VOLUME 4: MEDICAL SERVICES	Effective Date: 01/2006
CHAPTER 15	Revision Date: 04/2016
4.15.2 CORRECTIONAL TREATMENT CENTER PROCEDURE	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

This procedure outlines the requirements, responsibilities, and clinical conditions appropriate for admission to a Correctional Treatment Center (CTC) in order to provide patients with housing consistent with their health care needs.

II. DEFINITIONS

Correctional Treatment Center: A health facility operated by the California Correctional Health Care Services (CCHCS), California Department of Corrections and Rehabilitation (CDCR) that provides inpatient health services to patients who do not require a general acute care level of basic services and are in need of professionally supervised health care that cannot be provided on an outpatient basis.

Correctional Treatment Center Governing Body: A person, persons, board of trustees, directors, or other body in whom the authority and responsibility is vested for conduct of the CTC.

Health Care Provider: A Medical Doctor, Doctor of Osteopathy, Doctor of Podiatric Medicine, Clinical Psychologist, Marriage and Family Therapist, Dentist, Clinical Social Worker, Nurse Practitioner, or Physician Assistant.

III. RESPONSIBILITIES

A. Statewide

1. CDCR and California Correctional Health Care Services (CCHCS) departmental leadership at all levels of the organization, within the scope of their authority, shall ensure administrative, custodial, and clinical systems are in place, and appropriate tools, training, technical assistance, and levels of resources are available so that institutions can successfully implement CTC services as required by California Code of Regulations (CCR), Title 22, Chapter 12 and other regulatory bodies.
2. The Undersecretary, Health Care Services, CDCR, and the Directors, Health Care Operations and Health Care Policy and Administration, CCHCS, are responsible for statewide planning, implementation, and evaluation ofCTC services.
3. Health Care Placement Oversight Program (HCPOP) is responsible for management of CTC beds statewide as a part of specialized medical beds program in collaboration with health care services to ensure an appropriate level of care.

B. Regional

Regional Health Care Executives are responsible for implementation of this procedure at the subset of institutions within an assigned region.

C. Institutional

1. The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of a system to provide management of the scope of CTC services. The CEO delegates decision making authority to designated institutional health care executives for daily operations of the CTC procedure and ensures adequate resources are deployed to support the system.
2. The CEO and all members of the institution leadership team are responsible for ensuring all necessary resources are in place to support the successful implementation of this procedure at all levels including, but not limited to the following:
   a. Institution level.
   b. Patient panel level.
   c. Patient level.
3. The CEO and all members of the institution leadership team shall ensure access to and utilization of equipment, supplies, health information system, patient registries and summaries, and evidence-based guidelines.
4. The CTC Governing Body shall:
   a. Be responsible for the overall operation of the CTC.
   b. Appoint a Medical Director with delegated authority to carry out the functions of the CTC and the responsibility for ensuring that the CTC conforms to all applicable federal, state, and local laws, and regulations.
   c. Appoint a CTC Administrator whose authority, qualifications, and duties shall be defined in writing.
   d. Appoint a Mental Health Director (psychiatrist, psychologist, or master's level social worker) who shall have overall responsibility for mental health services provided in the CTC.
   e. Appoint a Director of Nursing whose administrative authority, responsibility, and accountability for the nursing services within the CTC shall be defined in writing. The Director of Nursing shall serve only one CTC in this capacity at any one time, except if the facilities are in the same geographic region, are operated by the same governing body, and a designated Registered Nurse (RN) is available on-site to perform the function of the Director of Nursing.
5. Each CTC shall have at minimum the following committees as per CCR, Title 22: Patient Care Policy, Infection Control, and Pharmaceutical Service. The minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed, and action taken. The institutions shall designate a reporting structure to the institutional Quality Management Committee.
6. A Physician-on-call (POC) shall be available 24 hours a day, seven days a week.
   a. The POC shall be contacted through the RN when health care assistance is required.
   b. The RN shall document the call or contact with the POC. Documentation shall include the time of the call/contact, the time of the POC's response, whether the POC responded by phone or in person, and any orders made by the POC at the time of this call. The RN shall enter this documentation into the patient's health record.
   c. The POC must be able to return to the facility within one hour of the call, if required.

7. An RN shall be on duty in the CTC 24 hours a day, seven days a week. Nurse staffing, at a minimum, shall meet the CCR, Title 22, staffing requirements.
8. Dental services shall be provided by the minimum number of dentists and auxiliary dental personnel to meet the needs of patients in the CTC.
9. Mental health shall meet the minimum staffing requirements as specified in the CCR, Title 22.
10. The CEO and all members of the institution leadership team as a part of the Quality Management process on an ongoing basis shall:
    a. Review the CTC performance, including the overall quality of services, assignment to the appropriate level of care, health outcomes, and assignment of consistent and adequate resources, utilization of Dashboards, Master Registries, Patient Summaries, and decision support tools.
    b. Address issues pertaining to delivery of CTC services.
    c. Provide CTC staff with adequate resources, including protected time, staffing, physical plant, information technology, and equipment and supplies to accomplish daily tasks.
    d. Work with custody staff to minimize unnecessary patient movement and ensure appropriate escort and transport.
11. The Chief Nurse Executive (CNE) is responsible for the overall daily CTC operations. The CNE is responsible for ensuring that the institution has designated supervisors to monitor CTC operations to include but not limited to, efficiency, coordination, supplies, equipment, physical plant issues, scheduling and access to care on a daily basis, as well as to identify and to address or elevate concerns regarding barriers.
12. The institution is responsible for maintaining a set of current and approved CTC policies and procedures according to CCR, Title 22.
13. Each patient shall have an interdisciplinary Patient Treatment Plan which documents patient problems, goals, interventions, discipline responsibilities, and dates to be met.

IV. PROCEDURE

A. Admission to the CTC

1. Medical conditions appropriate for admission to a CTC may include, but are not limited to those patients who:
    a. Have a severe illness or condition and potentially significant risk factors, with limited or no opportunity for improvement, stabilization, or cost control, and who do not require admission to a general acute care hospital (e.g., lung cancer, recent Myocardial Infarction, End Stage Renal Disease on dialysis, amputee, blind, or End of Life Care).
    b. Return from hospitalization and require continued observation or treatment (e.g., recent hospital admission for sepsis with significant co-morbid conditions).
    c. Require continuous or more than twice daily intravenous therapy or medication administration.
    d. Need significant assistance, are totally dependent for activities of daily living, have a high fall risk, or require mechanical lift transfer.

e. Require frequent suctioning, have a tracheostomy requiring extensive nursing intervention, or require special placement for a new tracheostomy pending patient adjustment (designated institution).
f. Requiring total parenteral nutrition (designated institutions).
g. Require total assistance with a colostomy, or with a suprapubic or foley catheter, with underlying complications.
h. Have a Gastric or Nasogastric tube for feeding requiring total nursing intervention.
i. Have complicated surgical wounds or pressure ulcers requiring frequent care by nursing staff including the use of a negative wound pressure device (wound vac).
j. Are on continuous oxygen therapy.
k. Have severe ill effects from radiation or chemotherapy.
l. Are confused or disoriented.
m. Are dangers to themselves, a danger to others, gravely disabled, or otherwise needing psychiatric observation, requiring mental health crisis bed (MHCB) placement.
n. Have an Intermaxillary Fixation (Wired Jaw) post procedure, until stabilized, and no longer on aspiration precaution and the dentist recommends release to a lower level of care.
o. Have premature labor, pregnancy complications, a high-risk pregnancy, or post cesarean section.
p. Require chest tube maintenance (designated institutions).
q. Require long-term care placement.

2. All admissions to a MHCB should be consistent with the Mental Health Services Delivery System Program Guide.
3. Select CTCs may provide additional services based on available resources as determined at the headquarters level.
4. Patients whose level of care or medical needs include any of the following shall not be housed in the CTC. The following list is not exhaustive; other health conditions may require transfer from a CTC to a higher level of care, as specified by a licensed health care provider.
   a. Cardiac monitoring.
   b. Chest tube insertion.
   c. Hyperbaric oxygen.
   d. Major surgery.
   e. Intensive care.
   f. Central venous pressure monitoring.

B. Admitting Provider Responsibilities

1. Admission orders to the CTC shall include the following:
   a. Admission diagnosis.
   b. Allergies.
   c. Diet.
   d. Condition.
   e. Level of activity.
   f. Orders for vital signs (including frequency).
   g. Lab and X-ray orders.

h. Medications with stop dates, as appropriate.

2. If admitted by a psychologist, he/she shall contact the primary care provider, psychiatrist, or appropriate on-call provider if after hours, to coordinate the writing of the following orders as necessary:
   a. Orders for vital signs (including frequency).
   b. Lab and X-ray orders.
   c. Medications with stop dates, as appropriate.
3. For MHCB, orders for suicide watch (SW), suicide precaution (SP), seclusion, or restraints shall be written according to Mental Health Services Delivery System Program Guide, policy memos, and state law.

C. Attending Provider Responsibilities

1. The attending provider shall conduct an evaluation which includes an admission history and physical examination within 24 hours of admission, for immediate care planing.
2. The attending provider shall re-evaluate the patient's condition, including the review of all orders and updating orders as indicated at least every 30 calendar days, upon change of attending provider, and upon transfer. For MHCB patients, treatment updates are required at least every seven calendar days, and according to policy for SW, SP, seclusion, or restraints.
3. The attending provider shall complete a progress note at least every three calendar days, or more often as the patient's condition requires. Each visit by the attending health care provider shall be documented. For MHCB, a licensed clinician shall see patients daily and document on a progress note.
4. Change to Level of Care:
   a. Patients in a CTC requiring admission to a higher level of care shall be transferred as medically necessary.
   b. Transfer to a higher level of care shall occur as indicated on a health care provider's order, but no later than 24 hours after the order is written.
   c. The health care provider shall complete a physician's order and a transfer or release note for any level of care transfer outside of a CTC.
   d. The attending provider shall complete a Medical Classification Chrono for any changes in the patient's level of care.

D. Nursing Responsibilities

1. The RN shall:
   a. Complete an Initial Assessment at the time of admission.
   b. Initiate a Nursing Care Plan within 72 hours of admission for all patients admitted to the CTC.
   c. Review the Nursing Care Plan at least monthly, and more often as the patient's condition warrants, the RN involved in the care of the patient shall review, evaluate, and update the Nursing Care Plan.
   d. Immediately notify the relevant attending licensed health care provider of the following:
      1) The admission of a patient.
      2) Any sudden and/or marked adverse change in signs, symptoms, or behavior exhibited by a patient.
      3) Any unusual occurrences involving a patient.

4) Any untoward response or reaction by a patient to medication or treatment.
5) Any error in the administration of a medication or treatment to a patient.
6) The CTC's inability to obtain or administer drugs, equipment, supplies, or services, as prescribed, in a prompt and timely manner when this presents a risk to the health, safety, or security of the patient.
7) The patient's refusal to accept a prescribed medication, treatment, or diagnostic procedure.

e. When a verbal order is given, document it and clearly show the health care providers name.
f. Ensure that required SW, SP, seclusion, or restraints checks on patients are documented according to mental health policy.
g. Ensure that an interactive discharge planning process has taken place prior to a patient's discharge from the CTC.

2. The Utilization Management (UM) Nurse shall:
   a. Assess and document the patient's level of care needs per UM guidelines upon placement, then every 30 days thereafter or whenever there is a change in patient's condition, to determine if the patient continues to be in the appropriate level of care placement.
   b. If a patient is no longer in the appropriate level of care, report findings to the Chief Medical Executive and CNE or their designee.
   c. Coordinate with the HCPOP for requests for changes in level of care placement.

V. REFERENCES

- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 5, Correctional Treatment Centers
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 11, Medication Management
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 34, Utilization Management
- Mental Health Services Delivery System Program Guide