TN Department of Correction

TDOC
INFIRMARY PROTOCOL

Revised September 2022

Includes:

1) **Management of the Infirmary – Procedures**
2) **Appendix-Definitions & Fall Risk interventions**

Supporting TDOC Policies:

1) **#113.30 – Access to Care**
2) **#113.32 – Levels of Care**
3) **#113.34 – Extended Health Services**
4) **#113.36 – Hunger Strike**
5) **#113.87 – Mental Health Levels of Care**
6) **#113.88 – Mental Health Seclusion and Suicide Monitoring**
7) **#113.93 – Withdrawal Management Services**

DEFINITION OF INFIRMARY HOUSING

Infirmary Housing is always an area located within a correctional institution, generally near the medical clinic area within the sight or sound of staff. Infirmary housing has nursing services under the direction of a full-time registered nurse and health care personnel on duty 24 hours per day whenever an inmate remains in the infirmary housing area. The department frequently places Inmates who do not require admission to an acute care hospital in infirmary housing for various conditions and special needs.

Policy 113.32 defines Infirmary Care as care for an illness or medical condition diagnosed by an appropriate health care provider requiring medical/nursing observation and management in the facility infirmary.

This manual provides recommended documentation guidelines for medical/mental health staff providing various levels of care in infirmary housing, defining the infirmary scope of care, admission and discharge procedures, technical nursing functions, and treatment procedures.

PURPOSE OF INFIRMARY PROTOCOL MANUAL

The purpose of this manual is to define the scope of service provided in infirmary housing and to give recommendations for documentation of care provided for each service level.

Inmates with an illness or diagnosis requiring skilled care for daily monitoring, medication administration, specific therapies, or assistance with activities of daily living above the level of routine outpatient care are admitted or transferred to an infirmary setting. The Infirmary is not an acute hospital or a licensed skilled nursing facility.

The Infirmary provides skilled healthcare 24 hours a day, seven days a week for inmates with medical or mental health problems that providers cannot appropriately manage in an outpatient (general population) or sheltered housing setting.

Documentation recommendations will vary depending on the "Status" of the inmate. The department defines the housing of Inmates placed in the Infirmary as one of the following:

- Observation Status
- Short Term/Acute Care Status
- Sub-Acute Care Status
- Long Term/Chronic Care Status
- Hospice/Palliative Care Status
- Mental Health Services Status

TN Department of Correction

INFIRMARY HOUSING OVERVIEW

Observation Status:

Infirmary observation status housing is for skilled nursing observation only. Infirmary observation status and discharge are by order of a provider. Observation status is temporary and should not exceed 24 hours. Examples of conditions commonly seen for observation are: post-seizure, complaints of nausea and vomiting, neurological checks for head injuries, post-op same-day surgery/outpatient procedures, or NPO/preparation for scheduled operations.

Short-Term/Acute Status:

Infirmary housing for short-term acute skilled nursing care. Short term/Acute Status is for inmates requiring greater than 24 hours of professional nursing care. Examples of conditions commonly requiring short term/acute care include post-op surgery, S/P CVA, trauma, infections, chemotherapy and radiation therapy, long term IV therapy, respiratory isolation, or recurrent admissions to an outside hospital. Admission history and physical or discharge are by order of provider.

Sub-Acute Care Status:

This category of Infirmary housing is for sub-acute skilled nursing care. Status is for inmates with disease processes that fall between acute and chronic that requires care above medical/nursing observation but does not require care at the level of extended clinical services. Inmate has been declared clinically stable by a provider. Admission history and physical or discharge are by order of provider.

Long Term/Chronic Care Status

Infirmary housing for long-term care. Inmates placed in infirmary housing frequently have conditions or require equipment that makes them unsuitable for general population housing and requires periodic skilled medical staff attention. Admission and discharge infirmary housing for long-term care is by the provider's order.

Hospice/Palliative Care Status	Infirmary housing for hospice/palliative care. Inmates are determined to have a terminal illness with a poor prognosis (Hospice) and/or require symptom and illness management that are considered curative or life-prolonging treatments (Palliative). Admission history and physical or discharge are by order of provider.
Mental Health Services Status	Psychiatric and mental health staff supervise placement for psychiatric/therapeutic intervention. Psychiatric and mental health staff manage services. The placement of inmates with a psychiatric diagnosis is led by psychiatric and mental health staff in conjunction with security and custody needs.
Housing Status	Infirmary housing by security or level of care. These inmates will be afforded the same level of care as other inmates. The department manages These patients as general population inmates.

TN Department of Correction

INFIRMARY PROTOCOL

I. Authority: T.D.O.C. Policy # 113.32

II. Purpose: To ensure appropriate levels of care are available to accommodate inmate clinical service needs.

III. Application: To all Clinical Services Qualified Health Care Professionals

IV. Definitions:

A. Infirmary Record: A designated section of the health record shall be maintained, and documentation shall reflect the care rendered during the stay in the infirmary housing area. The infirmary documentation can be in a separate document containing Infirmary 1 = 1 housing documentation or a separate section in the inmate's general medical record designated for infirmary documentation as per TDOC policy 113.50.

B. Health Record: A chronological documentation of an inmate's medical and mental health history and treatment. The record includes but is not limited to documentation of intake health screenings, progress notes, x-ray, and laboratory reports, physicians' orders, clinic and Infirmary records, medication administration records, treatment plans, immunization records, dental records, hospital and emergency room reports, specialty consultation reports, and mental health records.

C. Provider: A physician, psychiatrist, dentist, nurse practitioner (NP), or physician assistant (PA) licensed in the state and whose scope of practice allows the holder to write medical orders for inmate care.

V. Protocol: Infirmary care shall be available to inmates of this facility for an illness or diagnosis which requires observation or medical management but does not require admission to an acute care facility.

VI. Procedures:

A. Scope: The scope of infirmary care includes but is not limited to:

1. Short-term care for inmates with self-limiting illness or injuries.

2. Long-term care for inmates with chronic medical conditions needs services that cannot be provided in the general population.

3. When proper airborne isolation is available, healthcare for inmates with certain contagious conditions such as active tuberculosis.

4. Healthcare for inmates needing convalescent care related to medical or surgical diagnostic procedures after discharge from an acute care facility.

5. Healthcare for inmates needing intravenous fluids and medications.

6. Psychiatric care for psychiatric therapeutic intervention. Care is supervised by mental health staff and is subject to the requirements of this standard.

7. Dressing changes.

8. Care/medical observation and management which do not require admission to an acute care hospital.

B. Standard of Care:

1. All care shall comply with applicable local licensing requirements, state and federal statutes, and laws.

2. The medical director is responsible for the quality of care in the Infirmary.

3. There is a provider on call or available 24 hours each day.

4. All nursing care shall be under the supervision of a registered nurse on duty 24 hours per day when patients are present.

5. The health record shall always be maintained at the nurse's station.

6. The infirmary record shall be maintained in a separate and distinct section of the complete medical record.

7. All care and treatment rendered during the infirmary stay shall be documented before the chart is returned to Medical Records.

8. A nursing care procedure manual for use in the infirmary patient's care and treatment shall be located in the Infirmary.

9. An electric call bell system is in place to give the infirmary patient access to the infirmary staff if the patient cannot always be in sight or sound of a medical staff member.

10. Bed linens shall be changed weekly or more frequently as needed.

11. Upon admission, each inmate shall be instructed regarding safety and other regulations while in the Infirmary.

12. Any inmate exhibiting nausea, vomiting, severe pain, or fever deemed medically unstable shall not be discharged.

C. Admitting Authority:

1. A provider must order an admission after assessing the inmate or telephone consultation with an LPN, RN, NP, or PA who has evaluated the inmate.

2. An LPN or RN may place an inmate in the Infirmary for observation.

D. Admission Criteria (Must meet one of the criteria listed below):

1. The inmate requires direct nursing care because of health conditions preventing them from performing daily activities.

2. The inmate requires close observation by nursing staff for safety or diagnostic purposes.

3. The inmate requires frequent treatments.

4. The inmate requires IV fluids.

5. The inmate requires pre or postoperative care as an adjunct to hospitalization.

6. Inmates requiring extensive treatment for which the facility is not equipped will be transferred to a contracted community hospital, a regional sub-acute center, or DeBerry Special Needs after consultation with the medical director of DSNF or a regional subacute center.

7. An inmate may be monitored by healthcare staff for less than 24 hours in observation status for:

   a. Ordered preparation and "nothing by mouth" status before admission to an acute care facility for a medical, surgical, or diagnostic procedure.

b. Monitoring of inmate response to a changing therapy or medication.

c. Observation following a return from an outpatient procedure or emergency room visit.

8. A Morse Fall Scale, CR-4205, shall be completed on each patient at admission and with a change in the patient's clinical status. **See Appendix for scale & training of use**

9. Once admitted to the Infirmary, the inmate's Keep On Person (KOP) medication will be collected, reconciled, and documented on the MAR to ensure the medication regiment has been followed. The drug shall be retained for future administration. When the inmate is discharged from the Infirmary, the provider shall determine if the inmate is allowed to have KOPs per Policy# 113.71. If the provider determines KOP medications are appropriate, as evidenced by the discharge orders, the medication shall be re-issued to the inmate.

E. Orders for the Infirmary shall contain at a minimum:

1. Admitting diagnosis

2. Medication orders

3. Diet

4. Activity restrictions

5. Any diagnostic tests required

6. Frequency of vital sign monitoring

7. Mental Health admissions, in addition to the above, include:

a. Designation of 15 or 30-minute irregular checks

b. Property Restrictions

c. Suicide smock

d. Paper sheets

e. No hot beverages

f. No sharps

g. Any restraint orders (therapeutic or medical)

8. The provider will develop a treatment plan and issue initial orders to provide adequate care to the inmate.

F. Assessments:

1. The LPN, RN, NP, or PA will perform an initial assessment of the injured/ill inmate to determine if infirmary care is appropriate. The evaluation will be documented in the health record on the Problem-oriented progress Record, CR-1884.

2. When the inmate's initial assessment warrants admission to the Infirmary, the LPN, or RN, will contact the provider to obtain admission orders and document on the Physicians order, CR-1892.

3. Upon admission, the admitting nurse will use the Infirmary Protocol Admission Note, CR-4308, to document a physical assessment.

4. In the following shift, a health assessment by the assigned nurse will be performed and documented within the first two hours of the change on the Infirmary Protocol Shift Note, CR-4306.

5. Nursing assessments completed on infirmary patients by an LPN must be reviewed and co-signed by an RN/Charge nurse within the first four hours of the shift. The RN shall conclude the "Assessment" and "Plan" based on the Subjective and Objective data collected by the LPN. (Nursing, 2021)

6. Rounds will be made on each inmate assigned to infirmary care by infirmary nursing staff at least every two hours and documented on the Infirmary Protocol Shift Note, CR-4306.

7. Vital signs, fluid/oral intake, bodily output, and daily weights will be performed *as ordered* by the attending provider or as indicated in Section VI. (G) (2) and documented on the Graphic Sheet, CR-4031.

8. Depending on the patient's condition and diagnosis, more rounds, assessments, and/or vital signs may be ordered.

9. The Mid-level/RN will evaluate, report, and document the inmate's physical status of abnormalities/changes to the physician daily.

10. The provider will make rounds on each inmate assigned to infirmary care according to the patient's clinical status* and document each visit in the patient's medical record. The patient's acuity can increase the provider's frequency of rounds. * *See Appendix*

G. Monitoring:

1. The RN charge nurse shall see that a licensed nurse is assigned to provide care and treatment in the Infirmary.

2. Vital signs every four hours unless otherwise ordered by the attending provider or as indicated below:

   a. Mental health patients will have vital signs once every day.

   b. DSNF Unit 7C mental health patients will have vital signs once every day.

   c. DSNF Unit 6, Unit 7A, Unit 7b, and Unit 7d mental health patients will have vital signs every month.

   d. DJRC Unit 3 assisted living patients will have vital signs every month.

   e. Inmates housed in the Infirmary only for assistance with activities of daily living (ADL) will have vital signs every month.

3. A report shall be given to the oncoming shift regarding all pertinent patient information and progress.

4. Medications shall be given dose by dose to all infirmary patients. All medications will be recorded on the Medication Administration Record (MAR).

H. Discharge:

1. A discharge order must be received from a provider.

2. Upon discharge, the provider will write the discharge order(s) in the inmate's health record on the CR-1892 and compile a discharge summary and plans for follow-up care on the CR-1884.

3. If applicable, the provider will write an order to resume KOP medications or to begin administration dose by dose.

4. At the discharge time, the discharging nurse will use the Infirmary Protocol Discharge Note, CR-4307, to document a physical assessment and file it in the infirmary section (VII) of the health record. When an LPN initiates the CR-4307, the RN shall co-sign and conclude the "Assessment" and "Plan" based on the Subjective and Objective data collected by the LPN. (Nursing 2021)

I. Documentation:

1. The LPN or RN will notate admission and discharge orders onto the Physicians Order Sheet, CR-1892, unless the provider has documented the order.

2. The Infirmary Protocol Admission Note, CR-4308*, the Infirmary Protocol Discharge Note, CR-4307*, and the Infirmary Protocol Shift Note, CR-4306, will be filed in Section VII. of the health record. **See Appendix*

3. For psychiatric admissions, a Mental Health Seclusion/Suicide/Restraint Authorization, CR-3082, must be started by the attending mental health professional or the RN in the absence of mental health staff, as per policy 113.88, and filed in Section X. of the health record.

4. The CR-3082 must have a daily entry. The nursing staff is responsible for daily entries in the absence of the mental health professional.

5. An admission order must be written on a CR-1892 to coincide with each admission note.

6. A nursing assessment must be documented on the Infirmary Protocol Shift Note CR-4306* every shift. **See Appendix*

7. Pertinent observations related to the admission diagnosis shall be recorded on the Infirmary Protocol Shift Note CR-4306* at least four hours apart. **See Appendix*

8. Neurological checks shall be documented on the Neurological Function Checklist, CR-4300. **See Appendix for Eye Pupil Chart.*

9. More frequent evaluation, assessment, and documentation are required if prescribed and indicated.

10. Infirmary staff will document infirmary rounds on the Infirmary Protocol Shift Note, CR-4306. **See Appendix*

11. The time of and reason for admission, and the time of discharge, shall be entered into the infirmary log by the admitting and discharging nurses.

12. Patients with a medical diagnosis who remain in the Infirmary for more than 24 hours will have a Nursing Care Plan, CR-4271, prepared and filed in the Infirmary Section on top in chronological order. **See Appendix*

VII. APPLICABLE FORMS: CR-4031 (Rev. 9/22), CR-4205, CR-4271, CR-4300, CR-4306 (Rev. 9/22), CR-4307, and CR-4308 (Rev. 9/22)

VIII. ACA STANDARDS: 5-ACI-6A-09, 5-ACI-6E-02, 5-ACI-6E-04, 5-ACI-2C-11

_____ ___/___/___
TDOC Chief Medical Officer Date

_____ ___/___/___
Facility Medical Director Date

_____ ___/___/___
Facility Health Administrator Date

_____ ___/___/___
Facility Behavioral Health Administrator Date

References:

Nursing, T. S. (2021). *Rules of the Tennessee Board Of Nursing, Chapter 1000-02, Rules and Regulations Licensed Practical Nursing.* Nashville: Tennessee State Board of Nursing.

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VIII. ACA STANDARDS: 5-ACI-6A-09, 5-ACI-6E-02, 5-ACI-6E-04, 5-ACI-2C-11

TDOC Chief Medical Officer — Date: 9/19/2022

Facility Medical Director — Date: ___/___/___

Facility Health Administrator — Date: ___/___/___

Facility Behavioral Health Administrator — Date: ___/___/___

References:

Nursing, T. S. (2021). *Rules of the Tennessee Board Of Nursing, Chapter 1000-02, Rules and Regulations Licensed Practical Nursing.* Nashville: Tennessee State Board of Nursing.

APPENDIX

Morse Fall Scale:

Basic Nursing Care:

- Call light in reach
- Adequate lighting
- Bed wheel locks on
- Eliminate slip hazards
- Keep area free from clutter
- Proper fitting/non-skid footwear when ambulating
- Assist with out of bed
- Frequent rounding
- Place patient in a visible location
- Patient's personal items in reach
- Review side-effects of IV medications
- Communicate risk status via plan of care and change of shift report
- Wheelchair wheel locks in "locked" position when stationary
- Consider factors that may increase the risk for falls: illness/ medication timing and side effects such as dizziness, frequent urination, unsteadiness

Standard Fall Prevention Interventions (in addition to Basic Nursing Care)

- Fall risk signs
- Side rails up
- Bed alarm
- Ambulatory aid at bedside if appropriate
- Instruct patient to call for help with toileting
- Implement toileting/rounding schedule

High-Risk Fall Prevention Interventions (In addition to Basic Nursing Care & Standard Fall Interventions)

- Consider PT consult

Nursing Care Plans (NCP):

- The Nursing Care Plan, CR-4271 will be drafted by a Registered Nurse (RN) based on the clinical nursing diagnosis as referenced using the current edition of the Lippincott Nursing Procedure publication as approved by the Chief Medical Officer/designee.

- A Licensed Practical Nurse (LPN) may participate in the development of the plan of care/action in consultation with a Registered Nurse and contribute to the evaluation of the responses of individuals or groups to nursing interventions and participate in revising the plan of care where appropriate (Nursing, 2021).

- LPNs may contribute to the nursing assessment by collecting, reporting and recording objective and subjective data in an accurate and timely manner (Nursing, 2021).

- Frequency of NCP review will be based on clinical status. * See clinical status

- Each patient in the infirmary with a medical diagnosis will maintain two active NCPs, therefore as NCP goal is met, re-evaluation and drafting of a new NCP is warranted.

DEFINITIONS: The below are utilized as applicable to *all infirmaries*

Clinical Status Change: A clinical event that signals a worsening in a patient's condition requiring notification of a physician, change in the plan of care, transfer to a higher level of care, or a marked improvement in the patient's status.

Infirmary- an area located within the correctional facility generally near the medical clinic, accommodating patients who cannot be managed safely in an outpatient setting (general population) and may not require hospitalization.

(DSNF MLOC III)

Observation Status: Inmate placed in the infirmary for skilled nursing observation only.

Common clinical scenarios include:

- Post seizure
- Complaints of nausea and vomiting
- Neurological checks for head injury
- Post-op same day for surgery/outpatient procedures
- NPO/preparation for scheduled procedures

Provider Encounter

- Infirmary observation status and discharge from observation is by order of a provider

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Short Term/Acute Care Status: Patients admitted post-hospital discharge, directly admitted from the general population and/or requiring close medical attention and skilled nursing.

Common clinical scenarios are:

- Post-op surgery
- S/P CVA
- Trauma
- Infections
- Chemotherapy and radiation therapy

- Long term IV therapy
- Respiratory isolation
- Recurrent admissions to an outside hospital

Provider Encounter

- Initial admission, and
- Daily, for the first three consecutive workdays for all facilities and then a minimum of twice a week.

Patients must be seen within 72 hours of each specialty encounter to ensure specialty recommendations are addressed timely.

Nursing Care Plan: Status of NCP review documented on the CR-4271, during each shift assessment

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(DSNF MLOC II)

Subacute Care Status: these patients have been declared clinically stable by a provider, and diagnostic workups are completed.

Provider Encounter: Weekly

Nursing Care Plan: Status of NCP review documented on the CR-4271, daily during each 1st shift assessment

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(DSNF MLOC I)

Long Term/Chronic Care Status: these patients are classified as having stable chronic illnesses and/or are awaiting transfer to Skill I or another facility. All medical conditions are stable.

Provider Encounter: every six months or more often based on acuity and chronic disease control.

Hospice/Palliative Care: these patients are determined to have a terminal illness with a poor prognosis (Hospice) and/or require symptom and illness management that are considered curative or life-prolonging treatments (Palliative).

Provider Encounter: a minimum of every three days

Nursing Care Plan: Status of NCP review documented on the CR-4271, monthly during the corresponding 1st shift assessment.

ALL MEDICAL LEVELS OF CARE must be documented in the Provider's SOAP note and the Provider's Orders. All patients will have a point of care SOAP note as they are seen by providers.

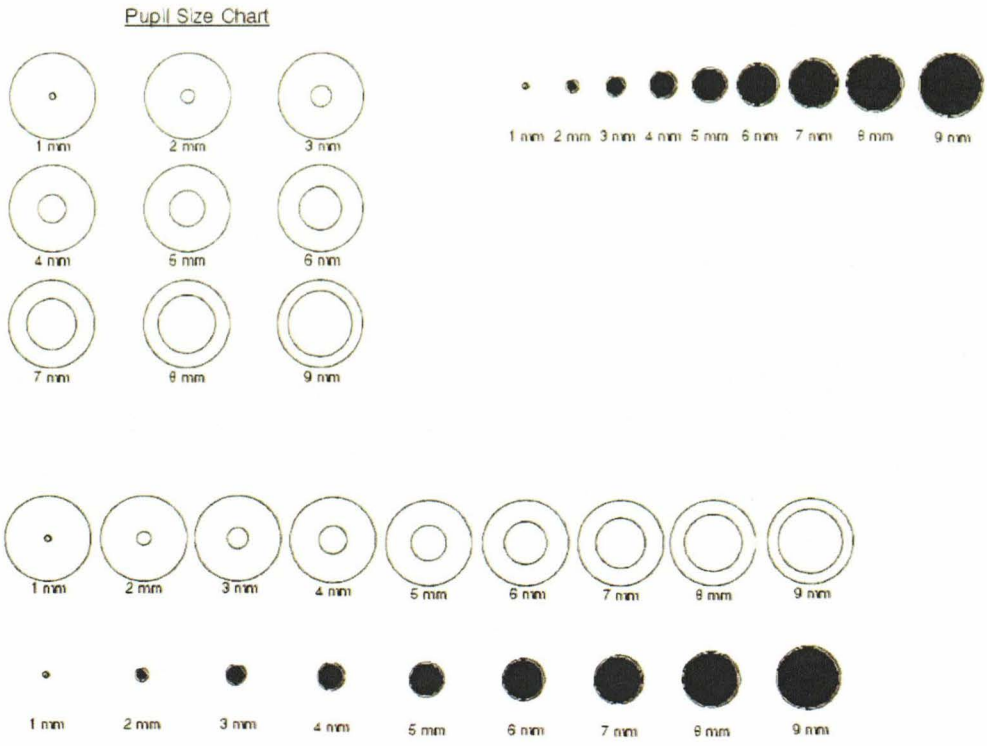
Narcan Admission/Overdose Infirmary Protocol:

When overdoses occur, patients are required to be admitted and monitored as 24-hour watch/observation in the infirmary.

- Patients should only be returned to their units from the infirmary if they are *medically and neurologically stable* – for a minimum of 24 hours

- Vital signs and neurological checks shall be ordered every two hours for the first 24 hours to assess the level of the drug induced/detox.

Once returned to housing unit the patient shall be monitored by a licensed nurse: Vital signs and neurological checks every 8 hours x 24 hours, every 24 hours x2.



ATTACHMENTS:

Graphic Sheet, CR-4031
Morse Fall Scale, CR-4205
Nursing Care Plan, CR-4271
Neurological Function Checklist, CR-4300
Infirmary Protocol Admission Note, CR-4308
Infirmary Protocol Discharge Note, CR-4307
Infirmary Protocol Shift Note, CR-4306

References:

Nursing, T. S. (2021). *Rules of the Tennessee Board Of Nursing, Chapter 1000-02, Rules and Regulations Licensed Practical Nursing.* Nashville: Tennessee State Board of Nursing.

TENNESSEE DEPARTMENT OF CORRECTION
GRAPHIC SHEET

Inmate Name: _____

(VS/I&O's) _____ Name of Facility TDOC ID: _____

DATE														
TIME														
TEMPERATURE														
PULSE														
RESPIRATIONS														
BLOOD PRESSURE S														
BLOOD PRESSURE D														
WEIGHT														
INTAKE														
ORAL														
IV SOLUTION														
PARENTAL														
SHIFT TOTAL														
24 HOUR TOTAL														
OUTPUT														
URINE														
GASTRIC (NG/Emesis)														
DRAIN (type)														
# OF STOOLS														
OTHER _____														
SHIFT TOTAL														
24 HOUR TOTAL														
INITALS														

SIGNATURE/ TITLE/INITIALS	Signature	Title	Initials	Signature	Title	Initials

TENNESSEE DEPARTMENT OF CORRECTION

MORSE FALL SCALE

_____
INSTITUTION

INMATE NAME: _____ TDOC ID: _____

Item	Item Score	Patient Score
1. History of falling (immediate or within 3 months)	No 0 Yes 25	
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	
3. Ambulatory aid None/Bed rest/Nurse assist Crutches/Cane/Walker Furniture	 0 15 30	
4. Intravenous therapy/heparin lock	No 0 Yes 20	
5. Gait Normal/bedrest/wheelchair Weak Impaired	 0 10 20	
6. Mental status Oriented to own ability Overestimates/forgets limitations	 0 15	
Total Score: Tally the patient score and record.		

Risk Level	MFS Score	Action
Low Risk	0 - 24	Basic Nursing Care
Moderate Risk	25 - 50	Implement Standard Fall Prevention Interventions
High Risk	≥ 51	Implement High Risk Fall Prevention Interventions

Actions implemented to prevent falls based on Risk Level: (Check all actions implemented)

Basic Nursing Care ☐ Standard Fall Prevention Interventions ☐

High Risk Fall Prevention Interventions ☐

_____ _____
Licensed Nurse Completing Assessment Date

TENNESSEE DEPARTMENT OF CORRECTION

NURSING CARE PLAN

_____

INSTITUTION

INMATE NAME: _____ TDOC ID: _____

Clinical Status: ☐Acute ☐Sub-Acute ☐Long-term

Date/Time Initiated	Nursing Diagnosis	Patient Goals	Nursing Interventions	Outcome Criteria

Date/Time of Review	Changes in Outcome Criteria Yes or No	Interventions Continued Yes or No	Nurse Signature and Title

TENNESSEE DEPARTMENT OF CORRECTION

INFIRMARY PROTOCOL-ADMISSION NOTE

_____
INSTITUTION

Name: _____ TDOC ID: _____

Date: _____ Time: _____ Allergies: _____

Subjective: Admitted to the Infirmary:

Reason for admission: _____

_____

Pain Scale (0-10): _____ ☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Cramping ☐ Constant ☐ Intermittent

Location of Pain: ☐ Abd ☐ Back/Neck ☐ Chest ☐ Extremity ☐ Head ☐ Other: _____

Associated Symptoms: ☐ None ☐ Nausea ☐ Vomiting ☐ SOB ☐Wheezing ☐ Fever/Chills ☐ Hives/Itching

☐ Facial/Neck Swelling ☐ Rash/ Blisters ☐ Difficulty Swallowing ☐ Anxiety/Fears

☐ Other: _____

Objective:

Vital Signs: T: P: R: BP: / O2 Sat: _____ Weight: _____

Gen Appearance: ☐ Alert, Oriented & No Distress ☐ Alert & Distressed ☐ Alert-Not Oriented ☐ Can't Stand/Walk

☐Lethargic ☐Anxious ☐Calm ☐Grimacing ☐Crying ☐Other: _____

Skin: ☐ Norm ☐ Dry ☐ Warm ☐ Moist/Clammy ☒ Pale ☐ Cyanotic ☐ Jaundice ☐ Diaphoretic

Tone: ☐Pink ☐Flushed ☐Pallor ☐Cyanotic ☐Ashen ☐Jaundiced ☐Other: _____

Turgor: ☐Normal ☐Delayed *Mucous Membranes*: ☐Moist ☐Dry ☐Pink ☐Blue/Gray

Pupils: ☐ Reactive ☐ Symmetrical ☐ Sluggish ☐ Dilated ☐ Pinpoint ☐ Asymmetrical ☐ Accommodating

Pulses: ☐Even ☐Uneven ☐Strong ☐Weak ☐Bounding ☐ Thready ☐Unable to palpate (Location): _____

Capillary refill: ☐< ☐ > 3 seconds

Lungs Sounds: ☐ Norm (CTA) ☐ Decreased ☐ Wheezing ☐ Crackles ☐ Absent *Location:* ☐RUL ☐RLL ☐LUL ☐LLL

Heart Sounds: ☐ Norm ☐ Extra Sounds **EXT Edema (1-4+)** ☐ None LU_____ RU_____ LL_____ RL_____

Abdomen: ☐Flat ☐Distended ☐Soft ☐Rigid *Guarding*: ☐RUQ ☐RLQ ☐LUQ ☐LLQ

Tenderness: ☐Flat ☐Rebound ☐Diffuse ☐Localized *Area*: ☐RUQ ☐RLQ ☐LUQ ☐LLQ

Muscle Strength (1-5/5) ☐ Norm Bilaterally LU_____ RU_____ LL_____ RL_____

Reflexes: ☐ Norm Bilaterally ☐ Absent: LU_____ RU_____ LL_____ RL_____

Bowel Sounds: ☐Present all 4 quads ☐Hypoactive ☐Hyperactive ☐Normal ☐Absent

Emesis: ☐None ☐Clear ☐Gastric ☐Undigested food ☐Bright red ☐Dark red ☐Coffee ground

Additional Notes: _____

_____

_____

**Use blank CR-1884 for addl. Documentation*

Assessment: _____

Plan: _____

_____ _____ _____
LPN Signature Printed Name Date

_____ _____ _____
RN Signature Printed Name Date/Time

TENNESSEE DEPARTMENT OF CORRECTION

INFIRMARY PROTOCOL-DISCHARGE NOTE

_____
INSTITUTION

Name: _____ TDOC ID: _____

Date: _____ Time: _____ Allergies: _____

Subjective: Orders received to Discharge from the Infirmary:

Reason for Discharge: _____

_____

Pain Scale (0-10): _____ ☐ Sharp ☐ Dull ☐ Burning ☐ Stabbing ☐ Cramping ☐ Constant ☐ Intermittent

Location of Pain: ☐ Abd ☐ Back/Neck ☐ Chest ☐ Extremity ☐ Head ☐ Other: _____

Associated Symptoms: ☐ None ☐ Nausea ☐ Vomiting ☐ SOB ☐Wheezing ☐ Fever/Chills ☐ Hives/Itching

☐ Facial/Neck Swelling ☐ Rash/ Blisters ☐ Difficulty Swallowing ☐ Anxiety/Fears

☐ Other: _____

Objective:

Vital Signs: T: P: R: BP: / O2 Sat: _____ Weight: _____

Gen Appearance: ☐ Alert, Oriented & No Distress ☐ Alert & Distressed ☐ Alert-Not Oriented ☐ Can't Stand/Walk

☐Lethargic ☐Anxious ☐Calm ☐Grimacing ☐Crying ☐Other: _____

Skin: ☐ Norm ☐ Dry ☐ Warm ☐ Moist/Clammy ☐ Pale ☐ Cyanotic ☐ Jaundice ☐ Diaphoretic

Tone: ☐Pink ☐Flushed ☐Pallor ☐Cyanotic ☐Ashen ☐Jaundiced ☐Other: _____

Turgor: ☐Normal ☐Delayed *Mucous Membranes*: ☐Moist ☐Dry ☐Pink ☐Blue/Gray

Pupils: ☐ Reactive ☐ Symmetrical ☐ Sluggish ☐ Dilated ☐ Pinpoint ☐ Asymmetrical ☐ Accommodating

Pulses: ☐Even ☐Uneven ☐Strong ☐Weak ☐Bounding ☐ Thready ☐Unable to palpate (Location): _____

Capillary refill: ☐< ☐ > 3 seconds

Lungs Sounds: ☐ Norm (CTA) ☐ Decreased ☐ Wheezing ☐ Crackles ☐ Absent *Location:* ☐RUL ☐RLL ☐LUL ☐LLL

Heart Sounds: ☐ Norm ☐ Extra Sounds **EXT Edema (1-4+)** ☐ None LU_____ RU_____ LL_____ RL_____

Abdomen: ☐Flat ☐Distended ☐Soft ☐Rigid *Guarding*: ☐RUQ ☐RLQ ☐LUQ ☐LLQ

Tenderness: ☐Flat ☐Rebound ☐Diffuse ☐Localized *Area*: ☐RUQ ☐RLQ ☐LUQ ☐LLQ

Muscle Strength (1-5/5) ☐ Norm Bilaterally LU_____ RU_____ LL_____ RL_____

Reflexes: ☐ Norm Bilaterally ☐ Absent: LU_____ RU_____ LL_____ RL_____

Bowel Sounds: ☐Present all 4 quads ☐Hypoactive ☐Hyperactive ☐Normal ☐Absent

Emesis: ☐None ☐Clear ☐Gastric ☐Undigested food ☐Bright red ☐Dark red ☐Coffee ground

Additional Notes: _____

_____

_____

**Use blank CR-1884 for addl. Documentation*

Assessment: _____

Plan: _____ **Discharge to**: ☐ Housing Unit ☐Other: Location: _____

_____ _____ _____
LPN Signature Printed Name Date

_____ _____ _____
RN Signature Printed Name Date

TENNESSEE DEPARTMENT OF CORRECTION

INFIRMARY PROTOCOL-SHIFT NOTE

_____
INSTITUTION

Name: _____ TDOC ID: _____

Date: _____ Time: _____ Allergies: _____

SUBJECTIVE:

Pain Scale (0-10): _____ Describe: _____

Location of Pain: _____

Associated Symptoms: _____

OBJECTIVE

Vital Signs: T: P: R:

BP: / O2 Sat:

Lungs Sounds:☐ Norm (CTA) ☐ Decreased ☐ Wheezing ☐ Crackles ☐ Absent *Location:* ☐RUL ☐RLL ☐LUL ☐LLL

Gen Appearance: ☐ Alert, Oriented & No Distress ☐ Alert & Distressed ☐ Alert-Not Oriented ☐ Can't Stand/Walk ☐Lethargic ☐Anxious ☐Calm ☐Grimacing ☐Crying Other:_____

Heart Sounds: ☐ Norm ☐ Extra Sounds
EXT Edema (1-4+) ☐ None LU_____ RU_____ LL_____ RL_____

Skin: ☐ Norm ☐ Dry ☐ Warm ☐ Moist/Clammy ☐ Pale ☐Cyanotic ☐ Jaundice ☐ Diaphoretic

Tone: ☐Pink ☐Flushed ☐Pallor ☐Cyanotic ☐Ashen ☐Jaundiced ☐Other: _____

Turgor: ☐Normal ☐Delayed *Mucous Membranes*: ☐Moist ☐ Dry ☐Pink ☐Blue/Gray

Pupils: ☐ Reactive ☐ Symmetrical ☐ Sluggish ☐ Dilated ☐ Pinpoint ☐ Asymmetrical ☐ Accommodating

Pulses: ☐Even ☐Uneven ☐Strong ☐Weak ☐ Bounding ☐ Thready ☐Unable to palpate (Location):_____

Capillary refill: ☐< ☐ > 3 seconds

Abdomen: ☐Flat ☐Distended ☐Soft ☐Rigid *Guarding*: ☐RUQ ☐RLQ ☐LUQ ☐LLQ *Tenderness:* ☐Flat ☐Rebound ☐Diffuse ☐Localized *Area*: ☐RUQ ☐RLQ ☐LUQ ☐LLQ

Muscle Strength (1-5/5) ☐ Norm Bilaterally LU_____ RU_____ LL_____ RL_____ **Reflexes:** ☐ Norm Bilaterally ☐ Absent: LU_____ RU_____ LL_____ RL_____

Bowel Sounds: ☐Present all 4 quads ☐Hypoactive ☐Hyperactive ☐Normal ☐Absent **Emesis:** ☐None ☐Clear ☐Gastric ☐ Undigested food ☐Bright red ☐Dark red ☐Coffee ground

Shift rounds:

Time: _____ ☐**Assessment unchanged**

Time: _____ ☐**Assessment unchanged**

Time: _____ ☐**Assessment unchanged**

Time: _____ ☐**Assessment unchanged**

Time: _____ ☐**Assessment unchanged**

Time: _____ ☐**Assessment unchanged**

Additional Notes: _____

_____

_____

_____

**Use blank CR-1884 for addl. Documentation*

_____ LPN Signature

_____ Printed Name

_____ Date

_____ RN Signature

_____ Printed Name

_____ Date/Time