



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES



Emergency Medical Response Program

Health Care Department Operations Manual (HCDOM), Section 3.7.1-1, Emergency Medical Response System (revised July 2019), is effective only at the institutions that have been fully trained according to the implementation schedule listed below*. Institutions that have not completed training shall follow HCDOM, Sections 3.7.1 through 3.7.5, Emergency Medical Response System policies and procedures (revised July 2012).

Training Schedule: Post COVID-19

<u>Dates</u>	<u>Institution</u>
May 10-21, 2021	California Correctional Institution
May 17-28, 2021	Chuckawalla Valley State Prison
June 7-11, 2021	Chuckawalla Valley State Prison
June 21-July 2, 2021	California Institution for Men
July 12-16, 2021	California Institution for Men
August 23-September 3, 2021	California Rehabilitation Center
September 13-17, 2021	California Rehabilitation Center
October 11-29, 2021	Salinas Valley State Prison
November 15-19, 2021	Valley State Prison
December 6-17, 2021	Valley State Prison
January 10-14, 2022	California Institution for Women
January 24-February 4, 2022	California Institution for Women
February 14-18, 2022	Central California Women’s Facility
February 28-March 11, 2022	Central California Women’s Facility
March 21-25, 2022	Ironwood State Prison
April 4-15, 2022	Ironwood State Prison
May 2-20, 2022	Correctional Training Facility
TBD	Richard J. Donovan Correctional Facility
TBD	Wasco State Prison
TBD	California City Correctional Facility
TBD	North Kern State Prison
TBD	Kern Valley State Prison
TBD	California Health Care Facility

* Schedule is subject to change. The most current version is posted on Lifeline and the CCHCS internet.

3.7.1-1, Emergency Medical Response System Definitions

9-1-1 Community Emergency Medical Services Activation: The community Emergency Medical Services (EMS) activation number utilized for all emergent ambulance transportation and community EMS transportation requests.

Advanced Cardiac Life Support: Emergency care consisting of Basic Life Support procedures and definitive therapy including the use of invasive procedures, medications, and manual defibrillation.

Advanced Practice Provider: Nurse Practitioner and Physician Assistant staff who are authorized to provide health care and dispense controlled substances by the state in which they practice.

Allied Health Care Staff: Respiratory Therapists, Physical Therapists, Occupational Therapists, Radiology Technicians, Laboratory Technologists/Technicians and Phlebotomists, and registered dietitians.

Basic Life Support: Emergency care performed to sustain life that includes cardiopulmonary resuscitation, automated external defibrillation, control of bleeding, treatment of shock, and stabilization of injuries and wounds.

Disaster: An internal or external occurrence disrupting the normal operating conditions and causing a level of dysfunction that exceeds the institution's capacity of adjustment and ability to manage using its own resources.

Emergency: A state in which normal procedures are suspended and extraordinary measures are taken in order to avert a disaster.

Emergency Medical Response and Review Committee: The committee designated to provide systematic assessment, risk stratification, and monitoring of the effectiveness of the Emergency Medical Response System and coordination at the regional and statewide levels.

Emergency Medical Response System: The organized pattern of readiness and response services within California Department of Corrections and Rehabilitation and California Correctional Health Care Services.

Emergency Medical Response Vehicle: A vehicle used to respond to medical emergencies.

Emergent Transport: Immediate transportation to a higher level of care for the purpose of treating an emergent medical condition.

First Aid: Care administered to an injured or sick patient before health care staff is available.

First Responder: The first staff member certified in BLS on the scene of a medical emergency.

Health Care First Responder: The first health care staff member certified in BLS to arrive at the scene of a medical emergency.

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

Health Care Staff: Physicians, Dentists, Registered Nurses, PAs, NPs, Licensed Vocational Nurses, Certified Nursing Assistants, Psychiatrists, Psychologists, Licensed Clinical Social Workers, Licensed Psychiatric Technicians, Medical Assistants, Pharmacists, Pharmacy Technicians, Registered Dental Assistants, and Registered Dental Hygienists.

Licensed Independent Practitioner: An individual, as permitted by law and regulation, and also by the organization, to provide care and services without direction or supervision within the scope of the individual's license and consistent with the privileges granted by the organization.

Medical Emergency: Any medical, mental health, or dental condition as determined by health care staff for which immediate evaluation and treatment are necessary to prevent death, severe or permanent disability, or to alleviate disabling pain. A medical emergency exists when there is a sudden, marked change in an individual's medical condition so that action is immediately necessary for the preservation of life, alleviation of severe pain, or the prevention of serious bodily harm to the patient or others.

Primary Care Provider: A Physician, NP, or PA designated to have primary responsibility for the patient's health care or, in the absence of a designation or if the designated Physician is not reasonably available or declines to act as primary Physician, a Physician who undertakes the responsibility.

Urgent Condition: Any medical condition that would not result in further disability or death if not treated immediately, but requires professional attention and has the potential to develop such a threat if treatment is not provided within four hours.

Chapter 3 – Health Care Operations
Article 7 – Emergency Medical Response

3.7.1-1 Emergency Medical Response System

(a) Policy

California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) shall ensure that an emergency medical response system (EMRS) is maintained at each institution to deliver emergency medical treatment to patients, employees, contractors, volunteers, and visitors 24 hours per day, 7 days per week.

- (1) This system shall ensure rapid identification, early intervention, and Basic Life Support (BLS) treatment of all medical emergencies that may include the 9-1-1 community emergency medical services (EMS) activation and appropriate transportation within the institution and/or community. Emergency care includes, but is not limited to, initial survey and assessment, interventions, stabilization for transfers, and transportation.
- (2) CDCR and CCHCS shall maintain a statewide standardized emergency medical response (EMR) training curriculum, including, but not limited to, BLS, cardiopulmonary resuscitation (CPR), competencies, training exercises, and drills. CDCR and CCHCS shall ensure administrative, correctional, and clinical systems are in place to support the EMRS, including, but not limited to, a standardized formulary of EMRS equipment and supplies.
 - (A) Community EMS response times differ per county; accordingly, institutions shall be prepared to provide ongoing necessary treatment and interventions pending EMS arrival, provide an appropriate handoff, and be prepared for immediate transport with necessary documentation upon EMS arrival.
 - (B) Institutions shall implement and maintain a system to ensure care is delivered according to the community 9-1-1 EMS response times (refer to [Community EMS Dispatch County Status and 9-1-1 Response Times](#) located on the [Lifeline Nursing Services](#) EMRP tab).
 - (C) Institutions shall establish and maintain a working relationship with community EMS agencies to ascertain appropriate resources, access, and transportation for all 9-1-1 community EMS activations.
- (3) CDCR and CCHCS shall identify key indicators, essential functions, and metrics to benchmark and monitor effectiveness and ensure that the EMRS is organized with an established pattern of response (i.e., access to care, alarm responses, transportation, and quality of clinical intervention). This shall include ongoing evaluation through After Action Reviews and other established forums to identify immediate corrective action and improvement opportunities. Statewide and institutional-level committees shall be identified to be responsible for monitoring EMR requirements, identifying trends, initiating and directing improvement activities, and responding to changes in technology and evidence based practice.

(b) Responsibility

(1) Statewide

It is the responsibility of CDCR and CCHCS departmental leadership at all levels of the organization, within the scope of their authority, to plan, implement, and evaluate the EMRS. The designated committee shall monitor EMRS performance metrics statewide to review and provide feedback on identified issues that present an increased level of risk to patients and the organization. These trends shall be referred to the regional executive teams, headquarters, and the institution's Emergency Medical Response and Review Committee (EMRRC) for quality improvement activities.

(2) Regional

Regional Health Care Executives are responsible for implementation of this policy and shall provide oversight and support at the subset of institutions within an assigned region. Each region shall ensure a regional forum is established to review the institutional trends related to the quality, timeliness, and efficacy of all EMRs, as well as direct process improvements through the institutions' performance improvement work plans and quality structure. The regional forum shall meet no less than quarterly to review and provide feedback to the institution for continuous quality improvement and sustainability of the EMRS.

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(3) Institutional

The Chief Executive Officer (CEO), health care, and the Warden have overall responsibility for implementation and ongoing oversight of the EMRS at the institutional level. Under the EMRS, the CEO, health care, and Warden shall delegate decision making authority to designated institutional health care staff and correctional executives.

(A) The CEO, health care, and Warden shall:

1. Ensure that the equipment is maintained with sufficient supplies in approved locations to meet the needs of the institution.
2. Implement the standardized EMR training, including, but not limited to, BLS, CPR, and drills with competencies for all staff and ensure that a tracking system is in place.
3. Implement an After Action Review process for immediate evaluation and necessary corrective action of emergency events.
4. Ensure that sufficient staff are available to respond to emergencies 24 hours per day, 7 days per week, and that all staff have the means to activate the EMRS including the 9-1-1 community EMS.
5. Ensure that all staff are appropriately trained and maintain current applicable licenses and certifications.
6. Ensure that appropriate transportation is available to transport patients in emergency situations.
7. Establish an EMRRC to:
 - a. Review EMR incidents.
 - b. Review the quality, timeliness, and efficacy of all EMRs.
 - c. Analyze local trends and outliers.
 - d. Provide systematic assessment, risk stratification, and monitoring of all identified groups of patients to ensure the effectiveness of the EMRS.
 - e. Develop corrective action measures to ensure continuous process improvement.
 - f. Report on Section (b)(3)7.a-e. to the Institution Quality Management Committee.
8. Ensure a local operating procedure is developed that outlines the institution's specific activities or requirements as indicated in Section (d).

(B) The CEO, health care, and Warden have joint, overall responsibility for oversight of the EMRRC at their institution. Identified issues that present an increased level of risk to patients and the organization shall be referred to the institution's EMRRC.

(c) Procedure Overview

This procedure describes the EMRS and processes which CDCR and CCHCS staff shall utilize to deliver emergency medical treatment to patients, employees, contractors, volunteers, and visitors 24 hours per day, 7 days per week. EMRS preparedness includes, but is not limited to:

- (1) Competencies.
- (2) Ongoing training programs.
- (3) Standardized equipment inventories.
- (4) Maintenance standards.
- (5) Disaster response.
- (6) Mass casualty response.
- (7) Ongoing multidisciplinary EMRS drills.
- (8) After Action Reviews.
- (9) Access to transportation.
- (10) Local Operating Procedures (LOP).
- (11) Fostering professional relationships with community Emergency Medical Services (EMS) agencies.

(d) Local Operating Procedure Requirements

Each institution shall develop an LOP to ensure the following minimum EMRS requirements are met:

- (1) A detailed process for all staff in 9-1-1 community EMS activation and transporting patients to a higher level of care.
- (2) 9-1-1 community EMS activation shall not be delayed solely due to waiting for the provider-on-call (POC) consultation or custody response.
- (3) Direct, in-person contact with the patient by licensed health care staff is provided for patients requiring urgent/emergent medical attention.

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- (4) In the event that the Health Care First Responder (HCFR) contacting the patient is of a lower licensure than a Registered Nurse (RN), a health care provider or RN shall be contacted for final disposition prior to releasing the patient back to their housing unit.
 - (5) A system is in place to document EMRS incidents including persons involved, actions taken, and timelines within the institution, and that copies of all documentation are provided to the EMRRC for quality assurance purposes.
 - (6) Designation of HCFR's assigned to respond to medical emergencies to ensure institution-wide coverage, 24 hours per day, 7 days per week.
 - (7) A multidisciplinary approach to disaster response via ongoing training based on tools set forth in this procedure, such as mock drills and skills training.
 - (8) Availability of a fully stocked EMR bag for each designated HCFR's use during EMRS events including, but not limited to, Triage and Treatment Areas (TTA), clinics, and medication rooms.
 - (9) A disaster response bag is stocked in each location designated in the institution's LOP. The location of the disaster response bag shall be clearly marked by signage and readily available to responding health care staff during an institution-wide incident response.
 - (10) Stock a treatment cart in each location identified as a TTA or licensed inpatient area. The location of the treatment cart shall be readily visible to be accessed by licensed health care staff for individuals and patients in need of urgent/emergent care. Other equipment and supplies shall be located in the locked drawers, boxes or cabinets and identified by appropriate signage. Medications stored in treatment carts used for Advanced Cardiac Life Support (ACLS) shall be independently secured and accessed only by a Licensed Independent Practitioner (LIP) pursuant to Health Care Department Operations Manual (HCDOM), Section 3.5.6, Emergency Drug Supplies.
 - (11) Designate an internal and external transportation plan designed to transport patients, in a medically appropriate manner, to a higher level of care, as needed, to ensure the rapid treatment of the patient's medical condition.
 - (12) Emergency equipment and supplies, EMR bags, disaster bags, emergency medical response vehicles (EMRV) and contents, treatment carts, oxygen delivery systems, Automated External Defibrillators (AED), and other required equipment and supplies are maintained as required in Section (i).
 - (13) Required equipment and supplies are readily accessible in the institution at all times to health care staff in the TTA, clinical areas, EMRVs, and other areas as deemed appropriate by the CEO, health care, and the Warden.
 - (14) A process is in place to document that required inventories and maintenance have been performed. Procedures shall ensure that the required documentation is retained for one year, audited monthly, and reviewed as part of the institution's EMRS quality improvement process.
 - (15) A preventative maintenance plan is in place for training equipment as specified in the manufacturer's recommendations/guidelines.
 - (16) Staff who utilize and access equipment supplies and medications have demonstrated competency in their use, purpose, application, and proper handling and maintenance.
- (e) Emergency Medical Response System Organization and Management**
- (1) First Responder**
- (A) Patients may request medical attention for an urgent or emergent health care need from any CDCR or CCHCS employee. In all instances the employee shall notify health care staff without delay.
 - (B) If notified of a possible emergency by any individual, the First Responder shall be at the patient's side within four minutes of notification.
 - (C) Upon notification or discovery of a health care emergency, the First Responder shall activate local EMRS via radio, personal alarm, whistle, or institutional EMR number; notify the designated clinical area; provide a brief report; request health care staff response; and activate 9-1-1 community EMS if indicated.
 - (D) Custody staff shall isolate, contain, and control the scene of the emergency and significant security threats to self or others including any circumstances causing harm to the involved patient. Custody staff requirements shall not unreasonably delay medical care during a medical emergency unless the safety of staff, patient, or the general public would be compromised.
 - (E) All staff shall utilize Personal Protective Equipment when responding to emergencies.
 - (F) The First Responder shall evaluate the situation and the patient to include the presence of pulse and spontaneous respirations, and initiate appropriate First Aid and/or BLS measures including establishing circulation, airway,

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breathing, controlling bleeding, and administering CPR until health care staff arrives to continue life support measures.

- (G) The First Responder shall provide a brief description of the nature of the emergency to health care staff.
- (H) First Responders shall document on the CDCR 837, Crime/Incident Report, the decisions made regarding immediate First Aid and/or BLS and actions taken or not taken including cases where First Aid and/or BLS is not initiated consistent with training, and/or situations that posed a significant threat to the First Responder or others.

(2) HCFRs shall:

- (A) Respond as quickly as conditions permit to the scene of the medical emergency with an EMR bag and AED.
- (B) Arrive at the scene within eight minutes of the initial notification of emergency.
- (C) Initiate, or continue/assist with, necessary BLS measures including CPR as indicated.
- (D) Take control of the medical response at the scene, continue appropriate treatment as clinically indicated, and determine subsequent action including, but not limited to:
 - 1. Notifying the TTA of the need for transportation.
 - 2. Transferring the patient to the TTA.
 - 3. Administration of Naloxone per policy, as clinically indicated.
 - 4. 9-1-1 community EMS activation, if not already activated by the First Responder.
 - 5. Transferring the patient directly to a higher level of care as the patient's conditions dictate.
 - 6. Continuing medical treatment until community EMS responders arrive, assume care, and transport the patient.
 - 7. Directing the transportation of the patient to the nearest site equipped and staffed for continuation of appropriate care in a setting such as a hospital emergency department under the care of a physician.
 - 8. Notifying the TTA immediately of the patient's disposition if the patient is sent to a higher level of care.
 - 9. Notifying the Medical Officer of the Day or POC of the patient's disposition if the patient is sent to a higher level of care.
 - 10. Licensed clinical staff clearly documenting the encounter including the disposition and the rationale for the disposition decision in the health record.
 - 11. Obtaining vital signs, other clinical data, and performing interventions within their scope of practice, as directed by RNs, physicians, or Advanced Practice Providers.
 - 12. Dispositions for urgent conditions shall be made at the RN level of licensure or higher.

(3) Documentation of Emergency Medical Response System Events

- (A) The HCFR shall document his/her findings and interventions at the scene as needed. Following the EMR, input the information into the health record.
- (B) The use of an AED shall be documented by health care staff.
- (C) The HCFR shall, if required by the local EMS authority, file a "Notice of Discharge of an AED" with the EMS authority utilizing the forms provided by that entity per the local EMS authority timeframes.
- (D) The HCFR shall have documentation relating to each EMRS event available to the designated Supervising Registered Nurse (SRN) II. The SRN II shall complete a CDCR 7186-1, Emergency Medical Response and Unscheduled Transport Event Checklist, before the end of the shift on which the EMR occurred. Documentation that shall be available includes, but is not limited to:
 - 1. TTA documentation.
 - 2. First Responder Form.
 - 3. Other pertinent clinical information.

(4) Transportation Requirements

- (A) Designated health care staff are responsible for determining the appropriate method of transportation based on the patient's clinical condition, distance to nearest the treatment facility capable of addressing the patient's health care, and other considerations (e.g., weather).
- (B) Emergency transportation shall be arranged via 9-1-1 community EMS activation and not by contacting the local EMS non-emergency number.

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- (C) Emergent or urgent unscheduled transportation of a patient via 9-1-1 community EMS activation shall not be delayed in order to complete the CDCR 7252, Request for Authorization of Temporary Removal for Medical Treatment, or to obtain other approvals from custody staff.
 - (D) The CDCR 7252, shall be initiated by designated health care staff and given to the designated custody representative for final completion and approval.
 - (E) Community EMS personnel will transport the patient to a community emergency facility according to local EMS agency policies and procedures.
 - (F) Custody and health care staff shall ensure proper documentation of incident timelines via a designated local process, which shall be provided to EMRRC at the institution. Sally port officers shall maintain a standardized log of emergency vehicle traffic entrances and exits, including times. The log shall be provided to the EMRRC for review.
 - (G) In the case of an unscheduled urgent/emergent transfer to a higher level of care facility, the Primary Care Provider (PCP) and/or RN shall communicate pertinent health care data to the receiving health care facility.
 - 1. Urgent/emergent unscheduled transfers to higher level of care facilities requires an accepting physician at the receiving facility. This shall be communicated to the responding community EMS transfer provider.
 - 2. Pertinent documentation shall be sent to the receiving facility with the patient pursuant to HCDOM, Section 3.1.9, Health Care Transfer.
 - 3. Communications to outside facilities regarding the patient's condition shall be documented in the health record.
 - (H) Custody and health care staff shall use clear language and avoid specialized terminology (i.e., jargon, acronyms) when requesting 9-1-1 community EMS activation.
 - (I) Appropriate language within the institution and outside agencies shall include urgent and emergent designations when describing the urgency of the response and transport. Code 1, Code 2, and Code 3 language shall not be used to describe health care emergencies or transportation.
- (5) Cardiopulmonary Resuscitation**
- (A) Once CPR is initiated, it shall be continued until one of the following occurs:
 - 1. Resuscitative efforts are transferred to a rescuer of equal or higher level of training.
 - 2. The patient is determined by a physician or Advanced Practice Provider to be deceased. Pronouncement of death is also possible by community EMS personnel utilizing local agency's protocol for determination of death in the field.
 - 3. Effective spontaneous circulation and ventilation have been restored.
 - 4. Emergency responders are unable to continue because of exhaustion or safety and security of the rescuer or others is jeopardized.
 - 5. 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.
 - 6. An RN determines that clear signs of death, outlined in Section (e)(5)(B)2., are present and directs that CPR be discontinued.
 - (B) Cessation of Cardiopulmonary Resuscitation
 - 1. The decision to terminate CPR shall be made by a physician, an Advanced Practice Provider, or community EMS personnel in the event that they determine that the patient is unable to be resuscitated.
 - 2. The decision to terminate CPR may also be made by an RN if CPR was initiated for a patient who exhibits clear signs of death as described below:
 - a. Rigor mortis
 - b. Dependent lividity
 - c. Tissue decomposition
 - d. Decapitation
 - e. IncinerationThe RN shall still contact a physician or Advanced Practice Provider to declare a time of death.

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(C) Determination of Death

A physician or Advanced Practice Provider shall pronounce the patient deceased after an in-person evaluation, including the exception of the RN's determination of the presence of the clinical findings listed in Section (e)(5)(B)2. Community EMS personnel may also pronounce a patient deceased utilizing local EMS Agency protocol for determination of death in the field.

(D) CDCR 7462, Cardiopulmonary Resuscitation Record

1. A detailed CDCR 7462 that includes all resuscitative measures and drugs administered by the LIP shall be scanned in to the health record by an RN, or designee, during following a respiratory and/or cardiac arrest event.
2. Drugs administered by the LIP during the respiratory and/or cardiac arrest event shall be documented by the recorder on the CDCR 7462, at the time of administration.
3. The names of the staff involved in the CPR event shall be documented on the CDCR 7462 and in the health record.

(f) Staffing

- (1) Health care staff shall provide emergency care consistent with their licensure/certification, training, competency, and legal scope of practice.
- (2) Licensed Vocational Nurses (LVNs) and Psychiatric Technicians (PTs), based on their level of licensure and training, and when under the guidance of an RN shall provide emergency care as directed by the RN based on clinical indications. The patient-specific orders shall be given verbally or telephonically.
- (3) Naloxone may be administered independently by LVNs and PTs pursuant to the regulatory board, clinical decision support, and the institution's Naloxone Emergency Medical Response LOP.
- (4) At least one RN shall be available onsite at each institution 24 hours per day, 7 days per week for emergency care. When a physician is not onsite, the highest priority for the RN shall be emergency care.
- (5) A provider shall be onsite during business hours.
- (6) A POC shall be available after hours, weekends, and holidays to provide consultation and onsite care as necessary. The POC shall be readily available to provide telephone consultation and shall respond within 15 minutes of the initial attempt to contact by institutional staff.
- (7) TTAs and clinical areas shall be properly staffed and equipped.
- (8) RN staff, based on their level of licensure, training, and demonstration of competency, shall provide emergency care based upon clinical indications and utilizing patient-specific individual orders or nursing standardized procedures. The patient-specific orders may be given verbally or telephonically when the provider is not present.

(g) Emergency Medical Response System Training/Certification

(1) Basic Life Support Certification Requirement

(A) BLS proof of certification or recertification shall be provided to institutional management and maintained pursuant to the HCDOM, Section 1.4.6, Licensed Medical Provider Credentialing and Privileging, for the following health care staff:

1. Medical staff.
2. Nursing staff.
3. Psychiatrists.
4. Psychologists who belong to the organized medical staff at their institutions and who have admitting privileges.
5. Dentists, dental hygienists, dental assistants.

(B) BLS certification is recommended but not required for the following health care staff:

1. Allied health care staff who have direct patient contact.
2. Licensed Clinical Social Worker.
3. Psychologists who do not have admitting privileges.

(2) Correctional peace officers shall, within the previous two years, have successfully completed a CPR course provided or approved by the Warden, or designee.

(A) The Warden, or designee, shall maintain a system to manage and track correctional peace officers' CPR requirements.

(B) Correctional peace officers shall carry a personal CPR mouth shield at all times.

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- (3) Advanced Cardiovascular Life Support Certification Requirement
 - (A) PCPs shall maintain current ACLS certification provided or approved by the American Heart Association. Proof of certification or recertification shall be submitted to institutional management and the headquarters Credentialing and Privileging Support Unit pursuant to HCDOM, Section 1.4.6, Licensed Medical Provider Credentialing and Privileging.
 - (B) Contract specialty providers who can perform procedures requiring procedural sedation at CDCR institutions shall, within the previous two years, have successfully completed a course in ACLS that is provided or approved by the American Heart Association. Proof of certification or recertification shall be received by the institutional CEO, health care, and the headquarters Credentialing and Privileging Support Unit prior to the contract specialist's start date and/or prior to the expiration of the contract specialist's ACLS certification.
- (4) Emergency Medical Response System Minimum Training and Training Exercise Requirements – Health Care Staff
 - (A) Each institution under the control of CDCR/CCHCS shall ensure minimum training requirements are met and tracked.
 - (B) The Chief Medical Executive (CME), Chief Nurse Executive (CNE), Chief of Mental Health, and Supervising Dentist, or their designees, shall ensure that EMRS skills trainings are scheduled on the education calendar and health care staff have the opportunity to participate in the skills and competency training appropriate to their licensure and classification. Emergency health care skills, in-service training, forms, materials, and documentation shall be maintained and tracked by designated health care staff.
 - (C) General skills training shall be conducted annually to ensure competency for health care staff based on their licensure and scope of practice. General skills training shall be conducted more frequently if EMRS deficiencies and remedial training needs are identified by the EMRRC.
 - (D) EMRS skills training and/or remedial training shall be documented in the employee's proof of practice (training) file or other approved location (e.g., the CCHCS Learning Management System).
 - (E) Joint EMRS training drills, that include custody, health care, and other institutional staff, shall be conducted in compliance with the requirements as defined in Section (h) below.

(h) Joint Emergency Medical Response System Training and Training Exercises

- (1) Institutional leadership shall:
 - (A) Determine the location, time, and scenario to be used for each drill.
 - (B) Coordinate and conduct drills between disciplines and departments.
 - (C) Ensure that staff participate in scheduled training and drills.
 - (D) Ensure institutional staff respond immediately to EMRS drills within their designated area.
 - (E) Determine responsibility for setting up and maintaining control of the CPR mannequins and/or other necessary EMRS equipment at the designated drill location.
- (2) Institutional fire departments shall respond immediately to EMRS drills within their designated institutions as specified in the institution's EMRS plan.
- (3) The CEO, health care, and the Warden shall conduct periodic EMRS training drills and exercises and shall provide access to skills training on an ongoing basis as outlined below.
 - (A) One drill shall be conducted in each lock-up unit (e.g., Administrative Segregation Unit, Long Term Restricted Housing, Short Term Restricted Housing, Psychiatric Services Unit, Security Housing Unit), Correctional Treatment Center, and Enhanced Outpatient Program building on each watch, each month.
 - (B) In addition to the above, all other yards shall conduct at least one EMRS training drill each month, on each watch, on a rotating basis (i.e., Month 1 - A Facility 2nd watch, B Facility 3rd watch, and C Facility 1st watch). Monthly drills shall be didactic in nature.
 - (C) Each drill shall address responses to medical emergencies in all areas of the institution and include participation of health care staff, custody staff, and other institutional staff as appropriate for the scenario being utilized.
 - (D) Institutions shall conduct live, hands-on simulation drills at least quarterly. The quarterly drill may suffice as the monthly drill described in Section (h)(3)(A)-(B). (i.e., a separate monthly drill does not have to be conducted for the month in which the quarterly drill was conducted). These drills shall include institution-wide scenario based training and shall be conducted on each shift. Programming shall be paused and/or modified during quarterly drills.
 - (E) The participants shall respond to the scenario as if they are responding to an actual emergency.

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- (F) An institution-wide live, hands-on simulation incident training shall be conducted at least annually. Monthly and/or quarterly drills do not need to be performed during the same month as an annual drill. Every effort should be made to coordinate with, and to include community EMS in the annual incident drill. Programming shall be paused and/or modified during annual incident drills.
 - (G) Each dental clinic shall conduct at least one EMRS drill annually. The drill shall include participation by dental and all other EMRS program staff (i.e., nursing and custody staff). Programming shall be paused and/or modified during annual drills.
 - (H) The drills may or may not be pre-announced, shall be conducted under varied conditions, and shall address a variety of potential scenarios to test processes and competencies.
 - (I) Once the drill is initiated and staff is gathered, the Drill Coordinator shall read the drill scenario to the staff participants. The drill scenario shall be read from and documented on the Emergency Medical Response System Mock Code Template (located on the [Lifeline Nursing Services](#) EMRP tab).
 - (J) Staff shall complete documentation that would be required in an actual emergency during the drill scenario.
 - (K) Immediately following the drill, the Drill Coordinator shall conduct a debriefing to allow the participants to evaluate their performance, incorporate lessons learned, and discuss additional steps or components necessary to remedy identified deficiencies.
 - (L) The Drill Coordinator shall submit a report to the EMRRC for all drills that includes, but is not limited to, the following:
 - 1. CDCR 7186-1.
 - 2. Emergency Medical Response System Mock Code Template (located on the [Lifeline Nursing Services](#) EMRP tab).
 - 3. Areas identified as positive or appropriate interventions.
 - 4. Recommendations on areas needing improvement or training.
 - 5. Development of a Corrective Action Plan (CAP).
 - (M) Copies of documentation and After Action Reviews shall be reviewed and signed by the EMRRC, and the results shall be reported to the institution Quality Management Committee (QMC) as described below.
- (i) Emergency Medical Response System Preparedness and Equipment**
- (1) Emergency Medical Response and Disaster Response Bags**
 - (A) EMR and disaster response bags shall be stocked and maintained in accordance with CDCR 7188-1, Emergency Medical Response Bag Checklist, and CDCR 7185-1, Disaster Response Bag Checklist.
 - (B) Designated health care staff shall inspect the EMR and disaster response bags at the beginning of each shift to ensure that the bags are complete, seals are intact, and that the bags and the contents do not appear to be damaged.
 - (C) Designated zippered compartments of each EMR bag shall be sealed (compartment zippers together) with a numbered plastic seal.
 - 1. The number of the seal shall be indicated on the appropriate checklist.
 - 2. The institution shall coordinate with their local Pharmacy Services to ensure that seals do not duplicate the color of those used to seal emergency drug supplies.
 - (D) If seals are broken, the contents of the bags shall be inventoried, fully restocked, and new seals affixed to the compartments. Each item within the bag shall be inspected prior to the new seals being placed to ensure that it has not reached its expiration date.
 - 1. Items within 30 calendar days of expiration or the next scheduled monthly inspection shall be replaced prior to resealing the bag.
 - 2. Items without a specific expiration date (e.g., mm/dd/yyyy) shall be considered to expire at 23:59 on the last day of the month indicated (e.g., mm/yyyy).
 - (E) An inventory of sealed compartments shall be completed monthly if the seal on a bag has not been broken and an inventory of that compartment has not been completed in the previous 30 calendar days. This inventory is standardized and shall be completed in compliance with the appropriate inventory checklist (refer to CDCR 7188-1 and 7185-1).
 - (F) Designated supervisory staff shall conduct random inspections, no less than once per month, of each EMR bag, disaster response bag, and the associated logs.

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- (G) All inspections (i.e., shift, monthly, supervisory) shall be documented and recorded on the appropriate checklist (refer to CDCR 7188-1 and 7185-1).
 - (H) Completed inventory checklists shall be collected by the SRN II when they are completed, no less than monthly, and retained for a period of no less than one year. Compliance with the requirements of this paragraph shall be reviewed as part of the institution's EMRRC and Quality Assurance (QA) Program.
- (2) Treatment Carts and Supplies**
- (A) The RN shall secure treatment carts with numbered seals. The number and integrity of the seal shall be checked during each shift and documented on CDCR 7544-1, Treatment Cart Daily Check Sheet. If the seal is not intact, the RN shall:
 - 1. Immediately notify the SRN responsible for the area and document the SRN notified on the CDCR 7544-1.
 - 2. If the medication drawer seal is not intact and/or needs restocking, immediately notify a Pharmacist and document the Pharmacist notified on the CDCR 7544-1 pursuant to HCDOM, Section 3.5.6, Emergency Drug Supplies.
 - 3. Complete the CDCR 7547-1, Treatment Cart Inventory Report, and document completion on the CDCR 7544-1.
 - 4. Secure the treatment cart with a yellow seal.
 - 5. Complete sections of the CDCR 7544-1, corresponding to date, time, printed name, and signature of the staff member completing the form.
 - (B) The RN shall replace missing equipment as indicated on the CDCR 7547-1.
 - (C) Treatment carts without complete equipment supplies shall be secured with a yellow seal by the RN until completely restocked (indicated by a red seal).
 - 1. Where quantity levels for replacement equipment are not prescribed, each institution's EMRRC shall evaluate usage and set local quantity requirements.
 - 2. Missing and non-functional equipment shall be replaced immediately to ensure continued availability for patient care.
 - 3. If equipment cannot be replaced immediately, the SRN II responsible for the area shall be notified. If the equipment is not immediately replaced, the SRN II shall notify the CNE.
 - (D) ACLS medications shall:
 - 1. Be available and accessible only to a LIP.
 - 2. Be controlled by the pharmacy pursuant to HCDOM, Section 3.5.6, Emergency Drug Supplies.
 - 3. Placed in locations in the designated treatment cart, or designated locked cabinet and clearly labeled and sealed with numbered seals provided by the pharmacy.
 - (E) LIPs shall access the medication supply and administer the medication or direct the administration only by RNs holding current certification in ACLS. The LIP shall be onsite and shall remain onsite with the patient until the patient has been transferred to a higher level of care.
 - (F) A defibrillator performance check shall be completed by the designated nursing staff at the beginning of every shift in accordance with manufacturer's instructions with the defibrillator unplugged and documented on the CDCR 7548-1, Defibrillator Performance Test.
 - (G) On the first business day of each month, the RN shall inventory treatment carts and document on the CDCR 7547-1.
 - 1. Equipment shall be restocked as necessary to maintain quantity requirements.
 - 2. Sterile items shall be checked for package integrity and expiration dates. Equipment, including sterile items, expiring within 60 calendar days shall be ordered for restocking during the next treatment cart inventory.
 - 3. Items within 30 calendar days of expiration or the next scheduled monthly inspection shall be replaced prior to resealing the cart. Items without a specific expiration date (e.g., mm/dd/yyyy) shall be considered to expire at 23:59 on the last day of the month indicated (e.g., mm/yyyy).
 - (H) The RN shall check laryngoscope function prior to placement in the treatment cart on a monthly basis.
 - (I) The RN shall replace oxygen cylinders with less than 1000 psi.
 - (J) Designated nursing supervisory staff shall conduct random inspections, no less than once per month, of each treatment cart and the associated logs.

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(K) The CDCR 7544-1, 7547-1, and 7548-1 shall be completed by the RN on duty no less than monthly and collected and retained for a period of no less than one year. Compliance with the requirements of this paragraph shall be reviewed as part of the institution's QA Program.

(3) Emergency Medical Response Vehicles

Institutions in possession of an EMRV shall implement the following procedure to ensure standardization and readiness:

- (A) EMRVs are exclusively for the response to and transportation of patients within the grounds of the institution. At no time shall an EMRV be used to transport patients outside of the institution for community medical services.
- (B) The Warden, or designee, shall ensure EMRVs are maintained and inspected daily for functionality and safety.
- (C) Designated custody staff shall drive EMRVs to the scene within an institution.
- (D) EMRVs shall be stocked in accordance with the CDCR 7187-1, Emergency Medical Response Vehicle Inventory Checklist.
- (E) At the beginning of each shift, designated health care staff shall perform a complete inventory of the EMRV and designated custody staff shall check functionality of the EMRV. The inspections shall be recorded on the CDCR 7187-1.
- (F) Designated nursing supervisory staff shall conduct random inspections, no less than once per month, of each EMRV and the associated logs. This inspection shall be recorded on the CDCR 7187-1.
- (G) Completed CDCR 7187-1s shall be collected no less than monthly and retained by the EMRRC for a period of no less than one year.
- (H) Compliance with the requirements of this paragraph shall be reviewed as part of the institution's QA Program.

(j) Emergency Medical Response and Review Committee

- (1) Each institution shall maintain a multidisciplinary EMRRC that is designated to review and analyze all EMRs and EMRS drills. The committee shall meet no less than monthly.
- (2) The EMRRC shall record minutes at each meeting. The minutes shall describe the cases and drills reviewed, recommendations and actions taken, referrals made, and any completed and/or outstanding action items. The minutes shall be reviewed and approved by committee members prior to signature by the Warden and the CEO, health care, and submitted to the institution QMC.
- (3) Clinical Review (Initial Event Review)
 - (A) Each business day the CME, or designee, and the CNE, or designee, shall review the documentation and the clinical care delivered during each EMRS incident for suicide attempts, deaths, and all unscheduled transfers out of the institution which have occurred since the prior review.
 - (B) When indicated, the CME, or designee, and/or the CNE, or designee, shall take immediate, appropriate action to prevent repeat events and to protect the safety and security of patients, employees, contractors, volunteers and visitors including, but not limited to:
 - 1. Referral to the CEO, health care, Warden, and/or the committee designated to review sentinel events in the institution.
 - 2. Gathering information, identifying system and process gaps, and training needs.
 - 3. Developing and implementing CAPs or opportunities for improvement.
 - 4. Communicating with the CME, CNE, relevant Primary Care Teams, TTA staff, and on-call providers regarding departures from the standard of care or policy.
 - 5. Identification of sentinel events and reporting via the Health Care Incident Reporting System.
 - (C) The CME and CNE shall maintain a log of each review conducted, recorded on the CDCR 7189-1, Emergency Medical Response and Review Committee Agenda Template and Minutes. At a minimum, the log shall contain the following information:
 - 1. Patient name and CDCR number.
 - 2. The date and time of the incident.
 - 3. Brief pertinent clinical details of the case and identified opportunities for improvement.
 - (D) For reviews where immediate action is indicated, or in cases which are sentinel events, a more detailed report may be indicated. It may be necessary to appoint a clinical staff member to further evaluate and prepare detailed reports of those cases for presentation to executive leadership or committees (refer to Section (j)(4) below).

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- (4) Process Review (EMRRC QA Review)
- (A) The following institutional staff shall be voting members of the EMRRC:
1. Warden, or designee.
 2. CEO, health care.
 3. CME, or designee.
 4. Chief Physician and Surgeon (CP&S) - The CP&S shall serve as the EMRRC chairperson.
 5. CNE, or designee.
 6. Chief Psychiatrist, or designee (Senior Psychiatrist, Supervisor, or designee for institutions that do not have a Chief Psychiatrist).
 7. Supervising Dentist.
 8. Emergency Medical Response Coordinator (EMRC).
 9. Nurse Instructor.
- (B) The following staff may be assigned to the EMRRC as necessary to support the operation of the committee:
1. Administrative support staff.
 2. Community EMS response representatives, when applicable.
 3. Fire Chief, or designee.
 4. Other personnel as deemed necessary.
- (C) The EMRRC shall designate in writing an EMRC who shall be at least at the level of an SRN II. The EMRRC shall ensure that the EMRC is supported by administrative staff from the institution's Quality Management Support Unit and the Health Care Access Unit.
- (D) The EMRC shall:
1. Assist the CME and CNE in identifying and documenting the daily clinical review of EMRs.
 2. Determine the documentation needed for the daily clinical review and for the monthly EMRS review meeting, and ensure the documentation is produced.
 3. Ensure completion of and collect Emergency Medical Response Event Checklists.
 4. Ensure completion of the initial report for presentation to the committee designated to review EMRs at the next scheduled meeting.
 5. Coordinate with the EMRRC chairperson to ensure that cases are reviewed by the committee at the next meeting after the event occurred. Events shall be reviewed within 30 calendar days of their occurrence.
- (5) The EMRRC shall review as applicable, the following documentation. Other relevant documentation shall be reviewed as the circumstances of the event requires.
- (A) The health record.
- (B) CDCR 837, Crime/Incident Reports, including each applicable supplemental report and attachments.
- (C) CDCR 7229-A, Inmate Death Report.
- (D) CDCR 7229-B, Inmate Death Report/Suicide, when available.
- (E) CDCR 7463, First Medical Responder – Data Collection Tool.
- (F) CDCR 7186-1.
- (G) Coroner's Report of Autopsy, when available.
- (H) Community Emergency Medical Services Field Report (Patient Care Record [PCR]). The EMRC shall forward a copy of the PCR to Health Information Management for inclusion in the health record.
- (I) Any other reports as necessary to determine if the emergency response and care provided was appropriate or necessary to evaluate systems, processes, or procedures that need improvement.
- (6) Emergency Medical Response and Review Committee Quality Management Reporting
- (A) The EMRRC shall submit monthly, quarterly, and annual reports to the institution QMC that analyzes, aggregates, and trends EMRS incidents for the reporting period.
- (B) The report shall be focused on processes and systems including, but not limited to:
1. Performance scorecards of drills and audits.
 2. Monthly analysis and benchmarking of the EMR performance indicators including coordination of activity, timeliness of responders, and clinical outcomes.
 3. Total number of EMRS cases evaluated by the EMRC and clinical management.
 4. Number of EMRS sentinel events.

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5. Summary report of CAPs.
6. Total number of unscheduled send outs with breakdowns by ambulance, air transportation, or state vehicle.
7. Total number of naloxone utilization cases, with a breakdown based on the provider level, and reported responses.
8. Total number of suicide attempts.
9. Total number of 9-1-1 community EMS activations.
10. Total number of direct dialed requests for urgent and emergent transports.
11. Analysis of the percentage of patients returned to institutions within 24 hours of send out or urgent and emergent transportation requests.
12. Actions taken at Population Management Working Sessions and by care teams in response to patients being sent to a higher level of care.

References

- *Plata v. Newsom*, U.S. District Court of the Northern District of California, Case No. C01-1351 JST
- California Penal Code, Part 3, Title 7, Chapter 2, Section 5054
- California Penal Code, Part 3, Title 7, Chapter 2, Section 5058
- California Code of Regulations, Title 15, Division 3, Chapter 1, Subchapter 4, Article 8, Section 3354(f)(1)
- California Code of Regulations, Title 15, Division 3, Chapter 2, Subchapter 2, Article 2, Section, 3999.210(a)
- California Code of Regulations, Title 16, Division 10, Chapter 1, Article 4, Section 1016
- California Code of Regulations, Title 22, Division 5, Chapter 1, Article 3, Section 70263, Pharmaceutical Service General Requirements
- California Code of Regulations, Title 22, Division 5, Chapter 3, Article 3, Section 72377, Pharmaceutical Service - Equipment and Supplies
- California Code of Regulations, Title 22, Division 5, Chapter 4, Article 3, Section 73375, Pharmaceutical Service - Equipment and Supplies
- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 3, Section 79671, Pharmaceutical Service - Equipment and Supplies
- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 5, Section 79817, Equipment Supplies
- California Correctional Health Care Services, Health Care Department Operations Manual, Chapter 1, Article 4, Section 1.4.6, Licensed Medical Provider Credentialing and Privileging
- California Correctional Health Care Services, Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.9, Health Care Transfer
- California Correctional Health Care Services, Health Care Department Operations Manual, Chapter 3, Article 5, Section 3.5.6, Emergency Drug Supplies
- California Department of Corrections and Rehabilitation, Mental Health Services Delivery System Program Guide, 2009 Revision, Chapter 10, Suicide Prevention and Response
- American Heart Association, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care
- National Commission on Correctional Health Care Standard P-A-10, Procedure in the Event of an Inmate Death, 2008

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