VOLUME 4: MEDICAL SERVICES	Effective Date: 01/2006
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4.17.2 MEDICAL EVALUATION FOR ASSAULTS, CELL EXTRACTIONS, AND USE OF FORCE PROCEDURE	Attachments: Yes ☐ No ☒

I. PROCEDURE OVERVIEW

California Correctional Health Care Services (CCHCS) health care staff shall follow the procedures set forth below regarding steps to take prior to and during controlled use of force, controlled use of force video recording requirements, decontamination and monitoring following controlled use of force, controlled use of force in licensed health care facilities controlled use of force reporting requirements, and evaluation and medical documentation of patients involved in an assault, cell extraction or use of force.

II. DEFINITIONS

Controlled Use of Force: The force used in an institution/facility setting when an inmate's presence or conduct poses a threat to safety or security and the inmate is located in an area that can be controlled or isolated. These situations do not normally involve the immediate threat to loss of life or immediate threat to institution security.

III. PROCEDURE

A. Prior to Controlled Use of Force

1. A Primary Care Provider (PCP), Licensed Mental Health Practitioner (LMHP), or Licensed Nursing Staff (LNS) (Registered Nurse [RN], Licensed Vocational Nurse, Licensed Psychiatric Technician) shall be notified by custody staff prior to controlled use of force, including but not limited to chemical agents such as Oleoresin Capsicum, Chloroacetophenone, and Orthochlorobenzalmalononitrile.
2. The LNS shall review the patient's health record and document the review. For patients housed in an inpatient setting, the inpatient RN shall conduct the review. For all other patients, the review shall be conducted by the Triage and Treatment Area (TTA) RN.
   a. The LNS shall also note any conditions that may predispose the patient to an adverse outcome from the use of force, and any known disabilities that will require accommodation during the controlled use of force.
3. Conditions that may predispose a patient to an adverse outcome from exposure to chemical agents include, but are not limited to the following:
   a. Cardiac insufficiency
   b. Acute reactive pulmonary disease (asthma)
   c. Chronic obstructive or restrictive lung disease
   d. Pregnancy
   e. Allergic reaction to the carrier or active ingredient
   f. Corneal or ocular injury
4. If the TTA RN identifies any medical or psychiatric condition or disability which may predispose a patient to increased risk of an adverse outcome from exposure to chemical

agents, the RN shall immediately contact the Incident Commander and explain in non-technical language the medical risks if chemical agents are used.

5. The TTA RN shall contact the PCP or psychiatrist if there are serious concerns about the use of chemical agents.
   a. The PCP or psychiatrist shall review the patient's health record and document the review. The documentation shall include any condition that may predispose the patient to an adverse outcome from the use of force.
6. In all situations that may require controlled use of force, mental health shall be consulted. A licensed mental health practitioner shall evaluate the patient and provide intervention, as appropriate, during a cool down period. The mental health practitioner shall collaborate with the team during this cool down period.
7. If there is disagreement among the collaborative team members (medical, nursing, mental health, and custody) regarding the strategies to be employed, the issue shall be elevated to the appropriate clinical and custodial managers up to and including the Chief of Mental Health or designee, Chief Medical Executive or designee, Chief Nursing Executive or designee, Chief Executive Officer or designee, and Warden or Chief Deputy Warden.
8. In the event the disagreement is not resolved at the institution level, the issue shall be elevated to the Regional Health Care Executives (Medical, Nursing, and Mental Health), and the appropriate Associate Director, Division of Adult Institutions (DAI).

B. During Controlled Use of Force

1. Controlled use of force shall not be accomplished without the physical presence of the LNS. The LNS shall be in close proximity to the incident to facilitate an immediate medical response, but not so near as to become involved in the controlled use of force. The LNS is not required to wear controlled use of force team equipment such as a helmet, personal protective equipment kit, etc.
2. Prior to commencing with the controlled use of force, the LNS shall ensure they are in possession of the appropriate medical supplies and equipment to respond to a medical emergency.
3. The LNS who reviewed the health record and the LNS who is on-site during the controlled use of force are not required to be the same person.

C. Controlled Use of Force Video Recording Requirements

1. As per the California Department of Corrections and Rehabilitation Department Operations Manual (DOM), each controlled use of force shall be video recorded.
2. Per the DOM, the onsite LNS and LMHP shall identify themselves on camera and confirm that the patient's health record was reviewed. The LNS shall indicate if the patient has any health conditions that put them at increased risk for adverse outcome from the use of chemical agents or other force options. The LNS shall also indicate any known disabilities the patient has that will require any accommodation before, during, or after the controlled use of force. The LNS shall not include specific conditions or any other protected health information.
3. Per the DOM, the LNS on-site during the controlled use of force shall also identify themselves on camera as performing that role and having the necessary medical equipment.

D. Decontamination and Monitoring Following Controlled Use of Force

1. Inmates exposed to chemical agents shall be decontaminated by custody staff as soon as practicable after exposure. The LNS shall document in the health record that decontamination services were provided by custody.
2. Health care staff shall determine whether other patients in the immediate area were exposed and provide necessary medical care.Health care staff shall advise the patient how to self-decontaminate in his/her cell using water from the sink and soap, if available, if the patient refuses decontamination by custody or if there are safety concerns regarding out-of-cell decontamination.
   a. Health care staff shall document in the health record that the patient refused decontamination by custody and was provided self-decontamination instructions.
3. Health care staff shall monitor patients exposed to chemical agents and who refuse decontamination by custody, at least three times, every 15 minutes, for no less than 45 minutes, starting from the time the patient was last exposed.
4. Health care staff shall document in the health record the time of each 15-minute monitoring check and document what they observed.
6. If the patient involved in use of force is housed in the general population and requires re-housing in the Administrative Segregation Unit, the LNS shall also complete a review of the patient's mental health record and, if indicated, refer the patient to mental health staff.
7. If an injury to a patient constitutes an emergency, staff shall implement the Inmate Medical Services Policies and Procedures, Volume 4, Chapter 12, Emergency Medical Response.

E. Controlled Use of Force in Licensed Health Care Facilities

1. When circumstances are such that a controlled use of force is considered within a health care facility (Correctional Treatment Center, Skilled Nursing Facility, Psychiatric Inpatient Program, Hospice, etc.), the LNS shall consider the impact on medical conditions and the possible need to relocate uninvolved patients in the immediate vicinity during a controlled use of force.
2. Administration of Involuntary Medication or Medical Treatment (PC 2602/Probate Code 3200): When force is necessary to administer medication or medical treatment within a health care facility, on-duty health care staff shall ensure medical authorization for the involuntary medication or treatment exists. Health care staff shall also consult with the treating psychiatrist, PCP, or mid-level provider, if available, to verify the current and critical need for involuntary medication or treatment. If the treating psychiatrist, PCP, or mid-level provider is not available, the physician or psychiatrist on-call shall be consulted.
   a. Health care staff shall advise the Incident Commander of such prior to the application of controlled use of force.
3. Application of Four/Five Point Restraints: Only departmentally approved four/five point restraints shall be applied by authorized LNS in health care facilities. Authorization for application of four/five point restraints shall only be given by health care staff in accordance with California regulations and the Mental Health Services Delivery System Program Guide. On-duty health care staff shall ensure authorization

exists and shall advise the Incident Commander of such prior to the controlled use of force under these circumstances.

4. Patient Refusal of Admission, Discharge, or Transfer to/from a Health Care Facility: When a clinician with admitting privileges to a California Department of Corrections and Rehabilitation health care facility has determined it is necessary to admit, discharge, or transfer a patient into/from a health care facility, health care staff shall ensure that a written order for the admission, discharge, or transfer exists, and shall advise the Incident Commander of such, prior to the controlled use of force.

F. Evaluation and Medical Documentation Following an Assault, Cell Extraction or Application of Use of Force

1. The LNS shall evaluate the patient as soon as practicable after the patient has been involved in an assault, cell extraction or any application of use of force.
2. The LNS shall document the incident with findings on a CDCR 7219, Medical Report of Injury or Unusual Occurrence (refer to California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 16, Medical Report of Injury or Unusual Occurrence, CDCR Form 7219) and document comprehensive medical information in the health record.

IV. REFERENCES

- California Penal Code, Part 3, Title 1, Chapter 3, Article 1, Section 2602
- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 4, Article 1.5, Sections 3268, 3268.1, 3268.2, 3268.3
- California Code of Regulations, Title 22, Chapter 12, Article 5, Section 79801 Clinical Restraint, Treatment Restraint, and Clinical Seclusion
- California Department of Corrections and Rehabilitation, Department Operations Manual, Chapter 5, Article 2, Sections 51020.9, 51020.12, 51020.12.3, 51020.12.4, 51020.15.4, 51020.17.6, 51020.17.8
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 1, Chapter 21, Clinical Resolution Pathway and Escalation
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 12, Emergency Medical Response
- California Correctional Health Care Services, Inmate Medical Services Policies and Procedures, Volume 4, Chapter 16, Medical Report of Injury or Unusual Occurrence, CDCR Form 7219