UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

LEONARD CAMPBELL, et al., Plaintiffs, v. ANDERSON McGRUDER, et al., Defendants.	Civil Action No. 1462-71 (WBB)
INMATES OF D.C. JAIL, et al., Plaintiffs, v. DELBERT C. JACKSON, et al., Defendants.	Civil Action No. 75-1668 (WBB)

NOTICE OF FILING

The defendants hereby file the attached completed drafts of the Emergency Response and Tuberculosis Protocols to be implemented by the Defendants according to the November 9, 1993 Order of the Court.

JOHN PAYTON
Corporation Counsel, D.C.
MICHAEL E. ZIELINSKI
Assistant Deputy Corporation Counsel
Civil Division
RICHARD S. LOVE
Assistant Corporation Counsel, D.C.
Chief, Correctional Litigation Section

DAVID A. FLYER, #430535
Assistant Corporation Counsel, D.C.
Correctional Litigation Section
441 4th Street, N.W.
6th Floor, South
Washington, D.C. 20001
(202) 727-6295 (Ex. 3468)

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Notice of Filing was mailed, postage prepaid, to Patrick Hickey, Tara Flynn, Shaw, Pittman, Potts & Trowbridge, 2300 N. Street, N.W., Washington, D.C. 20037; and to Jonathan Smith and Aurie Hall, D.C. Prisoners' Legal Services, 1400 20th Street, N.W., Suite 117, Washington, D.C. 20036 this 12th day of April, 1994.

DAVID A. FLYER
Assistant Corporation Counsel

PPD reading within the prior three (3) months, shall have a PPD test. All inmates shall have a screening test for pregnancy during intake.

2. The results of the pregnancy test shall be obtained within 24 hours. If the pregnancy test is negative, the female inmate shall have a chest x-ray within 24 hours. Lead apron screening shall be used.

3. Pregnant inmates who are PPD negative shall be tested for anergy to a panel of two or more antigens in addition to the PPD. All anergic patients shall have a chest x-ray. Lead apron screening shall be used.

4. A pregnant inmate shall only be x-rayed if she is PPD positive or exhibits signs or symptoms of TB. Lead apron screening must be used.[1]

5. All new female intakes shall be housed on the female intake tier of the female cellblock and segregated from the other inmates until the results of the PPD test and chest x-ray are read and a negative TB result is determined. The intake units shall be evaluated within 60 days to determine if the ventilation is adequate. The identity of the inspectors and the standards to be applied will be determined by the parties in consultation with the Special Officer within 30 days.

C. Reading and Recording of PPD Tests and Chest X-rays

1. The Chief Medical Officer of the Jail shall designate a sufficient number of licensed health care providers on each shift who will be responsible for the reading of PPD tests and the proper documentation of the results of all TB screening tests in the inmates' medical records. These individuals shall be responsible for the tracking of PPD tests and chest x-rays in accordance with a protocol to be developed by the TB Coordinator or an appropriately trained and qualified individual by May 18, 1994.

2. The site of the PPD injection is to be examined for any reaction by a designated licensed health care provider within 48 to 72 hours after implantation.

3. The diameter of any induration is to be measured, disregarding erythema or bruising. The result of this PPD reading is to be charted on the form appended as Attachment A and

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[1] With proper lead apron screening, there is no contraindication to x-raying a pregnant woman who has signs and symptoms of TB. Chest x-ray using proper lead screening is essential in these inmates.

placed in the inmate's medical record.

4. The PPD reading is to be recorded in millimeters (mm):

Positive - 10 mm or greater induration

Negative - 0 - 4 mm induration

Questionable - 5 - 9 mm induration

Consider questionable reading to be positive if:

* patient is HIV positive;
* patient has had a close recent contact with an infectious person; or
* patient has an abnormal chest x-ray consistent with TB.

If the reaction is swollen, red and painful, but there is no measurable induration, the PPD may have been given subcutaneously. If it appears that the PPD was improperly administered, it should be repeated, but only after 10 days from the original date of administration, to avoid the booster phenomenon.

5. Chest x-ray readings are to be recorded on the forms appended as Attachments A and B.

D. **Preventive Therapy**

1. PPD tests are to be repeated annually for all inmates.

2. All inmates with a positive PPD should be evaluated for INH prophylaxis tr atment when a negative chest x-ray rul s out active disease. Evaluation shall include the performance of liver function tests (SGOT, SGPT, Alkaline Phosphatase, Total Bilirubin).

3. Medical providers shall advise inmates of the potential risks and side effects associated with TB prophylaxis prior to prescribing the medication. Inmates who are prescribed TB medication solely as prophylaxis have the right to refuse the medication. Inmates who are PPD positive, but without active disease, are not subject to medical holds for refusing prophylactic medication.

4. The following PPD positive patients shall receive INH preventive therapy:

* Under 35 years old;

* previously untreated or inadequately treated persons with abnormal chest x-rays consistent with old healed TB - under 35;
* persons with HIV infection - any age;
* close contacts of infectious TB cases - any age;
* new tuberculin convertors: persons who have had a history of negative PPD or a change in size greater than 6 mm increase in skin test reaction within a two year period - any age;
* persons of any age with medical conditions that increase the risk of TB infection, including:
  - Silicosis
  - Diabetes Mellitus
  - Prolonged corticosteroid therapy
  - Immunosuppressive therapy
  - Hematologic and reticuloendothelial diseases
  - End-stage renal disease
  - Intestinal bypass
  - Postgastrectomy
  - Chronic malabsorption syndrome
  - Carcinomas of the oropharynx and upper GI tract
  - 10% or more below ideal body weight

5. Inmates over 35 years of age may be offered prophylactic treatment but the risks of liver toxicity must be clearly explained.

6. If an inmate is PPD positive and has an abnormal chest x-ray consistent with TB, the inmate shall be referred for TB therapy. HIV counseling and testing shall also be offered to any inmate who is PPD positive.

7. Prophylactic treatment shall be given as follows: Isoniazid (INH) 300 mg daily or 900 mg 2x weekly. Inmates who are HIV negative shall receive this course of treatment for 6 months. Inmates who are HIV positive shall receive this course of treatment for 12 months. This medication shall be given on a watch-take basis to ensure that the inmate ingests the medication. This involves watching the inmate swallow and checking the hands and mouth to ensure compliance.

8. Inmates receiving prophylactic INH shall be evaluated to determine if Vitamin B 6 therapy is necessary with particular attention to inmates with past or present signs or symptoms of neuropathy and inmates with signs of malnourishment. Inmates who are HIV positive shall receive multivitamins.

E. <u>Positive Chest X-ray or Symptomatic Inmate</u>

1. Any inmates with an abnormal chest x-ray consistent

with TB or with symptoms of TB, i.e., productive cough, coughing up blood, weight loss, loss of appetite, lethargy, weakness, night sweats, or fever shall be referred for therapy and to D.C. General Hospital for a sputum smear and culture within 24 hours.

2. Until the results of the sputum smear or culture are known, the symptomatic patient is a "suspect" case and shall be placed in respiratory isolation which conforms with the guidelines established for respiratory isolation by the Centers for Disease Control (CDC).

3. In accordance with D.C. Health Regulations, Chapter 5, Section 8-5:104, the medical provider who identifies any suspected or diagnosed case of TB must report to the Bureau of Tuberculosis Control in writing within 48 hours of diagnosis or the appearance of suspicious symptoms by completing the attached Tuberculosis Case Report form. (See Attachment C.)[2] The medical provider shall also provide a duplicate copy of the Tuberculosis Case Report to the TB Coordinator at the Jail for monitoring and follow-up.

F. Isolation

1. Inmates with active or suspected TB shall be transferred to isolation rooms that conform with current CDC guidelines in the Correctional Treatment Facility (CTF) or D.C. General Hospital until they are no longer infectious. Respiratory isolation rooms must have separate ventilation to the outside, negative air pressure in relation to adjacent areas, a minimum of six room air exchanges per hour, and properly shielded ultraviolet lights.

2. Any inmate who has had a positive sputum smear shall not be released from isolation until three (3) negative sputum smears are collected on consecutive days and the patient is receiving appropriate therapy.

3. Procedures such as sputum collection, bronchoscopy and the administration of aerosolized pentamidine are to be conducted at the CTF or D.C. General Hospital in an appropriate treatment room or booth with negative pressure in accordance with current CDC guidelines. Patients are to remain in the treatment room or booth until coughing has subsided.

4. DOC shall obtain proper inspections of the isolation rooms at the CTF annually.

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[2] This may be sent by facsimile in accordance with the correspondence appended as Attachment D.

G. **Treatment**

1. The following medications are used for the treatment of TB:

Isoniazid (INH)	300 mg daily or 900 mg 2x weekly
Rifampin (RIF)	600 mg daily if greater than 50 kg 450 mg daily if less than 50 kg or same dosages 2x weekly
Pyrazinamide (PZA)	20-30 mg/kg daily or 50 mg/kg 2x weekly
Ethambutol (EMB)	25 mg/kg daily or 50 mg/kg 2x weekly
OR	
Streptomycin	1 gm 2x weekly

2. Inmates receiving TB treatment shall be evaluated to determine if Vitamin B 6 therapy is necessary with particular attention to inmates with past or present signs or symptoms of neuropathy and inmates with signs of malnourishment. Inmates who are HIV positive shall receive multivitamins.

3. When symptoms and/or results of PPD test, chest x-ray, and sputum smear suggest active pulmonary TB, the inmate should be placed on a TB treatment regimen of medications as follows:

Recommended Treatment Regimens

Regimens	HIV Negative	HIV Positive
Initial Phase	2 months INH/RIF/ PZA/EMB daily	2 months INH/RIF/ PZA/EMB daily
Continuation Phase	4-7 months INH/RIF daily or 2x weekly	10 months INH/RIF daily or 2x weekly
Total	6-9 months	12 months

4. The treatment regimen of each patient shall be determined in accordance with the culture and sensitivity laboratory test result.

5. "Watch take" requirements should be implemented for all patients with evidence of active TB to ensure that the inmate ingests the medication.

6. Inmates with clinically active disease shall receive sputum examinations in an appropriate treatment room or booth with negative pressure at D.C. General Hospital or the CTF in accordance with standard medical practice, at least weekly until sputum conversion and then monthly until discharged. Discharge from the hospital or CTF will be based on the acquisition of three negative sputum smears on consecutive days.

7. Persistence or reappearance of organisms in the sputum smear necessitates an immediate evaluation of compliance with the medication regimen and the performance of drug susceptibility tests. All inmates shall remain in isolation until three consecutive sputum smears are negative.

H. Side Effects of Medication

1. Clinical staff who administer TB medications must be familiar with common side effects and adverse reactions. Specific protocols for management and evaluation of side effects shall be developed and the clinical staff shall receive the appropriate training.

2. The following patients should receive careful monitoring when given INH:

* Dilantin users - may need to decrease Dilantin;
* Alcohol users - higher incidence of INH hepatitis;
* Previous INH users - discontinued due to headaches;
* Concurrent use with other medications.

3. If an inmate exhibits signs or symptoms of drug toxicity, the medication shall be discontinued and the Bureau of Tuberculosis (202) 724-2191 shall be contacted for expert advice.

4. Expert advice for the handling of adverse reactions to medications and for the management of complicated cases (i.e., drug resistance, extrapulmonary disease, or disease in pregnant women) will be obtained from the Bureau of Tuberculosis Control at (202) 724-2191.

I. Refusal of TB Screening Procedures - Medical Hold

1. Any inmate who refuses any TB screening procedure shall be placed on "medical hold" for the protection of the prison community. A medical hold is the process by which an inmate is placed in an isolated area when refusing to accept screening, diagnosis, or treatment for a communicable disease which poses a public health threat to the safety of the inmate or

others.

2. Any inmate placed on medical hold due his/her refusal to participate in TB screening shall receive immediate, comprehensive and appropriate education from a licensed health care provider regarding the refused procedure at the time of refusal. All available literature regarding TB shall be provided. Inmates on medical hold shall receive counseling daily from the TB Coordinator regarding the importance of the screening procedure. Inmates on medical hold shall also be seen daily by a physician or physician assistant in order to observe any signs or symptoms of TB. Proper documentation of each visit by the TB Coordinator and physician or physician assistant shall be noted in the medical record.

3. If the inmate does not consent to the screening procedure within two weeks, and the inmate shows no signs or symptoms of TB in the judgment of a DOC physician, s/he shall be released to the general population. When a medical hold is extended beyond the initial two week period, the requirements of section I, paragraph 2 remain applicable.

J. **Inmate Education and Referral to Community Services**

1. When an inmate's PPD is read, the licensed health care provider shall distribute and explain written educational materials regarding TB control, prevention and treatment. The TB Coordinator shall be responsible for selecting appropriate materials in Spanish and English written at a basic literacy level.

2. When an inmate is prescribed INH or any other medication as TB prophylaxis or treatment, written information regarding follow up care in the event of release from the Jail during the course of treatment shall be given and explained. This information shall direct the inmate to contact Dr. James Wills, Area C Chest Clinic, 1905 E Street, S.E., Washington, D.C., 20003 at (202) 727-5155. The TB Coordinator shall develop the form to be provided and explained.

3. The TB Coordinator shall monitor daily the releases from the Jail to determine if any inmate on TB medications has been released. The identity of any such inmate shall be reported to the Bureau of Tuberculosis Control and the Area C Chest Clinic.

4. If the release date of an inmate taking TB medication is known to be prior to the completion of the inmate's treatment regimen, the inmate shall be provided with a two week supply of the prescribed medication upon release along with written instructions to contact the Area C Chest Clinic.

K. Tuberculosis Coordinator

1. The DOC shall hire a properly credentialed and appropriately trained full-time TB Coordinator to work at the Jail by April 18, 1994.

2. The TB Coordinator shall monitor the ongoing screening program at the Jail for continuity of care and follow-up. The TB Coordinator shall be responsible for monitoring TB intake screening, inmates placed on prophylactic treatment, inmates with active disease, inmates placed in the hospital for therapy, and those placed on medical hold related to TB.

3. The TB Coordinator shall function as the liaison with the Bureau of Tuberculosis Control, D.C. General Hospital and the laboratory.

4. The TB Coordinator shall obtain a comprehensive daily list of all persons undergoing intake physical examinations with TB screening. Results of PPD tests and chest x-rays shall be placed on the appropriate forms by the medical staff and monitored daily by the TB Coordinator. The TB Coordinator shall develop a protocol for the tracking of PPD tests and chest x-rays to be approved by the Chief Medical Officer of the Jail by May 18, 1994. The TB Coordinator shall monitor all inmates receiving prophylactic treatment or treatment for active TB.

5. The TB Coordinator shall maintain an accurate account of inmates tested, cleared, inmates not tested, inmates on medical holds, and referrals for inmates released into the community.

6. The TB Coordinator shall coordinate referrals and discharge planning for inmates receiving TB prophylaxis or treatment.

7. The TB Coordinator shall monitor the case reporting to the Bureau of Tuberculosis Control to ensure that all appropriate cases are reported properly and within the required time limits.

8. The TB Coordinator shall monitor at least monthly all inmates taking anti-TB medications. Special attention shall be given to inmates who are taking other medications or who have a history of alcohol abuse or liver disease.

9. The TB Coordinator shall develop and implement an educational program regarding TB for the inmate population, including monitoring the distribution of any written materials that are to be provided to the inmates housed at the Jail.

10. The TB Coordinator shall answer directly to the

Chief Medical Officer of the Jail and shall provide information and education to other providers at the Jail. The TB Coordinator shall submit a monthly report to the Chief Medical Officer at the Jail and the Bureau of Tuberculosis Control.

11. The TB Coordinator shall coordinate in-service training which will be provided to all staff at the DOC training academy. Specialized training will be provided to clinical staff by specialists from the Public Health Commission, Bureau of Tuberculosis Control, community hospitals and from other correctional institutions regarding clinical signs, symptoms, and treatment issues involving TB.

12. The TB Coordinator shall be responsible for conducting any contact investigations when pulmonary or laryngeal TB disease is suspected or diagnosed.

13. The TB Coordinator shall be responsible for developing a tracking system to provide notification to the medical units at other DOC facilities when a patient under treatment for TB or on prophylaxis is transferred from the Jail. This duty may be delegated to another licensed health care provider, however, the TB Coordinator is responsible to ensure that it is developed and implemented.

L. <u>Contact Investigation</u>

1. Whenever pulmonary or laryngeal TB disease is suspected or diagnosed, all close contacts should be skin tested unless there is a documented history of a positive skin test. Close contacts include all cell mates, all inmates and staff on the same tier, or all inmates and staff in the same building who share air, and visitors who have shared airspace.

2. The "concentric circle" approach can be used to determine the extent of contact investigation needed. First, identify those persons who were most likely to have been infected by the source case. This first group should include: persons who shared breathing space with the source case for the longest time, persons who may have spent less time with the source case but are immunosuppressed; and persons who have TB symptoms. If positive PPD tests are identified among persons in this first group or "circle" (with no previous history of TB infection), new infections have probably occurred. Expand the investigation into widening circles until PPD testing identifies a group of persons with no evidence of new TB infection

3. If exposure was less than 10 to 12 weeks prior to PPD testing, a contact with a negative PPD test should be retested 10 to 12 weeks after the initial negative PPD test.

4. The following contacts should receive a chest x-ray:

a) those who have a positive skin test -- greater than 5 mm;
b) those with a history of a positive skin test;
c) those who are HIV positive, regardless of skin test results.

If the chest x-ray is negative for evidence of the disease, these contacts should receive preventive therapy, unless medically contraindicated.

5. During contact investigations, the confidentiality of the infected person must be maintained.

M. Screening of DOC Employees

1. All DOC staff shall be strongly encouraged to receive PPD tests annually and these tests shall be made available to all employees free of charge. The defendants shall determine whether mandatory testing can be required and shall report to the Special Officer and plaintiffs' counsel within 60 days regarding this matter.

N. Review of Protocol

1. This procedure and protocol shall be reviewed annually by the DOC Assistant Director for Health Services to determine if any revisions should be made in light of new developments in the treatment of TB. Any proposed revisions shall be submitted to the Special Officer for approval. Plaintiffs' counsel must be advised of all proposed revisions to this document.

III. Effective Date

1. The defendants shall immediately implement the policies and procedures set forth in this document.

ATTACHMENT D

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
WASHINGTON, D. C. 20002

IN REPLY REFER TO:

November 20, 1990
D.C. Commission of Public Health
Bureau of Tuberculosis Control
1905 E St., S.E.
Washington, D.C. 20003

To whom it may concern:

The Bureau of Tuberculosis Control, Registry, has installed a Facsimile (FAX) machine to be used for the expressed purpose of receiving both case and laboratory reports or suspected and confirmed tuberculosis from health care providers.

The Fax machine will be available for receiving reports 24 hours a day, including weekends. It is anticipated that the availability of the Fax machine will improve both the timeliness and the accuracy of Tuberculosis case reporting.

The District of Columbia requires, as written in the D. C. Health Regulations, for Communicable and Reportable Diseases, Chapter 5, 1963, section 8-5:104 Denomination of Communicable Diseases: "the following diseases ------Tuberculosis--------- are hereby denominated communicable diseases and shall be reported in writing within 48 hours of diagnosis or the appearance of suspicious symptoms in the manner indicated in sections 8-5:106 and 8-5:107 of this part. The transmission of case and laboratory TB reports by Fax machine within 48 hours of diagnosis, fully satisfies the reporting requirements of the D.C. Health Regulations.

The Bureau of Tuberculosis Control, Registry Fax machine telephone number is: 202-724-2363. If there are any questions regarding the use of the Fax machine, please call Glenn Acham, Supervisory Public Health Advisor, at 724-2193.

Sincerely yours,

Hazel M. Swann, M.D., Chief
Bureau of Tuberculosis Control

P.S. Enclosed is a letter to Infection Control Practitioners, dated September 18, 1990, regarding the reporting of tuberculosis cases.

ATTACHMENT A

D.C DEPARTMENT OF CORRECTIONS
HEALTH SERVICES

TUBERCULOSIS SCREENING

Date: _____

1. Patient has / has not had previous skin testing for tuberculosis.

2. Last PPD was done on _____ at _____ and was neg / pos.

3. Mantoux skin testing was performed on _____ by _____
(initials)

4. Date read: _____ Results: _____ mm induration which is neg / pos _____**
(initials)

5. Chest X-Ray done on _____ is neg / positive / suspicious for active tuberculosis.

6. Recommendations: _____
_____
_____

Patient's Name: _____ DCDC #: _____
(Last) (First)

D.O.B.: _____ Race: _____ Sex: _____

** Center for Disease Control recommends that an induration of 5mm or greater in the immunocompromised be considered positive. In the non-immunocompromised host, an induration of 10mm or greater is positive.

ATTACHMENT B

PATIENT'S IDENTIFICATION	AGE	SEX	PF#	PREGNANT
NAME				☐ YES ☐ NO
DOB	EXAMINATION REQUESTED			
DCDC #	☐ ROUTINE CHEST			
	☐ OTHER			
FACILITY	REQUESTED BY			DATE OF REQUEST

PERTINENT CLINICAL HISTORY, OPERATIONS, PHYSICAL FINDINGS, AND PROVISIONAL DIAGNOSIS

DATE OF EXAMINATION *(include year)*	DATE OF REPORT	DATE OF TRANSCRIPTION

RADIOGRAPHIC REPORT

MD SIGNATURE

RADIOLOGY REQUEST / REPORT

IDPS 1647

ATTACHMENT C

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HUMAN SERVICES

TUBERCULOSIS CASE REPORT

Name *(last)* *(first)* *(middle/maiden)*	SSN #	Date of Report / /
Address	Telephone	Date of Birth / /
Marital Status / Sex / Race: ☐ Black ☐ American Indian or Alaskan Native ☐ White ☐ Asian or Pacific Islander	Ethnic Orgin: ☐ Hispanic ☐ Not Hispanic	Country of Orgin if not U.S. _____ Date arrv. in U.S. _____

Occupation	School or Place of Employment	Address

Classification

☐ Tuberculosis: current disease

☐ Tuberculosis no current disease

☐ Tuberculosis Suspect:

_____

☐ Tuberculosis Infection No disease

(If applicable)

Diagnosis

☐ Pulmonary

☐ Non-Pulmonary *(specify)*

☐ Miliary ☐ Meningitis

☐ Bones & Joints ☐ Pleural

☐ Lymphatic ☐ Peritoneal

☐ Genito-Urinary ☐ Other *(specify)*

☐ Reported at time of death

SIGNS & SYMPTOMS

Bacteriology

	PCS.	NEG.	Pending	Not Done
Smear	☐	☐	☐	☐
Culture	☐	☐	☐	☐

Type of Specimen

☐ Sputum ☐ Fluid

☐ Tissue ☐ Other *(specify)* _____

_____ (date(s) of collection)

_____ Laboratory Performed

DHS - 1467 (Rev. 3/91) 1-1188-1 wd-360

Chest X-Ray

☐ Not done
☐ Normal
☐ Abnormal
  ☐ Cavitary
  ☐ Non-cavitary
☐ Stable
☐ Worsening
☐ Improving

DATE OF X-RAY

/ /

Tuberculin Skin Test

☐ Not done
☐ Mantouz (PPD)
☐ Tine
☐ Other_____ *(specify)*
☐ Significant
☐ Not Significant

_____ mm

Chemotherapy Dosage

☐ Isoniazid _____
☐ Ethambutol _____
☐ Rifampin _____
☐ Pyrazinamide _____
☐ Streptomycin _____
☐ Other _____ *(specify)*

_____

atient to be followed by:

Previous diagnosis
☐ Yes date / / ☐ No

OMMENTS:

Hospitalization
Chart No._____
Admission Date: _____
Discharge Date:_____

] Send Additional Report Forms

eported by *(Print Name)*	Signature	Office or Hospital Address

TO BE COMPLETED BY HEALTH DEPARTMENT

ɔuce No.	Ward	Census Tract	Date Recorded in Registry	Case #	Verified

MEDICAL EMERGENCY RESPONSE PROTOCOL

I. Introduction

The parties, in consultation with the Special Officer and her experts, agree that this Medical Emergency Protocol, filed with the Court on April 11, 1994, will govern the policies and procedures regarding the response to medical emergencies at the Central Detention Facility pursuant to the November 9, 1993 Consent Order issued in Campbell v. McGruder, C.A. No. 1462-71 and Inmates of D.C. Jail v. Jackson, C.A. No. 1462-71. The defendants understand that they are obligated to promulgate policies which implement this protocol.

II. Procedures

A. Notification and Response

1. Any employee who determines that a medical emergency exists shall immediately notify the Command Center using the Emergency Direct Line Communication system where possible, or by calling extension 38136 through 38144. If an emergency occurs in a location where there is no telephone, the employee will go to the nearest telephone, or notify the Command Center by walkie talkie. The employee will then return to the location of the emergency.

2. The employee placing the call will give all necessary information to the Command Center Officer including the location of the injured or ill person, type of injury or illness, and if the injured person is conscious.

3. The Command Center Officer will immediately page the Medical Emergency Response Team (MERT) Leader. The Command Center Officer will then immediately notify a supervisor and the Sick Call Officer by the Direct Line Communication System, and inform them of the location of the person, type of injury or illness, and if the injured person is conscious. The Command Center Officer will then make the emergency announcement over the public address system. The Command Center Officer will only relay the location of the injured person on the public address system. The Command Center Officer shall also notify the Shift Commander who will immediately dispatch a correctional officer to ensure the proper operation and reception of the medical elevator on the floor where the emergency exists.

4. The respective Zone Supervisor will immediately respond to the location of all medical emergencies. The Supervisor will assist the MERT and ensure full cooperation by the correctional force to include timely correctional coverage, as well as security and escort requirements. Other correctional duties may include lifting residents onto stretchers.

5. The MERT will immediately respond to all medical emergencies with the portable emergency medical cart. They will use the medical elevator for all medical emergencies. A service elevator will be used when the medical elevator is inoperable. All employees will assist the MERT as requested.

6. The MERT Leader is responsible for directing emergency care and treatment. The MERT Leader shall determine the means of transportation to D.C. General Hospital, if necessary, and shall call 911 in all life-threatening emergencies.

7. The MERT Leader shall notify the Shift Commander when an injured person must be transported to D.C. General Hospital. The MERT leader shall inform the Shift Commander of the means of transportation, i.e., 911 or DOC ambulance. The Shift Commander shall facilitate the entry of the 911 staff as well as the prompt dispatching of EMTs and other designated staff for operation of the DOC ambulance. When the DOC ambulance is inoperable, 911 will be used for all emergency transfers to D.C. General Hospital.

8. The MERT Leader is responsible for ensuring that all medical emergencies are documented on the Medical Emergency Information Form immediately after each emergency. A copy of the form is appended as Attachment A. All completed Medical Emergency Information Forms shall be filed in a MERT log. The Sick Call Officer shall record all emergency call information in the Sick Call Officer's log-book.

B. Medical Emergency Response Team Composition

1. The MERT will be composed of three medical personnel. The MERT Leader will be a physician, with two other licensed medical providers (nurses or physician assistants).

2. The Chief Medical Officer is responsible for devising and posting a MERT schedule that includes alternates. This schedule will be completed by the second Monday in January and July of each year. The posting of the schedule will be accessible to the Sick Call Officer who must review it at the beginning of each shift.

3. The MERT Leader will wear a pager while on duty at all times. The pager will be transferred from MERT Leader to MERT Leader on each shift.

C. Location and Inspection of Emergency Medical Equipment and Supplies

1. The on duty charge nurse is responsible for having the emergency medical cart and the portable crash boxes inspected at the beginning of each shift and will make an entry in the

designated log books indicative of same. The Sick Call Officer in charge is responsible for inspection of the medical elevator and on board stretcher at the beginning of each shift. The officer will ride the elevator to all floors and check the operation of the gate locks on all floors. The inspection of the medical elevator and gate locks shall be noted in the shift activity report.

2. The elevator key shall be kept in the Infirmary Control Bubble and the Emergency Medical Cart shall be located in room 326. The medical cart will be taken to all medical emergencies and a medical stretcher will be kept on the medical elevator at all times.

3. The Zone Supervisor will include as part of her/his regular duties an inspection of the medical elevators to ensure that the medical stretcher is on the medical elevator. This inspection must be conducted at least twice daily and **all efforts** will be exhausted to replace the stretcher if it is not on the elevator.

4. The Chief Nurse is responsible for ensuring that the Charge Nurse restocks the Medical Emergency Cart per the inventory sheet as prescribed after each emergency. If it is necessary to restock the Medical Emergency Cart when the pharmacy is closed, back up medication will be stored in the psychotropic medication room.

5. The security bubble on each cellblock, the medical unit and the receiving and discharge unit shall be equipped within 60 days with an Ambu Bag to assist with mouth-to-mouth resuscitation and an Addis Wonder Knife or an equivalent emergency rescue tool to assist in cutting down hanging victims. Pending the receipt and installation of this equipment, each of the above-identified security bubbles shall be equipped with blunt-nosed scissors. All correctional officers shall be trained in the most effective use of the Ambu bag, emergency rescue tool and blunt-nosed scissors within 14 days of the installation of the equipment.

D. **Ambulance Inspection and Restocking**

1. The supervisory nurse is responsible for certifying that the ambulance has been sanitized and restocked at the beginning of each shift and after each use. The nursing assistant will sanitize the ambulance. The EMT will restock the ambulance and oversee sanitizing the unit after each use. Two separate log books will be maintained: one to indicate each medical run and the other to indicate each inspection. Both log books will be certified by the Chief Medical Officer bi-weekly. Maintenance documentation will be completed by the DOC Transportation Unit.

2. The DOC ambulance assigned to the Jail will be operated and maintained in full compliance with all applicable laws

and regulations of the United States and the District of Columbia. The ambulance shall not be used for any purpose other than emergency medical transport and shall not be used in circumstances necessitating advanced life support. The DOC must certify in writing to the Special Officer and plaintiffs' counsel when the DOC ambulance can be operated in accordance with the applicable laws and regulations of the United States and the District of Columbia. Until the DOC provides this written certification, only 911 will be used for all emergency medical transports.

E. Training

1. All medical staff and correctional personnel assigned to the Detention Facility shall receive C.P.R. training and training regarding the identification and appropriate clinical response to medical emergencies through DOC's in-service training program within 30 days. The training will include the following areas: medical emergencies such as asthma, heart attacks, strokes, seizures, outward effects of diabetics, hangings and other psychiatric emergencies. Refresher training will be held each year for all staff.

2. All medical staff and officers assigned to the Detention Facility will receive training in this emergency response protocol within three weeks. Refresher training will be held for all staff on an annual basis.

F. Officers' Duties

1. The duties of each and every correctional officer described in this procedure shall be specified in their respective post orders.

III. Effective Date

1. The defendants shall immediately implement the policies and practices outlined in this protocol.

ATTACHMENT A

Medical Emergency Log Book Form

Patient's Name: _____

DCDC No.: _____

Housing Unit: _____ Date: _____

If transportation was used, circle one: 911 DOC ambulance

Time Medical Staff Notified of Emergency: _____

Time Medical Staff Responded to Patient: _____

Identity of MERT Team Members who Responded:

_____

_____

_____

Nature of Emergency: _____

_____

_____

Describe Medical Intervention: _____

_____

_____

_____

Outcome: _____

_____

_____

Full Name and Title of Staff Member Completing this Form:

_____

_____

Comments: _____

_____

THIS FORM MUST BE INSERTED IN EMERGENCY LOG

ATTACHMENT B

SUPPLY INVENTORY

Portable Emergency Box	Quantity of Supplies
Proventil	1 inhaler
Epinephrine (1:1,000) (1:10,000)	 10 injectable 1 injectable
Benadryl	1 injectable
2% Lidocaine	1 bottle
Sodium Chloride .9%	1 bottle 50 ml.
Isuprel HCL .2 mg/ml	2 vials
Narcan .4mg	1 box
Atropine .4mg	2 vials
Monoject (Insulin reaction jell)	2 packs
Ipecac	1 bottle
Nitrostat Bottle .4mg	1 bottle
Ammonia Inhalants	1 box
Surgilube	1 tube
Syringes 35cc	2
Butterflys	2
Scissors	2
Tongue Blades	12
Compazine 5 mg/ml	1 vial

Supply Inventory

Angiocaths	2
Syringes 3cc	2
Gloves	1 box
Oxygen Tubing	2
Ambu Bag and mask	1

2nd Emergency Box

Laryngoscope and blade	1
Oral Airway	2
IV tubing	2
Mask	2
Sterile Gloves	2 pair
Oxygen Mask	2
Angiocaths	2
Syringes 3cc	2
Endotracheal Tubes	3
Alcohol pads	1 box
4x4	6 packs
Oxygen tank	1
Stretcher	1
Stethoscope	1
Blood Pressure Cuff	1
Nasal Cannula	2

Supply Inventory

Tape	1 roll
IV Solution	
Lactate Ringers	1
Normal Saline	1
Flashlights	2

TUBERCULOSIS SCREENING, PREVENTION, AND TREATMENT PROCEDURE AND PROTOCOL

I. Introduction

The parties, in consultation with the Special Officer and her experts, agree that this Tuberculosis Screening, Prevention, and Treatment Procedure and Protocol, filed with the Court on April 11, 1994, will govern the policies and procedures regarding tuberculosis screening, prevention and treatment at the Central Detention Facility pursuant to the November 9, 1993 Consent Order issued in Campbell v. McGruder, C.A. No. 1462-71 and Inmates of D.C. Jail v. Jackson, C.A. No. 75-1668. The defendants understand that they are obligated to promulgate policies which implement this protocol.

II. Procedures

A. Intake Procedure for Male Inmates

1. Upon entry into the Central Detention Facility, all male inmates, except those with a documented prior positive PPD reading or a documented negative PPD reading within the prior three (3) months, will be screened for tuberculosis (TB) with the Mantoux skin test. The Mantoux skin test is to be administered by intradermal injection of purified protein derivative (PPD) of killed tubercle bacilli on the inmate's inner forearm by a licensed medical provider.

2. All incoming inmates will have a chest x-ray within 24 hours except asymptomatic inmates who have had a documented normal chest x-ray within the previous six (6) months. Lead aprons will be used to minimize radiation to the gonads.

3. Any inmate exhibiting a clinical indication for a chest x-ray, i.e. fever, cough, weight loss, recent exposure to TB, or a new conversion to positive PPD status, shall have a chest x-ray within 24 hours regardless of the date of his last chest x-ray.

4. All new male intakes shall be housed on the intake cellblocks and fully segregated from inmates on other cell blocks until the results of the PPD test and chest x-ray are read and a negative TB result is determined. The intake units shall be evaluated within 60 days to determine if the ventilation is adequate. The identity of the inspectors and the standards to be applied will be determined by the parties in consultation with the Special Officer within 30 days.

B. Intake Procedures for Female Inmates

1. All incoming female inmates, except those with a documented prior positive PPD reading or a documented negative

PPD reading within the prior three (3) months, shall have a PPD test. All inmates shall have a screening test for pregnancy during intake.

2. The results of the pregnancy test shall be obtained within 24 hours. If the pregnancy test is negative, the female inmate shall have a chest x-ray within 24 hours. Lead apron screening shall be used.

3. Pregnant inmates who are PPD negative shall be tested for anergy to a panel of two or more antigens in addition to the PPD. All anergic patients shall have a chest x-ray. Lead apron screening shall be used.

4. A pregnant inmate shall only be x-rayed if she is PPD positive or exhibits signs or symptoms of TB. Lead apron screening must be used.[1]

5. All new female intakes shall be housed on the female intake tier of the female cellblock and segregated from the other inmates until the results of the PPD test and chest x-ray are read and a negative TB result is determined. The intake units shall be evaluated within 60 days to determine if the ventilation is adequate. The identity of the inspectors and the standards to be applied will be determined by the parties in consultation with the Special Officer within 30 days.

C. Reading and Recording of PPD Tests and Chest X-rays

1. The Chief Medical Officer of the Jail shall designate a sufficient number of licensed health care providers on each shift who will be responsible for the reading of PPD tests and the proper documentation of the results of all TB screening tests in the inmates' medical records. These individuals shall be responsible for the tracking of PPD tests and chest x-rays in accordance with a protocol to be developed by the TB Coordinator or an appropriately trained and qualified individual by May 18, 1994.

2. The site of the PPD injection is to be examined for any reaction by a designated licensed health care provider within 48 to 72 hours after implantation.

3. The diameter of any induration is to be measured, disregarding erythema or bruising. The result of this PPD reading is to be charted on the form appended as Attachment A and

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[1] With proper lead apron screening, there is no contraindication to x-raying a pregnant woman who has signs and symptoms of TB. Chest x-ray using proper lead screening is essential in these inmates.

placed in the inmate's medical record.

4. The PPD reading is to be recorded in millimeters (mm):

Positive - 10 mm or greater induration

Negative - 0 - 4 mm induration

Questionable - 5 - 9 mm induration

Consider questionable reading to be positive if:

* patient is HIV positive;
* patient has had a close recent contact with an infectious person; or
* patient has an abnormal chest x-ray consistent with TB.

If the reaction is swollen, red and painful, but there is no measurable induration, the PPD may have been given subcutaneously. If it appears that the PPD was improperly administered, it should be repeated, but only after 10 days from the original date of administration, to avoid the booster phenomenon.

5. Chest x-ray readings are to be recorded on the forms appended as Attachments A and B.

D. Preventive Therapy

1. PPD tests are to be repeated annually for all inmates.

2. All inmates with a positive PPD should be evaluated for INH prophylaxis treatment when a negative chest x-ray rules out active disease. Evaluation shall include the performance of liver function tests (SGOT, SGPT, Alkaline Phosphatase, Total Bilirubin).

3. Medical providers shall advise inmates of the potential risks and side effects associated with TB prophylaxis prior to prescribing the medication. Inmates who are prescribed TB medication solely as prophylaxis have the right to refuse the medication. Inmates who are PPD positive, but without active disease, are not subject to medical holds for refusing prophylactic medication.

4. The following PPD positive patients shall receive INH preventive therapy:

* Under 35 years old;

* previously untreated or inadequately treated persons with abnormal chest x-rays consistent with old healed TB - under 35;
* persons with HIV infection - any age;
* close contacts of infectious TB cases - any age;
* new tuberculin convertors: persons who have had a history of negative PPD or a change in size greater than 6 mm increase in skin test reaction within a two year period - any age;
* persons of any age with medical conditions that increase the risk of TB infection, including:
    - Silicosis
    - Diabetes Mellitus
    - Prolonged corticosteroid therapy
    - Immunosuppressive therapy
    - Hematologic and reticuloendothelial diseases
    - End-stage renal disease
    - Intestinal bypass
    - Postgastrectomy
    - Chronic malabsorption syndrome
    - Carcinomas of the oropharynx and upper GI tract
    - 10% or more below ideal body weight

5. Inmates over 35 years of age may be offered prophylactic treatment but the risks of liver toxicity must be clearly explained.

6. If an inmate is PPD positive and has an abnormal chest x-ray consistent with TB, the inmate shall be referred for TB therapy. HIV counseling and testing shall also be offered to any inmate who is PPD positive.

7. Prophylactic treatment shall be given as follows: Isoniazid (INH) 300 mg daily or 900 mg 2x weekly. Inmates who are HIV negative shall receive this course of treatment for 6 months. Inmates who are HIV positive shall receive this course of treatment for 12 months. This medication shall be given on a watch-take basis to ensure that the inmate ingests the medication. This involves watching the inmate swallow and checking the hands and mouth to ensure compliance.

8. Inmates receiving prophylactic INH shall be evaluated to determine if Vitamin B 6 therapy is necessary with particular attention to inmates with past or present signs or symptoms of neuropathy and inmates with signs of malnourishment. Inmates who are HIV positive shall receive multivitamins.

E. <u>Positive Chest X-ray or Symptomatic Inmate</u>

1. Any inmates with an abnormal chest x-ray consistent

with TB or with symptoms of TB, i.e., productive cough, coughing up blood, weight loss, loss of appetite, lethargy, weakness, night sweats, or fever shall be referred for therapy and to D.C. General Hospital for a sputum smear and culture within 24 hours.

2. Until the results of the sputum smear or culture are known, the symptomatic patient is a "suspect" case and shall be placed in respiratory isolation which conforms with the guidelines established for respiratory isolation by the Centers for Disease Control (CDC).

3. In accordance with D.C. Health Regulations, Chapter 5, Section 8-5:104, the medical provider who identifies any suspected or diagnosed case of TB must report to the Bureau of Tuberculosis Control in writing within 48 hours of diagnosis or the appearance of suspicious symptoms by completing the attached Tuberculosis Case Report form. (See Attachment C.)[2] The medical provider shall also provide a duplicate copy of the Tuberculosis Case Report to the TB Coordinator at the Jail for monitoring and follow-up.

F. Isolation

1. Inmates with active or suspected TB shall be transferred to isolation rooms that conform with current CDC guidelines in the Correctional Treatment Facility (CTF) or D.C. General Hospital until they are no longer infectious. Respiratory isolation rooms must have separate ventilation to the outside, negative air pressure in relation to adjacent areas, a minimum of six room air exchanges per hour, and properly shielded ultraviolet lights.

2. Any inmate who has had a positive sputum smear shall not be released from isolation until three (3) negative sputum smears are collected on consecutive days and the patient is receiving appropriate therapy.

3. Procedures such as sputum collection, bronchoscopy and the administration of aerosolized pentamidine are to be conducted at the CTF or D.C. General Hospital in an appropriate treatment room or booth with negative pressure in accordance with current CDC guidelines. Patients are to remain in the treatment room or booth until coughing has subsided.

4. DOC shall obtain proper inspections of the isolation rooms at the CTF annually.

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[2] This may be sent by facsimile in accordance with the correspondence appended as Attachment D.

G. **Treatment**

1. The following medications are used for the treatment of TB:

Isoniazid (INH)	300 mg daily or 900 mg 2x weekly
Rifampin (RIF)	600 mg daily if greater than 50 kg 450 mg daily if less than 50 kg or same dosages 2x weekly
Pyrazinamide (PZA)	20-30 mg/kg daily or 50 mg/kg 2x weekly
Ethambutol (EMB)	25 mg/kg daily or 50 mg/kg 2x weekly
OR	
Streptomycin	1 gm 2x weekly

2. Inmates receiving TB treatment shall be evaluated to determine if Vitamin B 6 therapy is necessary with particular attention to inmates with past or present signs or symptoms of neuropathy and inmates with signs of malnourishment. Inmates who are HIV positive shall receive multivitamins.

3. When symptoms and/or results of PPD test, chest x-ray, and sputum smear suggest active pulmonary TB, the inmate should be placed on a TB treatment regimen of medications as follows:

Recommended Treatment Regimens

Regimens	HIV Negative	HIV Positive
Initial Phase	2 months INH/RIF/ PZA/EMB daily	2 months INH/RIF/ PZA/EMB daily
Continuation Phase	4-7 months INH/RIF daily or 2x weekly	10 months INH/RIF daily or 2x weekly
Total	6-9 months	12 months

4. The treatment regimen of each patient shall be determined in accordance with the culture and sensitivity laboratory test result.

5. "Watch take" requirements should be implemented for all patients with evidence of active TB to ensure that the inmate ingests the medication.

6. Inmates with clinically active disease shall receive sputum examinations in an appropriate treatment room or booth with negative pressure at D.C. General Hospital or the CTF in accordance with standard medical practice, at least weekly until sputum conversion and then monthly until discharged. Discharge from the hospital or CTF will be based on the acquisition of three negative sputum smears on consecutive days.

7. Persistence or reappearance of organisms in the sputum smear necessitates an immediate evaluation of compliance with the medication regimen and the performance of drug susceptibility tests. All inmates shall remain in isolation until three consecutive sputum smears are negative.

H. Side Effects of Medication

1. Clinical staff who administer TB medications must be familiar with common side effects and adverse reactions. Specific protocols for management and evaluation of side effects shall be developed and the clinical staff shall receive the appropriate training.

2. The following patients should receive careful monitoring when given INH:

* Dilantin users - may need to decrease Dilantin;
* Alcohol users - higher incidence of INH hepatitis;
* Previous INH users - discontinued due to headaches;
* Concurrent use with other medications.

3. If an inmate exhibits signs or symptoms of drug toxicity, the medication shall be discontinued and the Bureau of Tuberculosis (202) 724-2191 shall be contacted for expert advice.

4. Expert advice for the handling of adverse reactions to medications and for the management of complicated cases (i.e., drug resistance, extrapulmonary disease, or disease in pregnant women) will be obtained from the Bureau of Tuberculosis Control at (202) 724-2191.

I. Refusal of TB Screening Procedures - Medical Hold

1. Any inmate who refuses any TB screening procedure shall be placed on "medical hold" for the protection of the prison community. A medical hold is the process by which an inmate is placed in an isolated area when refusing to accept screening, diagnosis, or treatment for a communicable disease which poses a public health threat to the safety of the inmate or

others.

2. Any inmate placed on medical hold due his/her refusal to participate in TB screening shall receive immediate, comprehensive and appropriate education from a licensed health care provider regarding the refused procedure at the time of refusal. All available literature regarding TB shall be provided. Inmates on medical hold shall receive counseling daily from the TB Coordinator regarding the importance of the screening procedure. Inmates on medical hold shall also be seen daily by a physician or physician assistant in order to observe any signs or symptoms of TB. Proper documentation of each visit by the TB Coordinator and physician or physician assistant shall be noted in the medical record.

3. If the inmate does not consent to the screening procedure within two weeks, and the inmate shows no signs or symptoms of TB in the judgment of a DOC physician, s/he shall be released to the general population. When a medical hold is extended beyond the initial two week period, the requirements of section I, paragraph 2 remain applicable.

J. <u>Inmate Education and Referral to Community Services</u>

1. When an inmate's PPD is read, the licensed health care provider shall distribute and explain written educational materials regarding TB control, prevention and treatment. The TB Coordinator shall be responsible for selecting appropriate materials in Spanish and English written at a basic literacy level.

2. When an inmate is prescribed INH or any other medication as TB prophylaxis or treatment, written information regarding follow up care in the event of release from the Jail during the course of treatment shall be given and explained. This information shall direct the inmate to contact Dr. James Wills, Area C Chest Clinic, 1905 E Street, S.E., Washington, D.C., 20003 at (202) 727-5155. The TB Coordinator shall develop the form to be provided and explained.

3. The TB Coordinator shall monitor daily the releases from the Jail to determine if any inmate on TB medications has been released. The identity of any such inmate shall be reported to the Bureau of Tuberculosis Control and the Area C Chest Clinic.

4. If the release date of an inmate taking TB medication is known to be prior to the completion of the inmate's treatment regimen, the inmate shall be provided with a two week supply of the prescribed medication upon release along with written instructions to contact the Area C Chest Clinic.

K. Tuberculosis Coordinator

1. The DOC shall hire a properly credentialed and appropriately trained full-time TB Coordinator to work at the Jail by April 18, 1994.

2. The TB Coordinator shall monitor the ongoing screening program at the Jail for continuity of care and follow-up. The TB Coordinator shall be responsible for monitoring TB intake screening, inmates placed on prophylactic treatment, inmates with active disease, inmates placed in the hospital for therapy, and those placed on medical hold related to TB.

3. The TB Coordinator shall function as the liaison with the Bureau of Tuberculosis Control, D.C. General Hospital and the laboratory.

4. The TB Coordinator shall obtain a comprehensive daily list of all persons undergoing intake physical examinations with TB screening. Results of PPD tests and chest x-rays shall be placed on the appropriate forms by the medical staff and monitored daily by the TB Coordinator. The TB Coordinator shall develop a protocol for the tracking of PPD tests and chest x-rays to be approved by the Chief Medical Officer of the Jail by May 18, 1994. The TB Coordinator shall monitor all inmates receiving prophylactic treatment or treatment for active TB.

5. The TB Coordinator shall maintain an accurate account of inmates tested, cleared, inmates not tested, inmates on medical holds, and referrals for inmates released into the community.

6. The TB Coordinator shall coordinate referrals and discharge planning for inmates receiving TB prophylaxis or treatment.

7. The TB Coordinator shall monitor the case reporting to the Bureau of Tuberculosis Control to ensure that all appropriate cases are reported properly and within the required time limits.

8. The TB Coordinator shall monitor at least monthly all inmates taking anti-TB medications. Special attention shall be given to inmates who are taking other medications or who have a history of alcohol abuse or liver disease.

9. The TB Coordinator shall develop and implement an educational program regarding TB for the inmate population, including monitoring the distribution of any written materials that are to be provided to the inmates housed at the Jail.

10. The TB Coordinator shall answer directly to the

Chief Medical Officer of the Jail and shall provide information and education to other providers at the Jail. The TB Coordinator shall submit a monthly report to the Chief Medical Officer at the Jail and the Bureau of Tuberculosis Control.

11. The TB Coordinator shall coordinate in-service training which will be provided to all staff at the DOC training academy. Specialized training will be provided to clinical staff by specialists from the Public Health Commission, Bureau of Tuberculosis Control, community hospitals and from other correctional institutions regarding clinical signs, symptoms, and treatment issues involving TB.

12. The TB Coordinator shall be responsible for conducting any contact investigations when pulmonary or laryngeal TB disease is suspected or diagnosed.

13. The TB Coordinator shall be responsible for developing a tracking system to provide notification to the medical units at other DOC facilities when a patient under treatment for TB or on prophylaxis is transferred from the Jail. This duty may be delegated to another licensed health care provider, however, the TB Coordinator is responsible to ensure that it is developed and implemented.

L. **Contact Investigation**

1. Whenever pulmonary or laryngeal TB disease is suspected or diagnosed, all close contacts should be skin tested unless there is a documented history of a positive skin test. Close contacts include all cell mates, all inmates and staff on the same tier, or all inmates and staff in the same building who share air, and visitors who have shared airspace.

2. The "concentric circle" approach can be used to determine the extent of contact investigation needed. First, identify those persons who were most likely to have been infected by the source case. This first group should include: persons who shared breathing space with the source case for the longest time, persons who may have spent less time with the source case but are immunosuppressed; and persons who have TB symptoms. If positive PPD tests are identified among persons in this first group or "circle" (with no previous history of TB infection), new infections have probably occurred. Expand the investigation into widening circles until PPD testing identifies a group of persons with no evidence of new TB infection

3. If exposure was less than 10 to 12 weeks prior to PPD testing, a contact with a negative PPD test should be retested 10 to 12 weeks after the initial negative PPD test.

4. The following contacts should receive a chest x-ray:

a) those who have a positive skin test -- greater than 5 mm;
b) those with a history of a positive skin test;
c) those who are HIV positive, regardless of skin test results.

If the chest x-ray is negative for evidence of the disease, these contacts should receive preventive therapy, unless medically contraindicated.

5. During contact investigations, the confidentiality of the infected person must be maintained.

M. Screening of DOC Employees

1. All DOC staff shall be strongly encouraged to receive PPD tests annually and these tests shall be made available to all employees free of charge. The defendants shall determine whether mandatory testing can be required and shall report to the Special Officer and plaintiffs' counsel within 60 days regarding this matter.

N. Review of Protocol

1. This procedure and protocol shall be reviewed annually by the DOC Assistant Director for Health Services to determine if any revisions should be made in light of new developments in the treatment of TB. Any proposed revisions shall be submitted to the Special Officer for approval. Plaintiffs' counsel must be advised of all proposed revisions to this document.

III. Effective Date

1. The defendants shall immediately implement the policies and procedures set forth in this document.

ATTACHMENT A

D.C DEPARTMENT OF CORRECTIONS
HEALTH SERVICES

TUBERCULOSIS SCREENING

Date: _____

1. Patient has / has not had previous skin testing for tuberculosis.

2. Last PPD was done on _____ at _____ and was neg / pos.

3. Mantoux skin testing was performed on _____ by _____
(initials)

4. Date read: _____ Results: _____ mm induration which is neg / pos _____ **
(initials)

5. Chest X-Ray done on _____ is neg / positive / suspicious for active tuberculosis.

6. Recommendations: _____

_____

_____

Patient's Name: _____ DCDC #: _____
(Last) (First)

D.O.B.: _____ Race: _____ Sex: _____

** Center for Disease Control recommends that an induration of 5mm or greater in the immunocompromised be considered positive. In the non-immunocompromised host, an induration of 10mm or greater is positive.

ATTACHMENT B

PATIENT'S IDENTIFICATION	AGE	SEX	PF#	PREGNANT
NAME				☐ YES ☐ NO
DOB	EXAMINATION REQUESTED			
DCDC #	☐ ROUTINE CHEST			
FACILITY	☐ OTHER			
	REQUESTED BY		DATE OF REQUEST	

PERTINENT CLINICAL HISTORY, OPERATIONS, PHYSICAL FINDINGS, AND PROVISIONAL DIAGNOSIS

DATE OF EXAMINATION *(include year)*	DATE OF REPORT	DATE OF TRANSCRIPTION

RADIOGRAPHIC REPORT

MD SIGNATURE

RADIOLOGY REQUEST / REPORT

IDPS 1647

ATTACHMENT C

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HUMAN SERVICES

TUBERCULOSIS CASE REPORT

Name *(last)* *(first)* *(middle/maiden)*			SSN #	Date of Report / /
Address			Telephone	Date of Birth / /
Marital Status	Sex	Race ☐ Black ☐ American Indian or Alaskan Native ☐ White ☐ Asian or Pacific Islander	Ethnic Orgin ☐ Hispanic ☐ Not Hispanic	Country of Orgin if not U.S. _____ Date arrv. in U.S. _____

Occupation	School or Place of Employment	Address

Classification	Diagnosis	Bacteriology
☐ Tuberculosis: current disease ☐ Tuberculosis no current disease ☐ Tuberculosis Suspect: _____ ☐ Tuberculosis Infection No disease *(If applicable)*	☐ Pulmonary ☐ Non-Pulmonary *(specify)* ☐ Miliary ☐ Meningitis ☐ Bones & Joints ☐ Pleural ☐ Lymphatic ☐ Peritoneal ☐ Genito-Urinary ☐ Other *(specify)* ☐ Reported at time of death **SIGNS & SYMPTOMS**	PCS. NEG. Pending Not Done Smear ☐ ☐ ☐ ☐ Culture ☐ ☐ ☐ ☐ Type of Specimen ☐ Sputum ☐ Fluid ☐ Tissue ☐ Other *(specify)* _____ _____ (date(s) of collection) _____ Laboratory Performed

DHS - 1487 (Rev. 3/91) 1-1188-1 wd-360

Chest X-Ray	Tuberculin Skin Test	Chemotherapy Dosage
☐ Not done ☐ Normal ☐ Abnormal ☐ Cavitary ☐ Non-cavitary ☐ Stable ☐ Worsening ☐ Improving DATE OF X-RAY / /	☐ Not done ☐ Mantouz (PPD) ☐ Tine ☐ Other _____ *(specify)* ☐ Significant ☐ Not Significant _____ _____ mm	☐ Isoniazid _____ ☐ Ethambutol _____ ☐ Rifampin _____ ☐ Pyrazinamide _____ ☐ Streptomycin _____ ☐ Other _____ *(specify)*

atient to be followed by:

Previous diagnosis ☐ Yes date / / ☐ No

OMMENTS:

Hospitalization
Chart No. _____
Admission Date: _____
Discharge Date: _____

] Send Additional Report Forms

eported by *(Print Name)*	Signature	Office or Hospital Address

TO BE COMPLETED BY HEALTH DEPARTMENT

ɔuce No.	Ward	Census Tract	Date Recorded in Registry	Case #	Verified

ATTACHMENT D

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
WASHINGTON, D. C. 20002

IN REPLY REFER TO:

November 20, 1990
D.C. Commission of Public Health
Bureau of Tuberculosis Control
1905 E St., S.E.
Washington, D.C. 20003

To whom it may concern:

The Bureau of Tuberculosis Control, Registry, has installed a ~~Facsimile~~ (FAX) machine to be used for the expressed purpose of receiving both case and laboratory reports of suspected and confirmed tuberculosis from health care providers.

The Fax machine will be available for receiving reports 24 hours a day, including weekends. It is anticipated that the availability of the Fax machine will improve both the timeliness and the accuracy of Tuberculosis case reporting.

The District of Columbia requires, as written in the D. C. Health Regulations, for Communicable and Reportable Diseases, Chapter 5, 1963, section 8-5:104 Denomination of Communicable Diseases: "the following diseases ------Tuberculosis--------- are hereby denominated communicable diseases and shall be reported in writing within 48 hours of diagnosis or the appearance of suspicious symptoms in the manner indicated in sections 8-5:106 and 8-5:107 of this part. The transmission of case and laboratory TB reports by Fax machine within 48 hours of diagnosis, fully satisfies the reporting requirements of the D.C. Health Regulations.

The Bureau of Tuberculosis Control, Registry Fax machine telephone number is: 202-724-2363. If there are any questions regarding the use of the Fax machine, please call Glenn Acham, Supervisory Public Health Advisor, at 724-2193.

Sincerely yours,

Hazel M. Swann, M.D., Chief
Bureau of Tuberculosis Control

P.S. Enclosed is a letter to Infection Control Practitioners, dated September 18, 1990, regarding the reporting of tuberculosis cases.

DHS-107

3-82

MEDICAL EMERGENCY RESPONSE PROTOCOL

I. Introduction

The parties, in consultation with the Special Officer and her experts, agree that this Medical Emergency Protocol, filed with the Court on April 11, 1994, will govern the policies and procedures regarding the response to medical emergencies at the Central Detention Facility pursuant to the November 9, 1993 Consent Order issued in Campbell v. McGruder, C.A. No. 1462-71 and Inmates of D.C. Jail v. Jackson, C.A. No. 1462-71. The defendants understand that they are obligated to promulgate policies which implement this protocol.

II. Procedures

A. Notification and Response

1. Any employee who determines that a medical emergency exists shall immediately notify the Command Center using the Emergency Direct Line Communication system where possible, or by calling extension 38136 through 38144. If an emergency occurs in a location where there is no telephone, the employee will go to the nearest telephone, or notify the Command Center by walkie talkie. The employee will then return to the location of the emergency.

2. The employee placing the call will give all necessary information to the Command Center Officer including the location of the injured or ill person, type of injury or illness, and if the injured person is conscious.

3. The Command Center Officer will immediately page the Medical Emergency Response Team (MERT) Leader. The Command Center Officer will then immediately notify a supervisor and the Sick Call Officer by the Direct Line Communication System, and inform them of the location of the person, type of injury or illness, and if the injured person is conscious. The Command Center Officer will then make the emergency announcement over the public address system. The Command Center Officer will **only** relay the location of the injured person on the public address system. The Command Center Officer shall also notify the Shift Commander who will immediately dispatch a correctional officer to ensure the proper operation and reception of the medical elevator on the floor where the emergency exists.

4. The respective Zone Supervisor will immediately respond to the location of all medical emergencies. The Supervisor will assist the MERT and ensure full cooperation by the correctional force to include timely correctional coverage, as well as security and escort requirements. Other correctional duties may include lifting residents onto stretchers.

5. The MERT will immediately respond to all medical emergencies with the portable emergency medical cart. They will use the medical elevator for all medical emergencies. A service elevator will be used when the medical elevator is inoperable. All employees will assist the MERT as requested.

6. The MERT Leader is responsible for directing emergency care and treatment. The MERT Leader shall determine the means of transportation to D.C. General Hospital, if necessary, and shall call 911 in all life-threatening emergencies.

7. The MERT Leader shall notify the Shift Commander when an injured person must be transported to D.C. General Hospital. The MERT leader shall inform the Shift Commander of the means of transportation, i.e., 911 or DOC ambulance. The Shift Commander shall facilitate the entry of the 911 staff as well as the prompt dispatching of EMTs and other designated staff for operation of the DOC ambulance. When the DOC ambulance is inoperable, 911 will be used for all emergency transfers to D.C. General Hospital.

8. The MERT Leader is responsible for ensuring that all medical emergencies are documented on the Medical Emergency Information Form immediately after each emergency. A copy of the form is appended as Attachment A. All completed Medical Emergency Information Forms shall be filed in a MERT log. The Sick Call Officer shall record all emergency call information in the Sick Call Officer's log-book.

B. Medical Emergency Response Team Composition

1. The MERT will be composed of three medical personnel. The MERT Leader will be a physician, with two other licensed medical providers (nurses or physician assistants).

2. The Chief Medical Officer is responsible for devising and posting a MERT schedule that includes alternates. This schedule will be completed by the second Monday in January and July of each year. The posting of the schedule will be accessible to the Sick Call Officer who must review it at the beginning of each shift.

3. The MERT Leader will wear a pager while on duty at all times. The pager will be transferred from MERT Leader to MERT Leader on each shift.

C. Location and Inspection of Emergency Medical Equipment and Supplies

1. The on duty charge nurse is responsible for having the emergency medical cart and the portable crash boxes inspected at the beginning of each shift and will make an entry in the

designated log books indicative of same. The Sick Call Officer in charge is responsible for inspection of the medical elevator and on board stretcher at the beginning of each shift. The officer will ride the elevator to all floors and check the operation of the gate locks on all floors. The inspection of the medical elevator and gate locks shall be noted in the shift activity report.

2. The elevator key shall be kept in the Infirmary Control Bubble and the Emergency Medical Cart shall be located in room 326. The medical cart will be taken to all medical emergencies and a medical stretcher will be kept on the medical elevator at all times.

3. The Zone Supervisor will include as part of her/his regular duties an inspection of the medical elevators to ensure that the medical stretcher is on the medical elevator. This inspection must be conducted at least twice daily and **all efforts** will be exhausted to replace the stretcher if it is not on the elevator.

4. The Chief Nurse is responsible for ensuring that the Charge Nurse restocks the Medical Emergency Cart per the inventory sheet as prescribed after each emergency. If it is necessary to restock the Medical Emergency Cart when the pharmacy is closed, back up medication will be stored in the psychotropic medication room.

5. The security bubble on each cellblock, the medical unit and the receiving and discharge unit shall be equipped within 60 days with an Ambu Bag to assist with mouth-to-mouth resuscitation and an Addis Wonder Knife or an equivalent emergency rescue tool to assist in cutting down hanging victims. Pending the receipt and installation of this equipment, each of the above-identified security bubbles shall be equipped with blunt-nosed scissors. All correctional officers shall be trained in the most effective use of the Ambu bag, emergency rescue tool and blunt-nosed scissors within 14 days of the installation of the equipment.

D. **Ambulance Inspection and Restocking**

1. The supervisory nurse is responsible for certifying that the ambulance has been sanitized and restocked at the beginning of each shift and after each use. The nursing assistant will sanitize the ambulance. The EMT will restock the ambulance and oversee sanitizing the unit after each use. Two separate log books will be maintained: one to indicate each medical run and the other to indicate each inspection. Both log books will be certified by the Chief Medical Officer bi-weekly. Maintenance documentation will be completed by the DOC Transportation Unit.

2. The DOC ambulance assigned to the Jail will be operated and maintained in full compliance with all applicable laws

and regulations of the United States and the District of Columbia. The ambulance shall not be used for any purpose other than emergency medical transport and shall not be used in circumstances necessitating advanced life support. The DOC must certify in writing to the Special Officer and plaintiffs' counsel when the DOC ambulance can be operated in accordance with the applicable laws and regulations of the United States and the District of Columbia. Until the DOC provides this written certification, only 911 will be used for all emergency medical transports.

E. Training

1. All medical staff and correctional personnel assigned to the Detention Facility shall receive C.P.R. training and training regarding the identification and appropriate clinical response to medical emergencies through DOC's in-service training program within 30 days. The training will include the following areas: medical emergencies such as asthma, heart attacks, strokes, seizures, outward effects of diabetics, hangings and other psychiatric emergencies. Refresher training will be held each year for all staff.

2. All medical staff and officers assigned to the Detention Facility will receive training in this emergency response protocol within three weeks. Refresher training will be held for all staff on an annual basis.

F. Officers' Duties

1. The duties of each and every correctional officer described in this procedure shall be specified in their respective post orders.

III. Effective Date

1. The defendants shall immediately implement the policies and practices outlined in this protocol.

ATTACHMENT A

Medical Emergency Log Book Form

Patient's Name: _____

DCDC No.: _____

Housing Unit: _____ Date: _____

If transportation was used, circle one: 911 DOC ambulance

Time Medical Staff Notified of Emergency: _____

Time Medical Staff Responded to Patient: _____

Identity of MERT Team Members who Responded:

_____

_____

_____

Nature of Emergency: _____

_____

_____

Describe Medical Intervention: _____

_____

_____

_____

Outcome: _____

_____

_____

Full Name and Title of Staff Member Completing this Form:

_____

_____

Comments: _____

_____

THIS FORM MUST BE INSERTED IN EMERGENCY LOG

ATTACHMENT B

SUPPLY INVENTORY

Portable Emergency Box	Quantity of Supplies
Proventil	1 inhaler
Epinephrine (1:1,000) (1:10,000)	 10 injectable 1 injectable
Benadryl	1 injectable
2% Lidocaine	1 bottle
Sodium Chloride .9%	1 bottle 50 ml.
Isuprel HCL .2 mg/ml	2 vials
Narcan .4mg	1 box
Atropine .4mg	2 vials
Monoject (Insulin reaction jell)	2 packs
Ipecac	1 bottle
Nitrostat Bottle .4mg	1 bottle
Ammonia Inhalants	1 box
Surgilube	1 tube
Syringes 35cc	2
Butterflys	2
Scissors	2
Tongue Blades	12
Compazine 5 mg/ml	1 vial

Supply Inventory

Angiocaths	2
Syringes 3cc	2
Gloves	1 box
Oxygen Tubing	2
Ambu Bag and mask	1

2nd Emergency Box

Laryngoscope and blade	1
Oral Airway	2
IV tubing	2
Mask	2
Sterile Gloves	2 pair
Oxygen Mask	2
Angiocaths	2
Syringes 3cc	2
Endotracheal Tubes	3
Alcohol pads	1 box
4x4	6 packs
Oxygen tank	1
Stretcher	1
Stethoscope	1
Blood Pressure Cuff	1
Nasal Cannula	2

Supply Inventory

Tape	1 roll
IV Solution	
Lactate Ringers	1
Normal Saline	1
Flashlights	2