed envelope marked "PARAMEDICS."

20. Communication (revised: Sep-12)

To promote a safe, transparent, and supportive work environment in correctional facilities, the following health care and correctional staff communicate to address inmate health issues and needs:

- Front line health care staff;
- Physicians;
- Psychologists;
- Other clinicians and contractors;
- Health care contractor;
- Medical director, Corrections Branch;
- Director, Health Services;
- Director, Mental Health Services;
- Correctional centre administrators; and
- Branch managers.

20.1. Professional Communication (revised: Sep-12)

1. Corrections Branch representatives and health care workers in correctional centres communicate—without violating the rules of patient medical confidentiality—regarding circumstances that:
    - Involve patient care and clinical standards; or
    - Might present a risk to the branch, centre or patient safety.
2. Communication is open and transparent. The director, Health Services and director, Mental Health Services are included in correspondence whenever necessary to:
    - Keep the branch informed of issues in patient care; and
    - Ensure good, safe practice.

3. Health care staff use their professional judgment in deciding when to communicate directly with correctional centre management or any other Corrections Branch representatives, the director, Health Services or the director, Mental Health Services.

20.2. Communicable Disease Outbreaks (revised: Mar-13)

1. The director, Health Services manages all communicable disease outbreaks in B.C. Corrections correctional centres. The director, Health Services also consults with the medical health officer of the local health authority and/or the provincial health officer, as required.

2. Once the director, Health Services has officially declared an outbreak or whenever an outbreak is suspected, the health care contractor and health care staff at the affected centre(s) participate in regular conference calls with the director, Health Services. These conference calls are directed by the director, Health Services.

3. To manage and contain an outbreak and bring it to a safe and rapid resolution, the director, Health Services, Corrections Branch instructs the health care contractor and health care staff regarding:

    - Proper precautions;
    - Patient assessment;
    - Care and isolation; and
    - Other strategies.

4. Only the director, Health Services communicates with the hospital, and local or B.C. Centre for Disease Control (BCCDC) laboratories during an outbreak.

5. Decisions and communication regarding the onset and cessation of outbreaks are made by the director, Health Services. These actions follow a communication protocol that includes:

    - Branch managers;
    - Warden(s);
    - Regional health authority representatives;
    - Health care contractor and health care staff; and
    - Correctional centre staff.

20.3. Critical Incident Reviews (revised: Sep-12)

1. A critical incident may be investigated by the Corrections Branch, Investigation and Standards Office, a police agency, and/or Office of the Coroner. Written notice is provided to the health care contractor prior to the commencement of a critical incident review. The health care contractor receives written confirmation from the branch that these investigations have been completed before interviewing staff or commencing its own investigation or review.

2. A critical incident review (CIR) is a formal process, initiated by the assistant deputy minister, Corrections Branch, to investigate—in a thorough and timely manner—incidents that may affect operations of a correctional centre or the branch.

3. The only CIR team members who may access inmate health care records are the:

    - Director, Health Services; and
    - Director, Mental Health Services.

4. Upon request by the chair of a CIR team, the health care contractor immediately provides all patient medical records to the:

    - Director, Health Services; and/or
    - Director, Mental Health Services.

5. Health care staff are interviewed by the CIR team when requested.

6. CIR recommendations are sent to the health care contractor following review by branch and centre management.

20.4. Complaints and Concerns (revised: Sep-12)

1. The Investigation and Standards Office (ISO), director, Health Services and director, Mental Health Services investigate complaints and health care concerns as part of their duties.

2. The health care contractor is advised of inquiries into serious complaints and concerns that are brought to the attention of the deputy provincial director, Adult Custody Division.

3. During the course of these inquiries, the health care record is reviewed. Health care staff involved in the patient's care may be consulted for information and discussion regarding the specific case.

4. Health care personnel provide information to an inquiry into a complaint or concern.

5. Information exchanges remain confidential between the ISO, director, Health Services and director, Mental Health Services when they investigate complaints and concerns.

6. For enhanced security, only the government email system (GEMS) is used for email exchanges of confidential medical information.

7. The health care contractor is notified of the outcome of such inquiries and recommendations.

21. Other References

1. Health care professionals need to be aware that other information, policies and procedures that relate to health care are documented elsewhere.

2. These references include: Restraint devices, inmate injuries, staff injuries, Occupational First Aid, control of dangerous substances, fire protection, shoes, mattresses and extra pillow requests, transsexual inmates, inmate death, and other issues.

3. The policies and procedures covering the above issues can be found in:

    - Adult Custody Policy;
    - ADM directives;
    - WorkSafe BC Rules and Regulations; and
    - Local operating policies and procedure manuals.

4. Copies of these manuals can be accessed through health care staff or deputy wardens, programs.