

Article 7 – Emergency Medical Response

3.7.1 Emergency Medical Response System

(a) Policy

California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) shall ensure that medically necessary emergency medical response, treatment, and transportation is available, and provided 24 hours per day to patients, employees, contract staff, volunteers, and visitors.

- (1) It is the responsibility of CCHCS to plan, implement, and evaluate the Emergency Medical Response System (EMRS). The organized pattern of readiness and response services within CDCR is set forth in this policy. CDCR shall collaborate in the implementation of this policy by participating in drills and events.
- (2) Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) treatment shall be provided consistent with the American Heart Association (AHA) guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care according to each individual's training, certification, and authorized scope of practice.
- (3) BLS and ACLS shall be documented on the CDCR 7462, Cardiopulmonary Resuscitation Record.
- (4) Trained CCHCS and CDCR staff or contractors shall perform the functions of First Aid, BLS, and ACLS.
- (5) The standard guidelines for responding to emergencies are:
 - (A) The response time for BLS capable personnel (First Responders) shall not exceed four minutes (the First Responder Response Time).
 - (B) The response time for health care staff shall not exceed eight minutes (Health Care Staff Response Time).

(b) Purpose

The purpose of this policy is to standardize:

- (1) The structure and organization of the CDCR EMRS facilities, equipment, and personnel training.
- (2) Procedures for emergency medical response.
- (3) Mechanisms for documentation, data management, medical oversight, and quality improvement activities.

(c) Responsibility

The Chief Executive Officer (CEO) and the Warden at each institution are responsible for implementation of this policy.

(d) General Requirements

- (1) System Organization and Management
 - (A) Patients may request medical attention for urgent/emergent health care needs from any CDCR employee. The employee shall, in all instances, notify health care staff.
 - (B) Direct contact with the patient by a Registered Nurse (RN) or physician, either in person or by telephone, shall be provided for all patients requesting urgent/emergent medical attention or who are referred by staff. The RN or physician on duty shall choose one of the following options for evaluating the patient:
 1. Arrange to have the patient brought to the clinic.
 2. Arrange to have the patient brought to the Triage and Treatment Area (TTA).
 3. Evaluate the patient in his/her housing unit or current location.
 4. Talk directly to the patient via telephone, complete a telephone triage, and give direction to the patient for subsequent care.
 - (C) At least one RN shall be available onsite at each institution 24 hours a day, 7 days a week for emergency health care. During those hours in which a physician is not onsite, the highest priority for the RN shall be emergency care. A Provider On-Call (POC) or Medical Officer of the Day (MOD) shall be available 24 hours a day, 7 days a week to provide consultation and onsite care as necessary.
 - (D) TTAs, standby licensed emergency departments, and all clinical areas shall be properly staffed and equipped.
 - (E) Local Operating Procedures approved by the designated management team shall be in place for communications, response, evaluation, treatment, and transportation of patients, staff, and visitors.
 - (F) Community Emergency Medical Services responders have ready entry and ready exit into and out of the institution through the vehicle sally port and throughout the facility in order to access the patient.
 - (G) CCHCS shall maintain a system to manage and track physician and mid-level staff ACLS certification requirements.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Health Care Department Operations Manual

(2) Facilities and Equipment

(A) Emergency equipment and supplies, emergency medical bags, oxygen and Automated External Defibrillators shall be maintained according to manufacturer's specifications and readily accessible to Health Care Staff in the TTA, all clinic areas, emergency medical response vehicles, and all other areas deemed appropriate by the CEO and the Warden in the institution.

(B) The location of the equipment shall be clearly identified by signage.

(C) The equipment shall be maintained, appropriately secured, and inventoried each shift.

(3) Personnel: Staffing and Training

(A) The CEO is responsible for assuring a system is in place to manage and track clinical staff BLS certification requirements.

(B) All correctional peace officers (custody) shall, within the previous two years, have successfully completed a course in CPR that is consistent with AHA guidelines. Custody staff shall maintain a system to manage and track correctional peace officers CPR requirements.

(C) For allied health care staff who have direct patient contact, BLS certification is recommended but not required.

(D) All health care staff with the exception of dental staff and Licensed Clinical Social Workers (LCSWs) shall, within the previous two years, have successfully completed a health care provider-level course in BLS that is consistent with the AHA guidelines. Psychologists who belong to the organized medical staff at their institutions and who have admitting privileges must also complete this course.

(E) Certification Requirements:

1. Dentists, dental hygienists, and dental assistants must provide proof of BLS certification which meets the requirements of their respective licensing board or committee.

2. Psychologists who do not have admitting privileges and LCSWs are not required to maintain BLS certification, although certification is recommended.

3. All primary care physicians and mid-level providers are required to obtain and maintain ACLS certification and submit proof of certification/recertification to institutional management and the headquarters credentialing unit.

4. Physicians and mid-level providers who are currently certified in ACLS are not required to have BLS certification.

5. Contract specialty consultants who may perform procedures requiring procedural sedation at CDCR institutions shall, within the last two years, have successfully completed a course in BLS that is consistent with the AHA guidelines. Proof of certification/recertification must be received by the CEO and the headquarters credentialing unit prior to the contract specialist's start date and/or prior to the expiration of the contract specialist's BLS certification.

(F) ACLS certification and maintenance of certification is desirable for the Supervising Registered Nurse in charge of the TTA, and TTA RNs.

(G) Nursing staff, based on their level of licensure and training, shall provide emergency care only under patient specific individual orders based on clinical indications. The orders may be given verbally or telephonically when the provider is not present.

(H) Nursing staff, based on their level of licensure and training, shall provide ACLS emergency care requiring cardiac rhythm interpretation only under orders of a provider who is at the scene and directly assessing the patient.

(4) Institutions shall conduct emergency medical response training drills and shall provide access to skills training on an ongoing basis pursuant to the Health Care Department Operations Manual, Section 3.7.2, Emergency Medical Response Training Drill and Nursing Skills Lab.

(e) Procedure Overview

Implementation of this procedure will ensure that medically necessary medical response, treatment, and transportation is available and provided 24 hours per day to patients, employees, contract staff, volunteers, and visitors.

(f) General Instructions

(1) All staff has the authority to initiate a 9-1-1 call for Emergency Medical Services (EMS).

(2) Any individual who encounters a medical emergency is responsible for summoning assistance by the most expeditious means available, e.g., personal alarm device, two-way radio, whistle, shouting, or telephone.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Health Care Department Operations Manual

- (3) Any patient may request medical attention for an urgent or emergent health care need from any CDCR or CCHCS employee. The employee shall in all instances notify health care staff without unreasonable delay.
- (4) To efficiently activate a community EMS response and notify appropriate facility staff of a medical emergency, Local Operating Procedures (LOPs) shall identify a single point of contact for reporting medical emergencies and establish the mechanism to contact appropriate parties.
- (5) Activation of the institutional Emergency Medical Response System and the community EMS system shall occur as necessary to ensure the most appropriate level of emergency medical care is available in the shortest time interval.
- (6) Preservation of a crime scene shall not preclude or interfere with the delivery of emergency medical care. Preservation of life shall take precedence over the preservation of a crime scene.
- (7) Custody requirements shall not unreasonably delay medical care during a medical emergency unless the safety of staff, patients, or the general public would be compromised.
- (8) If a patient is unable to be resuscitated, the decision to terminate CPR shall be made by a physician or a mid-level provider, community EMS personnel, or by an RN if CPR was initiated for a patient who exhibits clear signs of death as described in Section (g)(2)(D)1. Pronouncement of death shall only be determined and made by a physician or a mid-level provider per LOP.

(g) Procedure

(1) Urgent Response, Treatment, and Transportation

- (A) Upon notification or discovery of an urgent health care need, the staff member shall call the designated clinical area.
- (B) The requesting staff member shall provide a brief description of the nature of the request to the clinical staff.
- (C) Direct contact with the patient by licensed clinical staff shall occur in person or by phone and be provided for all patients requesting urgent medical attention.
- (D) An RN, physician, or mid-level provider shall evaluate the patient's request by one of the following options:
 1. Arrange to have the patient brought to the clinic.
 2. Arrange to have the patient brought to the TTA.
 3. Evaluate the patient in his/her housing unit or current location.
 4. Talk directly to the patient via telephone and thoroughly document the encounter on Interdisciplinary Progress Note.
- (E) The licensed clinical staff members shall document the evaluation in the health record using an appropriate form. Documentation of the encounter must clearly state the disposition and the rationale for the disposition decision.
- (F) The RN, physician, or mid-level provider may direct other licensed staff to obtain vital signs and other clinical data and report the information to them.
- (G) All urgent encounters resolved in the yard or yard clinic after hours shall be documented on an Interdisciplinary Progress Note, and discussed by the Primary Care Team the following business day.
- (H) All dispositions for urgent conditions shall be made at the RN level of licensure or higher.

(2) Emergency Medical Response

- (A) A First Responder (FR) shall evaluate the situation and initiate appropriate first aid and/or BLS measures, including establishing airway, breathing, circulation, controlling bleeding, and administering CPR. The FR shall also:
 1. Briefly evaluate the patient and situation, then immediately notify health care staff of a possible medical emergency, and summon the appropriate level of assistance.
 2. Inform the health care staff of the general nature of the emergency including the general status of the patient. This may include whether the patient is conscious, breathing, bleeding, or other observable patient conditions and complaints.
 3. Immediately initiate CPR if appropriate.
 4. Initiate community EMS activation if necessary.
 5. Clearly document the reason(s) if CPR is not initiated due to the condition of the patient.
- (B) Custody Protocol
 1. In medical emergencies, the primary objective is to preserve life. All peace officers who respond to a medical emergency shall provide immediate life support until medical staff arrives to continue life support measures. All peace officers must carry a personal CPR mouth shield at all times.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Health Care Department Operations Manual

2. The peace officer must evaluate and ensure it is reasonably safe to perform life support by effecting the following actions:
 - a. Sound an alarm (a personal alarm or, if one is not issued, an alarm based on the LOP must be used) to summon necessary personnel and/or additional custody personnel.
 - b. Determine and respond appropriately to any risk of exposure to blood borne pathogens by adhering to standard precautions.
 - c. Determine, isolate, contain, and control the emergency and significant security threats to self or others including any circumstances causing harm to the involved patient.
 - d. Initiate life saving measures consistent with training.
3. The responding peace officer shall document on a CDCR 837, Crime/Incident Report, the decisions made regarding immediate life support and actions taken or not taken (Section (g)(2)(D)1), including cases where life support is not initiated consistent with training and/or situations which pose a significant threat to the officer or others.

(C) RN/Licensed Vocational Nurse (LVN)/Licensed Psychiatric Technician (PT) shall:

1. Respond as quickly as conditions permit to the scene of the medical emergency with an emergency medical response bag and Automated External Defibrillator (AED), and initiate and/or assist with CPR if indicated.
2. Make an initial assessment of the situation and determine whether a medical emergency is present.
3. Notify the TTA with relevant clinical information within eight minutes of the initial call for an emergency medical response if an RN is not already at the patient location.
4. The Health Care First Responder (HCFR) shall initiate community EMS activation if needed and not already completed by the FR.

In all cases, an RN or higher level of licensure shall be responsible for determining the disposition of the patient and communicating this information to the HCFR either in person or via radio/telephone.

(D) The HCFR shall begin appropriate medical treatment and assume responsibility for directing any medical care already in progress.

1. The HCFR shall determine if CPR is appropriate and continue CPR in the absence of:
 - a. Rigor mortis.
 - b. Dependent lividity.
 - c. Tissue decomposition.
 - d. Decapitation.
 - e. Incineration.
2. If one or more of the above signs are present, then the HCFR shall determine the patient to be deceased. The official pronouncement of death is the responsibility of the physician or mid-level provider per LOP.
3. CDCR 7462, Cardiopulmonary Resuscitation Record:
 - a. The CDCR 7462, Cardiopulmonary Resuscitation Record, shall be maintained on the emergency/crash cart for immediate access, and be completed by an RN or designee during a respiratory and/or cardiac arrest event.
 - b. All drugs administered during the respiratory and/or cardiac arrest event shall be read back and documented by the recorder in the spaces provided on CDCR 7462, Cardiopulmonary Resuscitation Record, at the time of administration.
 - c. All other resuscitative measures shall be read back and documented in the spaces provided on the CDCR 7462 as they occur.
 - d. Names of the team members involved in the code shall be documented in the space provided. Sections of the CDCR 7462 that are not applicable to a specific patient shall be marked "N/A."
 - e. All team members involved in the code (e.g., Physician, RN, LVN) must sign the CDCR 7462 next to their name under the "Team Member" column.
4. Once started, CPR shall continue until:
 - a. Resuscitative efforts are transferred to a rescuer of equal or higher level of training.
 - b. The patient is determined by a physician or mid-level provider to be deceased.
 - c. Effective spontaneous circulation and ventilation have been restored.
 - d. Emergency responders are unable to continue because of exhaustion or safety and security of the rescuer or others is jeopardized.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Health Care Department Operations Manual

- e. A written, valid Do Not Resuscitate (DNR) order is presented. If there is any suspicion that a patient's cardiopulmonary arrest is not part of a natural or expected death (e.g., the patient's condition is a result of an attempted suicide), resuscitation efforts shall be continued regardless of the existence of a DNR, Physician's Orders for Life Sustaining Treatment, or Advance Directive to the contrary, and resuscitative efforts shall be commenced and continued until other indications to cease are present.
- f. An RN determines that obvious signs of death are present (Section (g)(2)(D)1) and may direct that CPR be discontinued.

(3) Definitive Care and Patient Transportation

(A) Based on the patient's clinical condition and emergency situation, the RN and the Primary Care Provider shall be responsible for:

1. The continuation of medical treatment until community EMS responders arrive and assume care and transport the patient.
2. Directing the transportation of the patient to the nearest site equipped and staffed for definitive care.
3. Continuing treatment on location and directing EMS personnel to the scene, if clinically appropriate.

(B) Transportation Requirements

1. Patients shall only assist with transportation if they are part of the fire crew.
2. CDCR 7252, Request for Authorization of Temporary Removal for Medical Treatment, shall be initiated by health care staff and given to the designated custody representative (e.g., Associate Warden of Health Care, Watch Commander) for final completion and approval. After the form is completed it is forwarded to the custody transportation team.
3. The transport of a patient via code three ambulance shall not be unnecessarily delayed in order to complete the CDCR 7252 or to obtain other approvals from custody staff.
4. EMS personnel shall transport the patient to a community emergency facility according to local EMS agency policies and procedures.

(C) Notification

1. During regular business hours (Monday through Friday) the TTA RN shall notify the Chief Medical Executive (CME), or designee, and TTA Supervising RN, or designee, of the medical emergency transport and the circumstances of the transport as soon as possible. The Chief of Mental Health shall be notified of all suicides, suicide attempts, and possible overdoses that require medical emergency transport.
2. During non-business hours on evenings, nights, weekends, and holidays the TTA RN shall notify the institution MOD or POC as soon as possible to inform him or her of the patient status and transport decision. The MOD or POC shall notify the CME, or designee, by the next business day.
3. For patients transferred to a community emergency facility, the TTA provider or RN shall contact the receiving facility and provide a report, including available clinical information.

(4) Documentation

(A) General Requirements

1. The RN shall complete a CDCR 7219, Medical Report of Injury or Unusual Occurrence, for all work-related injuries or per custody requirements.
2. The HCFR shall document his/her findings and interventions on the CDCR 7463, First Medical Responder – Data Collection Tool, and sign this form.
3. In the event of a patient death and if CPR is not initiated by non-health care staff, then non-health care staff shall document the reason(s) on a CDCR 837-A-1, Crime/Incident Report Supplement.
4. The use of an AED shall be documented by a health care staff member. If the AED has download capability, the electronic information record shall be downloaded, printed, and added to the health record.
5. Notice of discharge of an AED shall be reported to the local county EMS utilizing the forms provided by that entity.
6. Documentation of any additional care and treatment provided by other clinical responders at the scene shall be completed on an Interdisciplinary Progress Note.
7. The emergency medical response documentation shall be signed, dated, and timed. All documentation shall be delivered to the TTA RN immediately at the time the patient arrives in the TTA or as soon as possible if the patient was transferred directly to a community emergency department.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES
Health Care Department Operations Manual

8. The TTA RN shall contact the psychiatrist on duty regarding patients who present with self-inflicted injuries.

(B) TTA Documentation Requirements

1. A TTA Log shall be maintained in the TTA at each institution.
2. Care and treatment shall be documented on the CDCR 7464, Triage and Treatment Services Flow Sheet.
3. BLS and ACLS shall be documented on the CDCR 7462.
4. Care delivered pursuant to RN protocols shall be documented on the appropriate RN protocol forms.
5. On arrival at the TTA, the RN shall remain with the patient and continue monitoring the patient's status until any resuscitative efforts are terminated, or until emergency medical service personnel assume patient care. During this time, the RN shall record the following:
 - a. Patient identification data (CDCR number, or, if unavailable, other identifying data).
 - b. Description of initial events and patient presentation (patient location, position, and witness description of events).
 - c. Times various treatments and procedures are rendered.
 - d. Name and title of the RN, name and title of the person to whom the patient is transferred, the date and time of the transfer, and the RN's signature.
6. TTA staff shall attach all relevant documentation to the CDCR 7464 for inclusion in the health record.

(C) Transport Documentation Requirements

1. Copies of the CDCR 7464, Triage and Treatment Services Flow Sheet, CDCR 7462 if applicable, and all attachments shall be provided to the emergency medical service transport staff if the patient is sent out of the institution.
2. CDCR 7252.
3. Sally port officers are to maintain a standardized log of all emergency vehicle traffic entrances and exits, including times.

References

- California Code of Regulations, Title 15, Division 3, Chapter 2, Subchapter 3, Article 6, Section 3999.67, Dental Care
- Health Care Department Operations Manual, Chapter 3, Article 7, Section 3.7.2, Emergency Medical Response Training Drill and Nursing Skills Lab
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision, Chapter 10, Suicide Prevention and Response
- California Department of Corrections and Rehabilitation, Emergency Alarm Response Plan
- American Heart Association, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

Revision History

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