

IRISH PRISON SERVICE
HEALTH CARE STANDARDS

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Introduction

- **The need for a broad based set of health care standards to guide the provision of health services to prisoners has been identified in various reports, specifically in various Annual Reports of the Director of Prison Medical Services and in the Report of the Group to Review the Structure and Organisation of Prison Health Care Services (ch. 2.3). Recognising this, the Prison Service Strategy Statement for 2001 - 2003 has identified (Target 8.2) as a core target in the care area the need to define a set of health care standards.**
- **This document specifically refers to prisoner health care.**
- **These standards have been developed by a multidisciplinary group representing the various health related interests involved in prisoner health care.**
- **The standards recognise not only the need to define the services to be provided but also that the effectiveness of such services should be measurable.**
- **These standards are based on health care activities which are operationally essential taking account of the prison context, reflect good clinical practice within the general community, and are cost effective. It is desirable that all such activities are undertaken by staff who are professionally accountable.**
- **It is intended that these standards will provide Governors and other managers with clear guidance regarding the health services to be provided and the facilities required to provide them. The various criteria and targets outlined will assist in assessing whether or not the standards are being met.**

- **The standards outlined in this document are intended to assist in the formulation of the health care aspects of local Business Plans.**
- **For various health care staff - Doctors, Nurses, Dentists, Medical Orderlies, etc., the standards provide guidance regarding the range of health care services to be provided in accordance with good practice guidelines.**
- **Similarly, prisoners are provided with an outline of the level of service which they may expect to receive.**
- **These standards are intended to take account of similar approaches elsewhere as well as reflecting good clinical practice in the general community. They are set nationally in order to achieve consistency of care for all prisoners, regardless of location, which reflect the standards of care available to citizens covered by the General Medical Scheme (GMS) in the general community.**
- **It is recognised that the health care currently provided to prisoners is generally of a high standard. The purpose of defining various standards, etc., is to facilitate the implementation of a consistent level of care across the prison estate and to provide a mechanism whereby excellence can be acknowledged and any deficits addressed.**
- **Local prison business plans should outline envisaged time scales, targets, etc..**
- **The standards outlined in this document will constitute envisaged targets which will be audited on an annual basis. These standards will be reviewed annually and revised accordingly.**

Health Care Services : Core Aims and Underpinning Philosophical Values

Aim of Health Care

- The aim of Health care within the Irish Prison Service is to provide prisoners with access to the same quality and range of health services as that available to those entitled to GMS services in the community
- Priority is given to the promotion of health through the positive intervention of staff.

Philosophical Values

- Given the nature of imprisonment it is accepted that in the interests of overall prison operation it is essential that those detained be treated in a fair and consistent manner. In the context of custodial health care provision all prisoners, regardless of personal means, are regarded as citizens covered by the General Medical Scheme.
- The Prison Health Care Service is committed to treating all prisoners with dignity accepting that, notwithstanding the limitations on personal autonomy imposed by imprisonment, they should be directly involved in their health care. (See HC Policy A/1 - 'Complaints from Prisoners regarding Medical Treatment')
- All prison health care is provided on the basis of the same standards of consent and confidentiality as exist in the general community. (See HC Policy A/2 - 'Guidance for Healthcare Staff in Relation to the Responsibility to Safeguard the Confidentiality of Medical Information concerning Prisoners').
- In relation to the involvement of prisoners in health research projects please refer to HC Policy A/3 - 'Health Research Projects involving Prisoners'.

Notes on Format and Terminology

Each section of this set of health care standards

- defines the particular standard,
- outlines the criterion or criteria by which the particular standard is measured, and
- may indicate a target which would be reasonable to achieve.

These are defined as follows -

Standard : An item in relation to a particular aspect of Health Care by which the quality of that item may be measured.

Criterion : A single variable selected to facilitate the measurement of an element of care.

Target : The specification of the expected level of achievement.

Example :

To illustrate the above terms the following examples are offered :

Reception Assessment -

Standard : All prisoners to be medically assessed on reception.

Criterion : A nursing assessment be undertaken in the reception area.

Target : All receptions should have a thorough clinical assessment by a medical practitioner within 24 hours of entering prison.

Health Care Standard 1 :

Health Assessment on Initial Reception into Prison from the Community

Standard

1. All prisoners on reception will undergo a clinical assessment.
2. Initial Committal assessment will be carried out on the day of reception in the reception area or other appropriate clinical area. It is desirable that this initial committal assessment be undertaken by a qualified nurse in view of the various healthcare issues which may arise. In those prisons where nursing staff are not consistently available this function can be undertaken by medical orderlies.
3. Within 24 hours of reception a doctor will undertake a clinical assessment of the prisoner's physical and mental health.
4. Suitable interview and examination rooms which are properly equipped and maintained will be provided within the reception area and/or other suitable area within the prison.

1.1 Criteria: Organisational Matters

- 1.1.1 The reception process should be organised in such a way as to allow adequate time for initial screening by a Nurse.
- 1.1.2 The Governor, or other officer deputed by him, will be responsible for ensuring that any prisoner who is to undergo medical examination and assessment is produced for that purpose. He is also responsible for ensuring that information received from outside sources at the time of reception concerning the health status of a prisoner is relayed to the Nurse or Doctor.
- 1.1.3 The Governor is responsible for the maintenance of good order in any designated health care area of the prison.
- 1.1.4 A Nurse or, where a nurse is not available, a Medical Orderly will be available to assess and attend to the immediate health care needs of any prisoner on reception.

- 1.1.5 Initial health care screening will be carried out on the day of reception by a Nurse or Medical Orderly. This should occur in the Reception area or other appropriate clinical area prior to any cell allocation.
- 1.1.6 A Doctor will be available for consultation, either in person or by telephone, to address any urgent clinical concerns arising in relation to a newly received prisoner.
- 1.1.7 All prisoners will receive within 24 hours of reception a physical and mental health assessment by a Doctor. This should include examination of Heart, Lungs, Abdomen, CNS, and any other examination deemed appropriate by the doctor.
- 1.1.8 Any prisoner who refuses healthcare assessment will be required to sign a disclaimer to this effect. This disclaimer should be placed on his/her health care record and should be brought to the attention of the responsible doctor and be followed up by a nurse who should continue to offer medical assessment.
- 1.1.9 The weight (in kilograms) of the prisoner will be recorded at the time of each admission. The height (in centimetres) will be recorded on first admission only.
- 1.1.10 Each prisoner will be provided with information in a format understandable to him/her to explain how health care services are provided and how to seek help.
- 1.1.11 All health care interviews will be carried out in such a manner as to ensure the privacy and confidentiality of the interaction except where in the opinion of the health care staff, and based on advice from other prison staff, the prisoner requires an escort on the grounds of security.
- 1.1.12 Properly equipped and maintained interview/examination rooms will be provided within the reception area and/or other agreed place in the prison.
- 1.1.13 All health care records will be completed promptly and maintained accurately in computerised format. Such records will be kept in accordance with legal requirements and any professional ethical guidance.

1.2 Criteria: Initial Nursing Screening

Please refer to Standard – Item 2 above (relating to Initial Committal Assessment).

- 1.2.1 Sufficient time and adequate privacy will be allowed for each initial screening.
- 1.2.2 The Nurse will assess the prisoner's general health and will encourage discussion with the prisoner regarding health care matters.
- 1.2.3 The Nurse will assess the prisoner's self-injury/suicide risk and, if necessary, advise on appropriate immediate precautions.
- 1.2.4 If the prisoner is considered to be in urgent need of treatment the Nurse will consult the responsible Doctor immediately. Any action taken will be recorded in the health care record.
- 1.2.5 The Nurse will ensure that the initial screening record, together with any other related documentation, is made available to the Doctor carrying out the clinical examination of the prisoner. A summary of the nursing assessment must be documented in the Nurses notes. This summary must indicate conclusion as to the patient's health status.

1.3 Criteria: Doctor's Examination

- 1.3.1 The Doctor will carry out, in conditions appropriate to safeguard confidentiality, an assessment of the physical and mental state of every new prisoner, having due regard to information obtained during the committal interview.
- 1.3.2 Urgent cases will be seen on the day of reception. Under normal circumstances medical assessment will be undertaken on the day following reception. Adequate time should be available to enable a thorough consultation. (See HC Policy A/4 - 'Medical Assessment of New Reception').
- 1.3.3 The Doctor will take a medical and psychiatric history together with a history of substance misuse, including details of alcohol use, misuse of prescribed medication and/or illicit drug use and record the information on PMRS.

- 1.3.4 The Doctor will make specific enquiry regarding signs or symptoms relating to suicide or self-injury behaviour, depression, infectious diseases, and substance misuse and record the information on PMRS.
- 1.3.5 Any necessary or appropriate physical examination will be carried out. The physical examination will include examination of Heart, Lungs, Abdomen, CNS, and any other examination deemed appropriate by the doctor.
- 1.3.6 If further investigation or specialist examination is required this will be arranged by the Doctor.
- 1.3.7 Examination of a prisoner's mental health status should include account of any known psychiatric history, particularly in-patient admissions, alcohol and substance abuse, and any history of self-injury.
- 1.3.8 Where appropriate the Doctor will refer those with psychiatric illness to the visiting Psychiatrist for further assessment. Prisoners deemed to require psychiatric in-patient care should be transferred to an appropriate location under the terms of the appropriate legislation.
- 1.3.9 The Doctor will assess the prisoner's self-injury/suicide risk and, if necessary, advise on appropriate immediate precautions.
- 1.3.10 In the case of those prisoners suffering from chronic diseases (e.g. Asthma, COPD, Diabetes, Hypertension, Ischaemic Heart disease, Epilepsy, etc.), the Doctor will carry out a review of the management of the condition and compliance with treatment, and will consider the need for specialist review and other investigations.
- 1.3.11 Appropriate screening for communicable diseases (TB, HIV, Hepatitis) should be carried out (See HC Policy C/1 - 'Screening for Infectious or Communicable Diseases' and Appendix 2 - 'Protocol for the Management of Tuberculosis in Prison')
- 1.3.12 As in the general community there is an obligation on Prison Doctors to notify statutory public health authorities of any cases of a notifiable disease occurring in the prisoner population. (See HC Policy C/2 - 'Notifiable Diseases').
- 1.3.13 In relation to the conditions listed above (and any other relevant illnesses) a programme of regular review will be commenced.
- 1.3.14 On the basis of clinical assessment the Doctor will advise in relation to the prisoner's health care needs and location within the prison.

- 1.3.15 The Doctor will advise in relation to the prisoner's fitness for work and other occupation within the prison.
- 1.3.16 Requests from prisoners for access to healthcare on a private basis should be guided by HC Policy A/5 - 'Private Medical Arrangements by Prisoners'

1.4 Criteria: Facilities and Equipment

- 1.4.1 Each room provided for Nursing/Medical interview or examination will be of sufficient size to accommodate at least three people in comfort together with fixtures, furnishings and equipment.
- 1.4.2 Each interview/examination room will be equipped with a desk/table, three chairs, examination couch, wash basin, PMRS access, and secure storage for confidential papers. In addition each room used for medical examination will be equipped with a sphygmomanometer, scales, stethoscope, ophthalmoscope, auroscope, and eyecharts.
- 1.4.3 All rooms will be cleaned according to current infection control standards, well maintained and comfortably heated to current building and design standards.
- 1.4.4 All health care locations will be provided with a telephone with direct dialling facilities to the outside that can be disconnected when necessary.
- 1.4.5 Each Health Care Centre will have a Fax Machine, photocopier, and shredder.
- 1.4.6 Each clinical consulting room will be provided with access to the Prisoner Medical Record System (PMRS).
- 1.4.7 Requests for the provision of Medical Equipment should be in line with HC Policy A/6 - 'Acquisition of Medical Equipment'.

Health Care Standard 2:

Primary Care

Standard

1. Primary Care Services will be provided to a standard equivalent to that available in the general community (GMS standard).
2. Suitable, properly equipped accommodation and facilities for the delivery of primary care will be provided.
3. Access to specialist services appropriate to the health care needs of prisoners will be provided within the prison.
4. Efficient arrangements for referral to external outpatient facilities will be in place.

2.1 Criteria: Organisational Matters

- 2.1.1 A Primary Health Care Service will be provided on a 24 hour basis in closed prisons. A close working relationship will be developed between Health Care staff and relevant prison management. Appropriate arrangements will be made to ensure that all relevant staff are aware of the care plans for prisoners for whom they are responsible, and of their part in carrying out the plan.
- 2.1.2 A Nurse will be available to undertake nursing assessment on a 24 hours basis where appropriate.
- 2.1.3 A Doctor will be on call and available for consultation at all times outside normal hours of attendance and will attend as necessary.
- 2.1.4 Appropriate administrative support will be provided.
- 2.1.5 All aspects of primary health care will be provided as clinically appropriate (See HC Policy A/7 - 'Recruitment / Engagement of Medical or Therapeutic Staff' and HC Policy A/8 - 'Provision of Para-Medical Therapies at State Expense')
- 2.1.6 Urgent cases will always be seen as appropriate.

- 2.1.7 Requests for Healthcare interventions can be undertaken by a member of the health care team and any necessary follow-up arranged.
- 2.1.8 The Governor will ensure that prisoners who are required to see a Healthcare professional attend the Health Care Centre in good time. In the case of open centres the onus lies with the prisoner to make him/herself available to see the Healthcare professional.
- 2.1.9 Accurate Health Care Records will be maintained on all prisoners. Records should be maintained in the Prisoner Medical Record System (PMRS).
- 2.1.10 All health care record entries will be signed and dated by the health care staff directly responsible for providing treatment as appropriate.
- 2.1.11 Prisoners will be allowed access to their personal health care records in accordance with good clinical practice guidelines and any legislative provisions pertaining.
- 2.1.12 In relation to requests for medical reports concerning prisoners guidance is available in the following -
- HC Policy A/9 - 'Requests for Medical Reports on Prisoners'
 - HC Policy A/10 - 'Requests for Medical Information on Prisoners by the Parole Board.'
 - HC Policy A/11 - 'Freedom of Information Act'.
 - HC Policy A/12 - 'Repatriation of Prisoners under the terms of the European Convention on the Transfer of Sentenced Prisoners'.
 - HC Policy A/13 - 'Annual Medical Reports'

2.2 Criteria: Referral to External Hospitals

- 2.2.1 Prisoners will be referred to external specialist services as clinically indicated. Referral will be on the same basis as for citizens in the general community covered by the GMS (Medical Card) scheme.
- 2.2.2 Where a prisoner is committed with existing medical appointments procedural guidance is provided in HC Policy A/14 - 'Extant Medical Appointments on Committal'.
- 2.2.3 Decisions regarding where a prisoner should be referred should be a matter for clinical judgement, taking into account operational considerations.

- 2.2.4 Referrals should be accompanied by all relevant information. Where practical extracts from the prisoner's Health Care Record, including a clinical summary, will be provided to the receiving hospital. All referral letters will be generated on PMRS.
- 2.2.5 Any emergency attendance at an outside hospital will be effected with appropriate urgency.
- 2.2.6 Arrangements will be made by the Governor to ensure that prisoners keep appointments. In the event for operational reasons that such appointments are cancelled, the Governor is responsible for consulting or informing Healthcare.
- 2.2.7 It is important to keep prisoners appraised of the status of any external hospital appointment while bearing in mind the need to maintain security around exact dates.

2.3 Criteria: Prison-Based Specialist Services

- 2.3.1 Where appropriate, arrangements will be made with local H.S.E. or other health service providers, or with individual practitioners for the provision of specialist advice and treatment.
- 2.3.2 Prisoners will be referred to specialist services on the same basis as would apply to individuals holding Medical Cards in the general community (See HC Policy A/15 - 'Referral for Specialist Medical Assessment').
- 2.3.3 Arrangements will be made by the Governor to ensure that prisoners keep appointments.
- 2.3.4 Visiting Specialists will be provided with suitable accommodation and clinical facilities for their consultations. Arrangements will be in place to ensure that they are not unreasonably delayed either on arrival at the prison or in the course of consultations.

Health Care Standard 3:

Mental Health Services

Standard

1. To provide an integrated service that meets the needs of prisoners suffering from mental disorder. Services should include appropriate implementation of, a) policy on preventing self-injury among prisoners and, b) relevant mental health legislation.

3.1 Criteria - Organisational Matters

- 3.1.1 Suitable arrangements will be made for the provision of appropriate mental health services, including consultant psychiatric and other related services. The psychiatrist will attend the prison for assessment of referrals, routine reviews, etc.
- 3.1.2 The care regime available to prisoners will be multidisciplinary. Good working links should be established with relevant health and social services.
- 3.1.3 Appropriate use will be made of voluntary agencies such as the Samaritans or a counselling service.
- 3.1.4 Co-ordination of throughcare with local (Health Service Executive) mental health services will be developed.
- 3.1.5 The Governor will make arrangements to ensure that prisoners are available to be interviewed by visiting psychiatrists or CPNs at the appointed time, that such visiting psychiatric professionals are accorded speedy access to patients and their records, and that facilities for a confidential consultation are available.
- 3.1.6 Appropriate administrative support will be provided.
- 3.1.7 Any prisoner considered unfit to remain in prison will be referred to an appropriate specialist for assessment and opinion.
- 3.1.8 Health Care staff will be familiar with pertinent mental health legislation and its application in the prison context.

3.2 Criteria - Aspects of Care

- 3.2.1 A Mental Health Nurse should be available to provide specialist nursing care and advice where necessary.
- 3.2.2 Continuity of care will be provided.
- 3.2.3 A close working relationship will be developed between Health Care staff and relevant prison management. Appropriate arrangements will be made to ensure that all relevant staff are aware of the care plans for prisoners for whom they are responsible, and of their part in carrying out the plan.
- 3.2.4 Individualised care plans should be developed and maintained.
- 3.2.5 Any referrals to the visiting psychiatrist must be made either through, or in consultation with, the Prison Doctor.

3.3 Criteria - Suicide and Self-Injury Strategy

- 3.3.1 The prison Suicide Review Group will prepare and keep under review a local strategy for the care of the suicidal and the reduction of self-harm. This strategy should reflect national guidelines.
- 3.3.2 Membership of the prison Suicide Review Group should include members of the health care team.
- 3.3.3 All health care staff will be aware of, and follow, documentary procedures required by the IPS in the event of an incident of suicide or self-injury.
- 3.3.4 It will be a recognised duty of all members of staff to be alert to the feelings and actions of prisoners which may be indicative of suicide or self-harm risk and to take appropriate action.
- 3.3.5 In all cases of deliberate self-harm a Doctor or appropriate clinician will interview the prisoner in depth, seek to establish the reasons for the action, and organise any appropriate further clinical intervention. (See HC Policy C/3 - 'Food Refusal within Prison - Management Protocol').
- 3.3.6 Prisoners considered to be suicidal will be cared for in appropriate accommodation. (See HC Policy A/16 - 'Special Observation Lists (Medical)')

- 3.3.7 Seclusion should be used strictly in accordance with the Prison Rules 2007 and best clinical practice and in the case of prisoners considered to be at risk of suicide only as a short-term measure of last resort.
- 3.3.8 Appropriate shared accommodation should be available to facilitate the support and observation of vulnerable prisoners.
- 3.3.9 Arrangements should be made for the Samaritans or other suitably trained voluntary helpers (who may include prisoners) to be involved in befriending and supporting prisoners at risk.
- 3.3.10 Where a prisoner considered to be at risk of suicide or self-injury is transferred within or to another institution for any reason, suitable arrangements will be made to ensure that appropriate contact and monitoring is maintained. The Nurse Manager will ensure that an appropriate system is in place to notify the Healthcare staff at the receiving institution.

3.4 Criteria - Facilities

- 3.4.1 Where appropriate there should be specific accommodation for those with mental health problems. The design of such accommodation should be such as to enable disturbed or noisy prisoners to be separated from others.

Health Care Standard 4:

Transfer, Release and Throughcare

Standard

1. To ensure that the health care needs of prisoners are considered and taken into account before transfer to another prison and that these needs are provided for during transfer and on reception at the receiving prison.
2. To ensure that all prisoners with ongoing health care needs are assessed by a Doctor or Healthcare professional prior to planned release (and appropriate arrangements made for follow-up).

4.1 Criteria- Transfer to another prison

- 4.1.1 Prisoners being considered for transfer will be assessed regarding their health care needs and fitness to travel.
- 4.1.2 The Health Care Team of the sending prison will have access to data regarding the planned transfer of a prisoner and will arrange the assessment accordingly. (See HC Policy A/17 - 'Notification of the Impending Transfer of a Prisoner to Healthcare Staff').
- 4.1.3 The Nurse Manager will ensure that a system is in place to ensure all relevant clinical information will be communicated to the receiving prison to ensure continuity of care.
- 4.1.4 Prisoners requiring special nursing care or supervision while being transferred to another prison establishment will be accompanied by a Nurse.
- 4.1.5 In considering planned transfers due attention will be given to the issue of outstanding hospital appointments or pending in-patient procedures.
- 4.1.6 A prisoner's medical file must be transferred with him/her. (See HC Policy A/18 - 'Access to Medical files on Transfer').
- 4.1.7 Where medication has been dispensed for a patient, this will be transferred with him/her.
- 4.1.8 For transfer or release of prisoners availing of drug treatment services reference Healthcare Administrative policy A/24.

4.2 Criteria - Reception following Transfer

- 4.2.1 All prisoners received on transfer will have a Nursing assessment undertaken on reception (analogous to that outlined in HCS 1 above).
- 4.2.2 All transferred prisoners will receive within 24 hours a physical and mental health interview and assessment by a Doctor.
- 4.2.3 Any prisoner on ongoing medical treatment will have the treatment reviewed by the receiving Doctor and appropriate follow-up arrangements made as necessary.

4.3 Criteria: Release and Throughcare

- 4.3.1 The health care record of all prisoners under clinical supervision and/or receiving treatment immediately prior to release will be reviewed by the Doctor.
- 4.3.2 Any prisoner on prescribed medication will be provided with a prescription to maintain his/her treatment until s/he can consult his/her own General Practitioner.
- 4.3.3 Where there is a need for continuing care this will be communicated to the relevant agencies (GP/Hospital/Clinic) in the general community.
- 4.3.4 Any prisoner who, at the time of release, has pending hospital appointments will be given written notice of these on release.
- 4.3.5 A discharge summary will be prepared as necessary by the Prison Doctor. A letter signed by the doctor should be prepared providing information on the current treatment provided to the prisoner, any medication supplied to the prisoner on release and any outstanding medical appointments. This letter should be given to the prisoner on release to furnish to their GP.

Health Care Standard 5:

Clinical and Related Services for Promoting Health

Standard:

1. To provide services to prisoners which may prevent illness and promote health.
2. To provide prisoners with the information and opportunity to enable them to make reasoned choices regarding the adoption of a healthy lifestyle.

5.1 Criteria: Services to be Provided

- 5.1.1 These services will be delivered to prisoners by staff trained in relevant aspects of clinical practice and health promotion or by outside specialists/external agencies with relevant expertise.
- 5.1.2 Subjects addressed by the services will include (but not be confined to) those relevant to the prevention of:
 - HIV/AIDS
 - Hepatitis
 - Drug addiction/dependency
 - Misuse of Alcohol
 - Coronary Heart Disease & Stroke
 - Smoking
 - Mental Illness & Stress
 - Sexually Transmitted Diseases
 - Cervical Cancer
 - Dental disease
- 5.1.3 Health care staff will offer regular screening to defined prisoner groups (e.g. Women; Men over 45 years, etc.) which mirrors recommended clinical guidelines in the general community.
- 5.1.4 The Irish Prison Service will aim to promote a healthy lifestyle by including the implementation of a 'No-Smoking' policy. (See HC Policy C/4 - 'Nicotine Replacement Therapy').
- 5.1.5 Relevant external agencies will be accessed to ensure that all staff involved in health promotion keep up to date with current theory and practice and have access to appropriate teaching materials.

- 5.1.6 Staff involved in health promotion will encourage the provision for staff and prisoners of physical environments (including no smoking areas) conducive to health.
- 5.1.7 Self-help and peer support group initiatives will be encouraged and supported.
- 5.1.8 Active use will be made of community wide health promotion events (such as National Healthy Eating Week, World AIDS Day, etc.) to support local initiatives targeted at staff and prisoners.
- 5.1.9 Prior to release prisoners will be provided with information about how to make best use of health services in co-operation with community health agencies.
- 5.1.10 Prisons with female prisoners will develop Health Promotion services relevant to the needs of women's health.

Health Care Standard 6

Communicable Diseases

In keeping with statutory requirements doctors must inform the local Public Health services of all cases of notifiable diseases (See HC Policy C/2 - 'Notifiable Diseases' and Appendix 1 - 'List of Notifiable Diseases').

A. Tuberculosis

Standard:

1. To provide prisoners with appropriate screening facilities based on current public health advice.
2. To provide appropriate diagnostic and treatment facilities to prisoners considered at risk.
3. To provide throughcare and arrange appropriate aftercare where required.

6.1 Criteria

- 6.1.1 Care will be provided in a multidisciplinary context by prison health care staff, relevant visiting specialists and services, and external specialist services in line with good practice guidelines (See Appendix 2 - 'Protocol for the Management of Tuberculosis in Prison').
- 6.1.2 Appropriate hygiene and infection control procedures will be maintained.
- 6.1.3 Where possible shared-care protocols will be developed between prisons and relevant community health care services.
- 6.1.4 The appropriate confidentiality of clinical information will be maintained by health care staff.

B. HIV

Standard:

1. To provide prisoners with an appropriate clinical assessment and treatment of HIV related illness.

2. To provide information and guidance to prisoners regarding the advantages and disadvantages of testing where appropriate.
3. To provide throughcare and arrange appropriate aftercare.

6.2 Criteria

- 6.2.1 Care will be provided in a multidisciplinary context by prison health care staff, relevant visiting specialists and services, and external specialist services in line with good practice guidelines.
- 6.2.2 Appropriate hygiene and infection control procedures will be maintained.
- 6.2.3 Where possible shared-care protocols will be developed between prisons and community health care services.
- 6.2.4 The confidentiality of clinical information, including that relating to HIV/AIDS, will be maintained by health care staff.
- 6.2.5 A test for HIV disease will be undertaken only when requested by a prisoner or where, following consultation, a prisoner gives informed consent to a test on the clinical recommendation of the doctor involved. This does not preclude the use of voluntary anonymised testing for research or survey purposes.
- 6.2.6 Irrespective of actual result all prisoners receiving the result of a HIV test should receive counselling from an appropriately knowledgeable person in relation to the medical, psychological, and social implications of the result.
- 6.2.7 Any HIV test result should be provided to a prisoner in a situation suitable to facilitate appropriate post-test counselling.
- 6.2.8 Any newly-diagnosed HIV positive prisoner will be offered early specialist assessment by an appropriate clinician.
- 6.2.9 Appropriate arrangements will be in place to facilitate clinical review and support by both general and specialist practitioners.
- 6.2.10 Any special arrangements for the care of pregnant prisoners with HIV disease will be addressed.
- 6.2.11 Treatments available to GMS patients in the community will be made available to prisoners.

6.2.12 Condoms/Dental dams should be made available where appropriate.

6.2.13 In the interests of health maintenance sterilising tablets and instructions on their use should be provided to prisoners.

C. Hepatitis B

Standard

To provide prisoners with clinical services which include -

1. Advice regarding Hepatitis B infection and, where clinically indicated, testing for Hepatitis B.
2. Immunisation against Hepatitis B where appropriate (See HC Policy C/5 - 'Hepatitis Vaccination Policy').
3. Appropriate treatment for those who are carriers or are suffering the effects of Hepatitis B.

6.3 Criteria

6.3.1 Hepatitis B testing will be offered where clinically appropriate. Testing will be undertaken only when requested by a prisoner or where, following consultation, a prisoner gives informed consent to a test on the clinical recommendation of the doctor involved.

6.3.2 Prisoners who are identified as Hepatitis B carriers will be given appropriate advice and treatment.

6.3.3 Immunisation against Hepatitis B will be offered to those at risk.

D. Hepatitis C

Standard

To provide prisoners with a health care service which includes -

1. General health information in relation to Hepatitis C.
2. Advice and testing for Hepatitis C where clinically indicated.
3. Referral to appropriate specialist services.
4. Treatment and support for those infected with Hepatitis C.

6.4 Criteria

- 6.4.1 Hepatitis C testing will be offered where clinically appropriate. Testing will be undertaken only when requested by a prisoner or where, following consultation, a prisoner gives informed consent to a test on the clinical recommendation of the doctor involved.
- 6.4.2 Prisoners who are infected with Hepatitis C will be given appropriate advice and treatment (See HC Policy C/5 - 'Hepatitis Vaccination Policy').

E. Rubella

Standard

1. In prisons holding women all practical steps will be taken to minimise the risk of exposure of pregnant prisoners to Rubella.
2. All possible steps will be taken to ensure that female prisoners of childbearing age are immune.

6.5 Criteria

- 6.5.1 Information and discussion about the importance of rubella immunisation will be included in all health promotion programmes, especially those organised in female prisons.
- 6.5.2 Where appropriate tests to check an individual's immune status will be offered.
- 6.5.3 All female prisoners of childbearing age who are shown not to be immune to Rubella will be offered immunisation.

F. Scabies

Standard

1. To ensure that any affected prisoners and their close contacts are treated at the earliest opportunity.
2. To ensure that all recommended Public Health measures are taken to prevent spread of infections.

6.6 Criteria

- 6.6.1 All prisoners, at time of reception, will be routinely questioned as to the presence of a rash or itch.
- 6.6.2 Any prisoner suspected of suffering from scabies will be referred to a Doctor for assessment, diagnosis, and treatment.
- 6.6.3 The Doctor will record the presence or absence of burrows in the Health Care Record.
- 6.6.4 Once a diagnosis is made the prisoner, together with any identified close contacts, particularly cell mates, will be treated simultaneously.
- 6.6.5 Choice of treatment will be in line with current Public Health guidelines.
- 6.6.6 Application should follow product instructions
- 6.6.7 Any prisoner undergoing treatment for scabies should have a change of all bed linen and clothing following treatment.
- 6.6.8 The prisoner should be informed that the itch may take some time to settle. Similarly, prisoners should be informed that in a proportion of cases further spots may break out and require a further course of treatment.
- 6.6.9 All staff involved in the treatment of patients with infection should act in accordance with recommended infection control policies.

G. Routine Immunisation

Standard

1. All programmes of immunisation offered to prisoners will be in line with national guidelines recommended by the Department of Health & Children or by local Health Boards.

6.7 Criteria

- 6.7.1 Hepatitis B immunisation will be offered to prisoners in line with prevailing policy guidelines.
- 6.7.2 Hepatitis A vaccination will be offered to prisoners who are Hepatitis C positive and do not show evidence of previous Hepatitis A infection.
- 6.7.3 Meningitis C vaccination will be offered to prisoners under the age of 23 years who have not previously received this immunisation. (See HC Policy C/6 - 'Meningococcal C Immunisation Programme').
- 6.7.4 Young offenders who have not completed their programme of school-based immunisation will be offered the opportunity to complete these.
- 6.7.5 Other immunisation programmes will be offered in line with pertaining Public Health guidelines. (See HC Policy C/7 - 'Influenza Vaccination for Prisoners').

Ref: **Immunisation Guidelines for Ireland - 2002 edition**

Available on:

www.doh.ie/publications/immuguid.html

www.ndsc.ie/Publications/Immunisation/ImmunisationGuidelines

Anaphylaxis packs, containing Adrenaline, must be available at all times before giving vaccines.

See Appendix 3.3 - "Best Practice Guidelines in the Management of Anaphylaxis"

Health Care Standard 7

The Use of Medicines

Standard

1. To provide pharmaceutical services to prisoners that are efficient, cost effective, meet legal and professional requirements, and reflect good professional practice.
2. To provide a safe and effective system for enabling prisoners to hold prescribed medicines in their possession for self-administration.
3. To provide a system of management for controlled drugs which complies with the relevant legislation and regulations.

7.1 Criteria: Organisational Matters

- 7.1.1 The service will meet the requirements of the Misuse of Drugs Act 1977 and 1984, Misuse of Drugs Regulations 1998 and (Amended) Regulations 1993, Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998 and Medicinal Products (Prescription and Control of Supply) Regulations 2003, and all relevant regulations together with any other statutes controlling the use of medicines.
- 7.1.2 Arrangements will be made to allow for the dispensing of medicines to be carried out by appropriately qualified pharmacy staff under the direct supervision of a registered Pharmacist. There will be no secondary dispensing.
- 7.1.3 The administration of medicines will follow current good practice guidelines as advised by An Bórd Altranais and IPS. All health care staff will be aware of, and will adhere to these guidelines.
(See HC Policy C/8 - "Policy on Medication Administration")
- 7.1.4 All prescribing will be undertaken by fully registered Medical or Dental practitioners in accordance with DOHC good practice guidelines.
- 7.1.5 Prescribing will reflect the guidance contained within a national Prison Service Medicines Formulary, when developed by a Drugs and Therapeutics Committee.
- 7.1.6 Each prison will have a supply of treatments to include analgesics and simple antacids, available to prisoners under protocol.

(See Appendix 3.1 - “Administration of Medicines under Protocol”)

- 7.1.7 All pharmaceutical products will be stored in appropriate conditions of security.
- 7.1.8 Controlled Drugs will be stored and handled as required under the Misuse of Drugs Act and related regulations.
- 7.1.9 Any In-Possession (I/P) policy will be in accordance with Standard 7.6.
- 7.1.10 Equipment, medicines, and dressings will be available for use in an emergency situation and such supplies will be regularly monitored to ensure that equipment is in working order and that other supplies are not time expired.

7.2 Criteria: Pharmaceutical Services

- 7.2.1 Pharmaceutical practice within the prison system will adhere to practice guidelines issued by the Pharmaceutical Society of Ireland.
- 7.2.2 Advice and information to ensure safe and appropriate use of medicines will be made available to Health Care staff.
- 7.2.3 Professional pharmacy advice will be utilised to promote the cost effective purchase of medicines and other equipment; and advice on medicine budgets and comparative costs to achieve a rational and economic use of medicines.
- 7.2.4 Prisoners will be effectively informed regarding the pharmaceutical management of their condition.
- 7.2.5 Pharmacy staff will advise on all aspects of the security of pharmaceutical products.

7.3 Criteria: Acquisition, Storage and Disposal of Medicines

- 7.3.1 The range and quantity of medicines within prison establishments will be determined by consultation between the medical, nursing, and pharmacy staff.
- 7.3.2 Any medicines due for disposal on the grounds of expiry, completion or discontinuation of treatment, etc., will be returned to the pharmacy.
- 7.3.3 The pharmacist will be responsible for the disposal of medicines.

- 7.3.4 In the event of the death of a patient who was on a course of medication, the medication(s) concerned must be retained until clearance is given.

7.4 Criteria: Prescribing

- 7.4.1 All prescribing will be undertaken by fully registered Medical or Dental practitioners in accordance with DOHC good practice guidelines.
(See HC Policy C/9 - "Use of Benzodiazepine Hypnotics")
- 7.4.2 The purpose of, and any known risk from, prescribed medicines will be explained to the patient at the time of initial prescription.
- 7.4.3 All prescriptions will be recorded on the PMRS.
(See Appendix 4.1 - "Prescription Writing Guidelines")
- 7.4.4 Prescribing will reflect guidelines contained within any national IPS formulary once this is developed.

7.5 Criteria: Administration of Medicines

- 7.5.1 Administration of prescribed medicines will follow an agreed policy.
(See HC Policy C/8 - "Policy on Medication Administration")
- 7.5.2 The patient will be correctly identified before administration of medication.
- 7.5.3 Arrangements will be in place to ensure that simple OTC antacid and analgesic preparations are available to prisoners. Records will be kept of such medicines issued.
(See Appendix 3 - "Administration of Medicines under Protocol")
- 7.5.4 The prescriber will be contacted if there is any doubt regarding the prescription.
- 7.5.5 On return from temporary release, where concern exists regarding the safety of medication administration, reference should be made to HC Policy C/10 - "Administration of Medicines to Prisoners following return from Temporary Release"
- 7.5.6 The patient will be fully informed about his/her medication when it is prescribed and when it is first administered.

- 7.5.7 A contemporary, signed, legible record in electronic format will be made of each medicine administered, withheld, refused by the patient, or not given for whatever reason.
- 7.5.8 The person administering the medication should do so under appropriate health care supervision.
- 7.5.9 Where a medicine is not available or is refused the prescriber will be informed and the same will be recorded on the PMRS.
- 7.5.10 Medication will only be given to prisoners with consent, except where indicated in an emergency situation. In such emergency circumstances medication will be administered in accordance with an agreed clinical protocol.

7.6 Criteria: Self-Administered Medication

- 7.6.1 It will be the responsibility of the prescriber in consultation with healthcare staff and Prison Management to decide which prisoners should be allowed have medication in their possession.

7.7 Criteria: Controlled Drugs

- 7.7.1 Drugs controlled under the Misuse of Drugs Acts 1977 and 1984 and subsequent regulations will be kept in a locked, safe cabinet which meets professional and legal guidelines. This cabinet should be in a location which is designed to prevent unauthorised access to such drugs.
- 7.7.2 Prescriptions for Controlled Drugs will conform to the requirements of the relevant legislation - Misuse of Drugs Act 1977 and 1984, Misuse of Drugs Regulations 1988 and 1993, and Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998. (See Appendix 4.2 - "Prescription Writing Requirements")
- 7.7.3 A register, as required by legislation, will be kept at each location where Controlled Drugs are kept.
- 7.7.4 All Controlled Drugs received from prisoners, at time of committal or otherwise, will be recorded, witnessed and destroyed. (See HC Policy A/19 - 'People entering Prison with Methadone Supplies')

References:

Misuse of Drugs Act 1977

Misuse of Drugs Act 1984

Misuse of Drugs Regulations 1988 and (Amendment) Regulations 1993

Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998

Medicinal Products (Prescription and Control of Supply) Regulations 2003

“The Practice of Pharmacy Guide”, P.S.I. 1999

“Pharmaceutical Society of Ireland Best Practice Guidelines on the Provision of Pharmacy Services to Residential Homes by Community Pharmacies”

“Pharmaceutical Society of Ireland Best Practice Guidelines on the Use of Dosage Compliance Systems”

Relevant Medical Council Guidelines

Bord Altranais Guidelines on Medication Management

Health Care Standard 8

Dental Services

Standard

To provide dental treatment to prisoners of an equivalent standard to that normally available to citizens in the general community covered by the GMS Dental Schemes. (See Appendix 5 - “Dental Services for Prisoners - Operational Policy”)

8.1 Criteria: Treatment

- 8.1.1 Every Prison will have access to the services of a qualified dentist.
- 8.1.2 A prisoner requesting treatment should normally be seen by the prison dentist within a reasonable period of time.
- 8.1.3 A prisoner with severe dental pain that has not responded to initial analgesic treatment should be seen at the next available clinic.
- 8.1.4 Any treatment that is available under the GMS/Social Welfare public dental schemes will be provided to a prisoner if he/she requires it.
- 8.1.5 The dentist will maintain a full clinical record of all treatments undertaken on prisoners.
- 8.1.6 The dentist will have ready access to the prisoner’s medical history.

8.2 Criteria: Accommodation and Equipment

- 8.2.1 Every dental surgery should be equipped to current professional standards, with the appropriate fixtures, furnishings, and equipment.
- 8.2.2 All dental equipment must be serviced and checked according to current standards, including any applicable legislation.
- 8.2.3 Effective cross-infection prevention procedures will be in place.
- 8.2.4 Each dental surgery will have sufficient instruments, hand pieces, etc., to allow all sterilisation procedures to proceed without hindering treatment.
- 8.2.5 All prison dental surgeries will be provided with a telephone and adequate means to summon other staff in case of emergency.

Health Care Standard 9

Drug Treatment Services

Standard

1. To provide clinical services for the assessment, treatment, and care of substance misusers comparable to those available in the community, and which are appropriate to the prison setting.

All Methadone Treatment delivered to prisoners will be based on IPS Methadone Guidelines as derived from the European Methadone Guidelines - see Appendix 6.

9.1 Criteria: General Principles

- 9.1.1 If a prisoner has been on a treatment programme (e.g. methadone) in the community immediately prior to entering prison, then, if clinically appropriate, this treatment should be continued.
- 9.1.2 Substitute or detoxification prescribing practice will be in line IPS policy based on best practice guidelines. (See Appendix 6 - "Methadone Guidelines")
- 9.1.3 Any prisoner seeking treatment for substance misuse may be required to enter into an agreed contract.
- 9.1.4 Where drug use becomes problematic during the course of a sentence, etc., a detoxification may be considered subject to the prevailing clinical criteria.
- 9.1.5 All drugs prescribed as part of a drug treatment programme must be administered on a supervised, individual dose basis, within a safe and secure environment.
- 9.1.6 Initiation of methadone maintenance while in prison for a prisoner who has not previously been on such a programme in the community should only be undertaken following consultation with the relevant substance abuse specialist, so as to ensure continuity of treatment after leaving prison.
- 9.1.7 Subject to accepted clinical criteria treatment using other appropriate pharmaceutical agents (e.g. Lofexidine) may be considered. Any such treatment should be based on specialist advice and supervision.

9.2 Criteria: Initial Reception

- 9.2.1 All drug misusing prisoners will be assessed by a Nurse as part of the general reception process. A specific history of drug use, including method of administration, duration of use, previous treatment contacts, etc., should be elicited.
- 9.2.2 Opioid use should be confirmed by means of urinalysis. It is important to remember that urinalysis will only confirm the presence of a drug. It will not provide any information regarding the extent of use or dependence. (see HC Policy A/20 - 'Potential Contamination of Urinalysis Results for Drugs of Abuse').
- 9.2.3 Methadone supplies accompanying new receptions to prison will be confiscated (See HC Policy A/19 - 'People Entering Prison with Methadone Supplies').
- 9.2.4 Prior to commencing any form of treatment it is essential that a full clinical assessment be undertaken by a doctor. (See Methadone Guidelines, page 73 below)
- 9.2.5 Prescribing is the sole responsibility of the doctor who signs the prescription. This responsibility cannot be delegated. (See Appendix 4.2 - "Prescription Writing Guidelines")
- 9.2.6 A new committal into prison should not receive methadone until the day following reception (See HC Policy C/11 - 'Precautions in Relation to Initiating Methadone Treatment for Opiate Abusers')
- 9.2.7 Detox should be carried out in line with the Methadone Guidelines Document (see P.76 below).
- 9.2.8 Methadone should, where possible, be administered in the morning to allow for monitoring of clinical condition during the day.

9.3 Criteria: Prisoners considered for Maintenance Therapy

- 9.3.1 In line with current Department of Health and Children policy, Prisoners who
 - have been on a recognised maintenance programme immediately prior to reception,

- have a verified place on a community treatment programme available to them on release
- are addicted pregnant women
- have a recent diagnosis of HIV
- are juveniles in need of drug treatment (See HC Policy C/12 - 'Prescription of Methadone to Patients under 18 years')

may be considered for continuation of maintenance while in prison.

- 9.3.2 A doctor can, in consultation with a consultant specialist in substance misuse, initiate treatment in cases falling outside the above criteria.
- 9.3.3 Continuation of maintenance treatment will require regular clinical assessment by a Doctor.
- 9.3.4 Verification of prior treatment, dosage, etc., should be obtained from the Central Treatment List and the community prescriber.
- 9.3.5 Detoxification and unstable service users should be seen by a Doctor weekly and, if as they achieve stability, fortnightly and then monthly.
- 9.3.6 Detox and unstable Methadone maintenance patients should have random twice weekly urine screens.
- 9.3.7 Prisoners stable on methadone maintenance should have random weekly urine screens.
- 9.3.8 Any prisoner receiving methadone maintenance may be expected to sign a contract agreeing to comply with the regime associated with such treatment within the prison situation.

APPENDICES

- 1. List of Notifiable Diseases**
- 2. Protocol for the Management of Tuberculosis in Prison**
- 3. Clinical Guidelines and Policies on Administration of Medicines under Protocol**
 - 3.1 Policy on the issuing of Paracetamol to Prisoners
 - 3.2 Clinical Guidelines on use of Narcan
 - 3.3 Best Practice Guidelines in the Management of Anaphylaxis
 - 3.4 Guidelines on the Use of Controlled Drugs
- 4. Prescription Writing Guidelines**
 - 4.1 Prescription Writing Guidelines
 - 4.2 Controlled Drug Prescription Writing Requirements
- 5. Dental Services for Prisoners - Operational Policy**
- 6. Methadone Treatment Programme Guidelines for the Irish Prison Service, based on European Methadone Guidelines**

APPENDIX 1

LIST OF NOTIFIABLE DISEASES

Infectious Diseases (Amendment)(No.3) Regulations 2003 (SI No. 707 of 2003)

- **Acute anterior poliomyelitis**
- **Acute infectious gastroenteritis**
- **Ano-genital warts**
- **Anthrax**
- **Bacillus cereus food-borne infection/intoxication**
- **Bacterial meningitis (not otherwise specified)**
- **Botulism**
- **Brucellosis**
- **Campylobacter infection**
- **Chancroid**
- **Chlamydia trachomatis infection (genital)**
- **Cholera**
- **Clostridium perfringens (type A) food-borne disease**
- **Creutzfeldt Jakob disease**
- **Nv Creutzfeldt Jakob disease**
- **Cryptosporidiosis**
- **Diphtheria**
- **Echinococcosis**
- **Enterococcal bacteraemia**
- **Enterohaemorrhagic Escherichia coli**
- **Escherichia coli infection (invasive)**
- **Giardiasis**
- **Gonorrhoea**
- **Granuloma inguinale**
- **Haemophilus influenzae disease (invasive)**
- **Hepatitis A (acute)**
- **Hepatitis B (acute and chronic)**
- **Hepatitis C**
- **Herpes simplex (genital)**
- **Influenza**
- **Legionellosis**
- **Leptospirosis**
- **Listeriosis**
- **Lymphogranuloma venereum**
- **Malaria**
- **Measles**
- **Meningococcal disease**
- **Mumps**
- **Non-specific urethritis**
- **Noroviral infection**
- **Paratyphoid**

- **Pertussis**
- **Plague**
- **Q Fever**
- **Rabies**
- **Rubella**
- **Salmonellosis**
- **Severe Acute Respiratory Syndrome**
- **Shigellosis**
- **Smallpox**
- **Staphylococcal food poisoning**
- **Staphylococcus aureus bacteraemia**
- **Streptococcus group A infection (invasive)**
- **Streptococcus pneumoniae infection (invasive)**
- **Syphilis**
- **Tetanus**
- **Toxoplasmosis**
- **Trichinosis**
- **Trichomoniasis**
- **Tuberculosis**
- **Tularemia**
- **Typhoid**
- **Typhus**
- **Viral encephalitis**
- **Viral meningitis**
- **Viral haemorrhagic fevers**
- **Yellow Fever**
- **Yersiniosis**

APPENDIX 2

PROTOCOL FOR THE MANAGEMENT OF TUBERCULOSIS IN PRISON

Many of the issues relevant to the management of tuberculosis in a prison setting are dealt with in the Report of the Advisory Committee On Communicable Diseases In Prison (May, 1993). Sections 1.4-1.7 and 6.5 are of particular relevance. The following is intended to complement the recommendations of the Advisory Committee and assist in their implementation with a view to enhancing the quality of medical care for persons in prison.

This protocol is based on advice received from the Department of Public Health, ERHA.

As circumstances change, these recommendations may have to undergo periodic revision.

Index of suspicion

Transmission of tuberculosis in prisons presents a health problem for the institution and may also be a problem for the community into which the inmates are released. The incidence of tuberculosis is likely to be higher in prison inmates than in the general community. In order to prevent or contain tuberculosis, it is essential that there is a high index of suspicion for the disease.

Screening of inmates

All inmates should be screened on committal. As part of the screening process, it is desirable that all inmates complete a screening questionnaire (see suggested Screening Form appended) eliciting symptoms of current illness, any relevant previous illness, present medication together with a history of contact with tuberculosis or other infectious disease.

Initial screening would include review of the prisoner's questionnaire response with particular reference to symptoms suggestive of infectious disease, documentation of BCG status including the presence of vaccination scar, recording of weight and temperature. Any diagnostic tests should be undertaken in consultation with local Public Health Services. This preliminary screening examination could be carried out by a suitably trained nurse.

Inmates with known or suspected HIV infection should ideally receive a chest radiograph as part of their initial screening at the time of first committal, regardless of tuberculin skin-test or BCG status.

All inmates should, if possible, be housed in single cell accommodation until such time as they have been medically assessed.

Role of nurse

The nurse would be responsible for

- Organising a formal record system for each individual. This should contain records of tests carried out and their results, together with medical notes
- Prioritising patients to be seen by the prison doctor
- Ensuring that inmates suspected of having an infectious disease are isolated in appropriate accommodation pending confirmation of the diagnosis
- Ensuring inmates are receiving prescribed medication, including directly observing therapy (DOTS) where indicated
- liaison with the Public Health Department on cases of notifiable disease occurring in the prison (suspected and confirmed, including denotification where appropriate).

Nursing personnel should have specific training in relation to tuberculosis, with an understanding of the issues involved in the control of the disease. Such training should include placement in a TB hospital and a community based clinic. Nursing personnel should also have the skills required to deal with the particular client group encountered in a prison setting.

It would be desirable to have a nurse on duty during office hours on a Monday to Saturday basis.

Nursing personnel should report to the Prison Doctor on all matters relating to the inmates health status and liaise with the relevant Public Health Department as appropriate.

Diagnosis of tuberculosis

Provision must be made for appropriate diagnostic measures e.g.. Sputum smear and culture and/or chest radiograph for all persons who are symptomatic.

Confirmed tuberculosis

Confirmed cases will normally be under the care of a consultant physician. Inmates with pulmonary involvement should remain in hospital accommodation until confirmed non-infectious.

All inmates with confirmed tuberculosis must be monitored by trained personnel for signs and symptoms of adverse reaction during chemotherapy. Therapy should be directly observed where possible. Ideally those with drug-resistant organisms should not remain in prison. Where it is not possible to release them, special emphasis must be placed on their close supervision and care.

All confirmed cases should be notified in writing by the Prison Doctor to the local Medical Officer of Health so that contact tracing can be put in place.

To ensure continued medication and follow-up, if an inmate is to be released before completion of therapy, the local Medical Officer of Health should receive prior notification of the release.

Chemoprophylaxis

Prisoners on chemoprophylaxis should also have directly observed therapy. To ensure continued medication and follow-up, if an inmate is to be released before completion of chemoprophylaxis, the local Medical Officer of Health should receive prior notification of the release.

Repeat skin tests

Repeat testing of prisoners or staff should be based on Public Health advice. If data from previous screening and TB case finding are available, the frequency of repeat skin testing should be determined based on the need for timely surveillance information.

It is important to remember that the tuberculin test is merely a screening test. A negative test does not rule out tuberculosis, nor does a history of previous BCG. Where there is a high index of suspicion e.g. cough, weight loss, night sweats, a chest X-ray should be performed and the individual referred for specialist opinion. Individuals with documented evidence of a previous positive tuberculin test (Heaf>2, Mantoux>10mm) should not be retested.

Assessment

Inmates are transferred frequently. Thus, record systems for tracking and assessing the status of persons with TB and tuberculous infection in the prison facilities are essential. These systems must be maintained by using current information on the location, treatment status, and degree of infectiousness of these persons. Prompt action must be taken to reinstitute drug therapy should treatment lapse for any reason.

Further advice

The Public Health Department or local Medical Officer of Health may be contacted for further information on any aspect of tuberculosis prevention and control.

TUBERCULOSIS SCREENING FORM

- 1. NAME:**

- 2. ADDRESS:**

- 3. AGE:**

- 4. Do you have a cough?**
 - 4(a) If yes, how long have you had this cough?**

- 5. Have you ever been treated before for tuberculosis?**
 - 5(a) If yes, what hospital did you attend?**

- 6. Have you been in close contact with anyone who has been diagnosed with tuberculosis?**

(In terms of initial screening it is considered that questions 4 & 4a are the key questions).

BCG vaccine

Bacille Calmette Guerin (BCG) vaccine, contains a live attenuated strain derived from *Mycobacterium bovis*. The efficacy of BCG in preventing tuberculosis has varied in reported studies over the years, but is probably most consistently effective against tuberculosis meningitis and miliary tuberculosis, with protection lasting approximately 15 years. Irish studies have indicated a protective efficacy against childhood tuberculosis. Indications for BCG vaccine continue to be re-evaluated but at present it is recommended that neonatal BCG be continued.

Dose and route of Administration

BCG vaccine may be given concurrently with another live vaccine, but if they are not given at the same time an interval of at least three weeks should be allowed between such vaccines. When BCG is given to infants there is no need to delay primary immunisations.

Adults and children over three months

The recommended dose is 0.1 ml, by intradermal injection, reconstituted with 1 ml of sterile 'Water for injection' or normal saline which has been allowed to stand for one minute. Subjects who give a history of previous BCG immunisation should only be given BCG if there is no characteristic scar and they are tuberculin negative. If reimmunisation with BCG is being considered expert advice should be sought.

Infants of three months of age or less

The recommended dose is 0.05 ml, by intradermal injection in two divided doses in adjacent sites. Babies up to three months of age may be immunised without prior skin testing.

The vaccine should be given in the arm, over the insertion of the deltoid muscle.

Once reconstituted and prepared, any vaccine remaining at the end of the session (maximum four hours) should be discarded safely. No further immunisation should be given for at least three months in the arm used for BCG vaccination because of the risk of regional lymphadenitis.

Indications

The vaccine is indicated for prophylactic immunisation in tuberculin negative individuals.

Those at normal risk

- a) New born babies

- b) Children or adults where the parents or individuals themselves specifically request BCG immunisation, unless contraindicated
- c) Schoolchildren between the ages of 10 and 14 years who have not previously been immunised or who are tuberculin negative and who have no characteristic scar
- d) Students in teacher training colleges
- e) Members of the travelling community - due to the logistical difficulties of providing alternative control measures and follow-up of contacts

Those at higher risk

- a) Health care staff who may have contact with infectious patients or their specimens
- b) Veterinary staff who handle animal species known to be susceptible to tuberculosis
- c) Contacts of cases with active respiratory tuberculosis. Children under five years of age in contact with smear positive tuberculosis should be given chemoprophylaxis and then immunised with BCG on completion of the course if tuberculin negative
- d) Newborn infants where there is a positive family history of tuberculosis
- e) Immigrants from high incidence countries and their children
- f) Those intending to visit high incidence countries for more than one month

Contraindications

BCG vaccine should not be given to those:

1. Receiving corticotrophins or systematic corticosteroid therapy (other than as replacement)
2. Receiving other immunosuppressive treatment including x-irradiation
3. Suffering from blood dyscrasias, lymphoma, or malignant neoplasms involving bone marrows or the lymphoreticular system, or with gamma globulin deficiency or abnormality
4. With pyrexia
5. With generalised eczema or infected dermatosis. The effect of BCG vaccine may be exaggerated in these patients, and a more generalised infection is possible
6. Who are pregnant
7. With positive tuberculin tests

HIV positivity

BCG vaccine should not be given to HIV positive persons.

Adverse reactions

Local: side effects include local induration, pain and occasionally ulceration, lupoid reaction, inflammatory and suppurative adenitis.

General: rash, fever and rarely generalised lymphadenopathy can occur.

Interactions

The vaccine should not be given within three months of blood or plasma transfusion or administration of human serum globulin in excess of 0.01 ml/kg body weight.

APPENDIX 3

IRISH PRISON SERVICE

CLINICAL GUIDELINES

AND

POLICIES ON ADMINISTRATION OF MEDICINES UNDER PROTOCOL

- 3.1. POLICY ON THE ISSUING OF PARACETAMOL TO PRISONERS**
- 3.2. CLINICAL GUIDELINES ON USE OF NARCAN**
- 3.3. BEST PRACTICE GUIDELINES IN THE MANAGEMENT OF ANAPHYLAXIS**
- 3.4 GUIDELINES ON THE USE OF CONTROLLED DRUGS**

Appendix 3.1

IRISH PRISON SERVICE

**POLICY ON THE ISSUING OF
PARACETAMOL
TO PRISONERS**

Issued by:

Dr. E. Dooley
Director Prison Health Care

Deirdre O'Reilly
Co-ordinator of Pharmacy Services

Frances Nangle-Connor
Co-ordinator of Nursing

September 2002

POLICY ON THE ISSUING OF PARACETAMOL TO PRISONERS

POLICY

The Irish Prison Service policy is to make available to prisoners Paracetamol tablets or liquid within the terms of the protocol as stated below.

Introduction:

Within the community, a number of medications including Paracetamol, can be purchased at a Pharmacy without consulting a Doctor, and so on the basis of equity of care, within a prison setting Paracetamol should also be made available, without the need to consult the Doctor.

Paracetamol, when used properly, is a very effective and safe treatment to relieve mild to moderate pain associated with such conditions as headache, toothache and minor injuries etc. It can also be used to reduce temperature.

However, Paracetamol has the potential to be a very dangerous medication, if not used properly.

Overdose of Paracetamol can result in liver damage, and possibly death, therefore the following protocol must always be used.

POLICY ON THE ISSUING OF PARACETAMOL TO PRISONERS

PROTOCOL PRINCIPLES

1. A nurse or medical orderly may issue Paracetamol, on request of a prisoner in accordance with this protocol.
2. All relevant staff must read, and sign to confirm that they have read this protocol before they are authorised to issue Paracetamol.
3. Prisoners must initiate the request for painkilling medication such as Paracetamol. In issuing the medication, staff are not expected to make a medical judgement or diagnosis.
4. The issuing of Paracetamol in this way does not remove the right of access to healthcare services.
5. The imperatives of security must be taken into account at all times.
6. Responsibility for the implementation of the protocol lies with the Governor.
7. Responsibility for arranging local training in the protocol lies with the Governor.
8. Staff must only administer Paracetamol in accordance with this protocol.
9. This policy will be reviewed annually.

POLICY ON THE ISSUING OF PARACETAMOL TO PRISONERS

PARACETAMOL:

1. CLINICAL CONDITION:

Mild to moderate pain (e.g. headache, toothache etc.), pyrexia.

2. CRITERIA FOR EXCLUSION:

It is the responsibility of the Healthcare team to ensure that the prisoner knows if he/she should not take Paracetamol.

DO NOT USE IF PATIENT IS ALLERGIC TO PARACETAMOL.

3. TREATMENT:

Paracetamol 500mg tablets or Paracetamol 250mg/5ml suspension

Dose: 1-2 tablets (500mg to 1g) taken orally, every six to eight hours or
10-20ml, taken orally every six to eight hours

Max. Daily dose: 8 tablets (4g) or 80ml (4g) in 24 hours

Max. Period of treatment (before G.P. Consulted) 48 hours

Paracetamol must **NOT** be given to any patient already receiving a medicine containing paracetamol e.g. Kapake, Solpadol, Tylex, Paramol, Solpadeine, Uniflu plus etc. - check in MIMS/B.N.F.

4. ADMINISTRATION

If the authorised staff member is satisfied that there are no contra-indications, and in his/her opinion administration is appropriate, he/she may administer the drug.

Following details must be recorded in the patient's PMRS file ;

- symptom
- name of preparation, dose, date and time

The medication must be administered with a glass of water, and prisoner must be observed to ensure that the medication has been swallowed.

5. FOLLOW-UP

If problem persists or 48 hours treatment is insufficient, this should be brought to the attention of the Doctor, whose advice should be sought.

Prisoners who make repeated intermittent requests must be referred to the Doctor.

Appendix 3.2

IRISH PRISON SERVICE

CLINICAL GUIDELINES

**ON THE
USE OF**

NARCAN (NALOXONE)

IN THE TREATMENT OF OPIOID OVERDOSE.

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Date of preparation: October 2003

Revised: February 2004

Review date: September 2005

Prepared following consultation with all prison doctors and nurses.

NALOXONE

Introduction:

These Guidelines refer to the administration of Naloxone, where indicated, by clinical staff i.e. Prison doctors and nurses.

This means that Narcan may be administered by a nurse, in an emergency, without prescription, as outlined in these guidelines.

The signs and symptoms of overdose with Methadone parallel those for other opioids, namely profound respiratory depression, pinpoint pupils, hypotension, circulatory failure and pulmonary oedema and coma.

The specific antidote Naloxone is indicated for the reversal of coma and the restoration of spontaneous respiration.

NARCAN 400micrograms/ml ampoules contain Naloxone HCl 400micrograms/1ml.

NARCAN (Naloxone) 400micrograms/1ml amps.

ADMINISTRATION: Naloxone may be given as outlined in these guidelines, where indicated, by prison doctors and nurses.

CLINICAL INDICATIONS:

Narcan may be used for the complete or partial reversal of opioid depression, including mild to severe respiratory depression induced by natural and synthetic opioids, including Dextropropoxyphene and Methadone.

It may also be used for the diagnosis of suspected acute opioid overdose.

Narcan is not effective against respiratory depression caused by non-opioid drugs.

CONTRAINDICATIONS:

Not to be used if patient known to be hypersensitive to Naloxone.

ADMINISTRATION:

In the prison setting, Narcan should be given **by i.m. or s/c injection**. Duration of action is dependent on dose and route of administration. The i.m. route produces a more prolonged effect.

A full record of administration must be made in the patient's PMRS file.

DOSE:

Opioid overdose:

Initial dose of **400 - 2000 micrograms** (1 to 5ml of 400microgram/ml amp.) **i.m. or s/c**.

This may be repeated at 2 - 3 minute intervals, to a maximum of 10mg if respiratory function does not improve.

Since Naloxone has a shorter duration of action than many opioids, including Methadone and Dextropropoxyphene, repeated injections may be necessary according to the respiratory rate and depth of coma.

If no response after 10mg administered, diagnosis of opioid induced or partial opioid induced toxicity should be questioned.

Partial recovery from Methadone overdose may be seen, but relapse can frequently occur if respiratory depression returns as the effects of Naloxone wear off.

(Methadone has a half-life of 15 - 20 hours initially and the half life increases with continued administration. The half life of Naloxone is approximately 64 minutes, therefore repeated doses of Naloxone may be required.)

Heroin has a much shorter half life and so the response to Naloxone administration is rapid.

In patients where respiratory depression is caused by Methadone, and who do not respond to repeated doses of Narcan, immediate transfer to hospital is required to allow for the administration of an i.v. infusion of Narcan, to produce sustained antagonism to the opioid, where the rate of administration can be adjusted according to the response and based on close monitoring of vital signs.

In addition to Narcan, other resuscitative measures such as maintenance of a free airway, artificial ventilation, cardiac massage and vasopressor agents should be available and employed when necessary in a hospital setting.

Any patient who has been treated with Naloxone **should not** be given any further medication, particularly respiratory depressants, until the patient has been reviewed by the doctor.

SPECIAL WARNING/CAUTION:

Narcan should be administered with great caution to patients who have received large doses of opioids or to those physically dependent on opioids, since too rapid reversal may precipitate an acute withdrawal syndrome in such patients.

Caution should be exercised when Narcan is administered to patients with renal insufficiency/failure or those with liver disease.

Should be used with caution in patients with pre-existing cardiac disease or patients who have received potentially cardio-toxic drugs.

The safety of Narcan for use in pregnancy has not been established, it should therefore be used with caution in pregnancy.

ADVERSE EFFECTS:

Abrupt reversal of opioid depression may result in a range of symptoms from nausea, vomiting, sweating, tachycardia to pulmonary oedema and cardiac arrest, which may result in death.

OVERDOSE:

No reports of acute overdosage. Has not been shown to produce tolerance or to cause physical or psychological dependence.

FOLLOW -UP:

Patients who have responded satisfactorily to Narcan should be referred to hospital for assessment, as they should be monitored closely for 48 hours after apparent recovery, in case of relapse.

Ref: Narcan Summary of Product Characteristics, Bristol Myers Squibb, Jan 2002
and Irish Pharmaceutical Healthcare Association Data Sheet and Summary of
Product Characteristics Compendium 2001-2002, 11th edition
British National Formulary 43, March 2002, British Medical Association and
Royal Pharmaceutical Society of Great Britain.

Appendix 3.3

IRISH PRISON SERVICE

BEST PRACTICE GUIDELINES

IN THE

MANAGEMENT OF ANAPHYLAXIS

These guidelines reflect current best practice as outlined by :

"The Emergency Medical Treatment of anaphylactic Reactions for First Medical Responders and for Community Nurses" Jan. 2002
The Resuscitation Council (UK): Project Team of the Resuscitation Council (UK)

and

"Immunisation Guidelines for Ireland" 2002,
Immunisation Advisory Committee, Royal College of Physicians of Ireland.

and are issued by:

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November 2002

ANAPHYLAXIS:

The following guidelines should be followed by qualified clinical staff.

In situations where such staff are not present, current practice in the management of anaphylaxis should be maintained.

Introduction:

Anaphylaxis is an acute generalised allergic reaction that can lead to asphyxia and cardiac arrest. It can vary in severity and rapidity of onset.

While the incidence of anaphylaxis is rare, it requires immediate intervention.

Recognised risks:

1. Medicinal products - those mainly used in prisons include
 - Vaccines
 - Antibiotics
 - Aspirin and other NSAID's
2. Insect stings - particularly wasp and bee stings
3. Certain foods, including
 - Nuts, peanuts
 - Eggs, fish

In the case of medication, anaphylaxis is more likely after parenteral administration: resuscitation facilities must always be available for injections associated with special risk.

Anaphylaxis packs should be available in every surgery.

When exposed to a particular antigen, antigen specific immunoglobulin E (IgE) antibodies cause the release of histamine. Other vasoactive mediators are released from mast cells and basophils producing circulatory, respiratory, cutaneous and gastrointestinal effects. Anaphylactic reactions can vary in severity and can be slow, rapid or (unusually) biphasic. Occasionally the onset may be delayed by a few hours and even persist for longer than 24 hours.

Type	Signs and Symptoms
Mild	Urticarial rash Pruritis Rhinitis Nausea and vomiting
Severe	Tachycardia Dyspnoea and cough Wheezing Malaise Laryngeal oedema Angioedema Hoarseness Hypotension Tachycardia Cold and clammy Sub-sternal or abdominal pain Collapse

Emergency Treatment of Anaphylaxis in Adults	
1.	Clinical features of severe allergic-type reaction
v	Discontinue Administration of the Suspected Drug/Substance
v	Call Medical Staff
v	Recline Patient into a Comfortable Position (If unconscious, insert airway)
v	Administer Oxygen (10-15 L/min)
2.	Stridor, wheeze, respiratory distress or clinical features of shock
v	Administer Adrenaline 0.5ml of 1:1,000 solution I.M.
3.	No clinical improvement after 5 min or deterioration
v	Repeat Adrenaline 0.5ml of 1:1,000 solution I.M.
4.	Administer Antihistamine (Chlorpheniramine) 10-20 mg I.M.
IN ADDITION	
v	For all severe or recurrent reactions and patients with asthma give hydrocortisone 100-500mg IM/or slowly IV
	and/or
	If clinical manifestations of shock do not respond to drug treatment give 1-2 litres IV fluid. Rapid infusion or one repeat dose may be necessary

If profound shock is considered to be immediately life threatening, start CPR/Advanced Life Support if Necessary

ANAPHYLAXIS PACKS:

10 X 1ML ADRENALINE 1 IN 1000 AMPS (1MG/ML) FOR I.M. USE
5 X SOLU-CORTEF 100MG + 5 X 2ML W.F.I.
5 X 1ML PIRITON 10MG/ML AMPS
1 X 1ML SYRINGE + 2 X 2ML SYRINGE
2 X 21G NEEDLES + 5 X 23G NEEDLES
2 X 21G NEEDLES + 5 X 23G NEEDLES
6 X MEDI-SWABS
RANGE OF GUEDAL AIRWAYS (2,3,4)

A complete record of any intervention or treatment given must be recorded in the patient's PMRS file.

CHECKING AND RECORDING:

At least one anaphylaxis pack, with contents as outlined above, should be available in every surgery.

The contents of this pack and the expiry date of each item should be *checked and recorded weekly*.

Any product within one week of its expiry date should be replaced.

As soon as any item is used, it should immediately be replaced.

NOTES:

1. An inhaled beta-agonist such as salbutamol may be used as an adjunctive measure if bronchospasm is severe and does not respond rapidly to other treatment.

CAUTIONS:

1. Patients who are taking tricyclic antidepressants (especially amitriptyline or imipramine) or M.A.O.I.'s are considerably more susceptible to adrenaline and should receive only 50% of the usual dose of adrenaline. Administration of adrenaline may cause potentially dangerous hypertension and arrhythmias. Cocaine may also sensitise the heart to adrenaline and so the use of adrenaline is contraindicated.

2. Beta-blockers may increase the severity of an anaphylactic reaction and antagonise the response to adrenaline, calling for the use of salbutamol. Adrenaline may cause severe hypertension in those receiving beta-blockers.

Ref: Project Team of the Resuscitation Council (UK) Jan. 2002

B.N.F 41, Mar. 2001 3.4.3

Immunisation Guidelines for Ireland 2002

Appendix 3.4

Irish Prison Service

GUIDELINES

On the use of

CONTROLLED DRUGS

Reference:

MISUSE OF DRUGS ACTS 1977 AND 1984
MISUSE OF DRUGS REGULATIONS 1988 AND 1993
MISUSE OF DRUGS(METHADONE) REGULATIONS 1998

May 2003
Updated July 2007

EXPLANATORY NOTE REGARDING USE OF CONTROLLED DRUGS

This memo outlines the more common Controlled Drugs in Schedules 2 and 3 of the above regulations, with a description of the requirements relating to prescribing, storage, recording and dispensing. This note does not purport to be a legal interpretation, rather it is an explanatory note.

SCHEDULE 2 DRUGS:

CLASS OF CONTROLLED DRUG	PROPRIETARY PRODUCTS
Buprenorphine	Temgesic, Transtec
Cocaine	
Codeine	Preparations containing more than 100mg or 2.5% per unit dose
Dextromoramide	Palfium
Dihydrocodeine	DF118, DHC Continus
Fentanyl	Durogesic, Sublimaze
Hydromorphone	Palladone, Palladone SR
Methadone	Pinadone, Phymet
Methylphenidate	Ritalin, Concerta XL
Morphine	Cyclimorph, Oramorph, Sevredol, MST Continus, MXL, Morstel SR,
Oxycodone	Oxycontin, Oxynorm
Pethidine	
Pholcodine	

SCHEDULE 3 DRUGS

CLASS OF CONTROLLED DRUG	PROPRIETARY PRODUCT
Amylobarbitone	Amytal, Sodium Amytal
Butobarbitone	Soneryl
Flunitrazepam	Rohypnol
Methohexitone	Brietal
Phenobarbitone	Gardenal Sodium 200mg
Temazepam	Normison, Tenox, Nortem, Euhypnos

This is not an exhaustive list of Controlled Drugs, but lists those that are more commonly used and it may be amended from time to time. If you are unsure, always check before use whether a drug is controlled or not, by reference to the current legislation.

SCHEDULE 2 DRUGS

These drugs must be stored in the Controlled Drugs Safe.

Every transaction involving Schedule 2 drugs must be recorded in the register.

Full prescription writing requirements apply.

SCHEDULE 3 DRUGS:

These drugs must be stored in the Controlled Drugs Safe.
Full prescription writing requirements apply

Notes:

1. The following are controlled under Schedule 4 and 5, and so the requirements as outlined for Schedule 2 and 3 controlled drugs **do not apply**:

- a. Preparations containing not more than 100mg per dosage unit of phenobarbitone(calculated as base) e.g. Phenobarbitone 15mg, 30mg, 60mg tablets
- b. Preparations (other than injections) containing not more than 100mg per dosage unit of codeine or in undivided preparations not more than 2.5% of either drug e.g. Codeine Phosphate 30mg tabs, Codeine Linctus 15mg/5ml(Codinex), Benylin with Codeine(5.7mg/5ml of Codeine Phos), Dimotane Co(10mg/5ml Codeine Phos), Pholcolin (Pholcodine 5mg/ml), Expulin (Pholcolin 5mg/5ml).
- c. Preparations (other than injections) containing not more than 10mg per dosage unit of Dihydrocodeine or in undivided preparations not more than 1.5% e.g. Paracodin syrup(0.1%), tablets (10mg) or drops(1%)
- d. Preparations of dextropropoxyphene, for oral use, containing not more than 135mg per dosage unit e.g. Distalgesic

NOTE:

Where a nurse is on duty, s/he will be held responsible for the safe custody of Controlled Drugs and compliance with the regulations.

1. RECORDING OF CONTROLLED DRUG USAGE (for CD2 Drugs)

1.1 REGISTER:

Every transaction involving CD2 drugs must be recorded in a register kept for that purpose in the form specified. The register must be retained for 2 years after date of last entry and must be available for inspection.

Entries must be in ink, in chronological sequence and be made on the day of the transaction.

A running stock balance must be made at each transaction.

1.1a. Opening balance:

On commencement of the use of the register, a stock balance should be carried out i.e. The total stock in the surgery should be counted - to include all full bottles and any stock in open bottles (e.g. Methadone) or the number of tablets in stock (e.g. DF118).

This should be entered as "Opening Stock balance" on the first line of the register.

1.1b. Daily Issue:

1. Daily Issue Sheets:

- a. As a daily record of the administration of Methadone is kept, to comply with record keeping requirements it is acceptable to make a single entry in the register for the total amount of Methadone dispensed each day i.e. on 7.7.2005, total of 2,500mls administered, therefore entry in register is 2,500mls used on that day.
- b. The daily sheet must state each individual prisoner's name, DOB, PRIS, quantity administered to each patient. In addition it must state the total quantity issued on each day and must be signed by two healthcare staff members.
- c. A stock check should be carried out at the end of each daily administration.
- d. The total quantity administered as per daily sheet should be subtracted from the opening balance. This is the calculated balance.
- e. The actual balance is then measured - this is the actual quantity left in stock.
- f. The calculated balance and the actual balance should be identical, however due to the viscosity of the liquid, a slight discrepancy is acceptable. The adjustment should always be minimal and must be recorded also.
- g. The balance forward is the actual amount in stock at the end of the day and this is then carried forward as the opening balance for the next day.

1.1c. Register:

- a. An entry is then made in the CD register, stating the actual balance remaining at the end of each day.

The register and the daily issue forms constitute the complete record for the use of Methadone.

1.1d. Receipt of new supplies:

- a. Each new supply of Methadone received in the surgery must be recorded in the register and the stock balance adjusted accordingly.

Although it is not acceptable practice and should not happen, in the event of an emergency supply being loaned to or borrowed from another prison surgery, such transactions must also be recorded in the CD Register.

No cancellation, obliteration or alteration is permitted. Corrections, where necessary, must be made by way of marginal note or footnote in ink which must specify the date on which the correction was made.

2. STORAGE:

Schedule 2 and 3 Controlled Drugs should be stored in a locked safe. No other items, except controlled drugs, should be stored in this safe.

The key of this safe should at all times be kept on the person of one accountable staff member who is accountable for the controlled drugs and should be passed on to the staff member taking over on the next shift. It should be kept separate from all other keys and should never be left in the lock, in a drawer or any other area. No other person should have access to this key.

The stock should be checked and signed off at each change over of staff by two healthcare staff.

3. ADMINISTRATION:

Schedule 2 and 3 drugs should only be dispensed on foot of a written prescription by a doctor.

The administration of CD2 drugs should be conducted by two healthcare staff members.

The checking, preparation, administration or destruction of these drugs should be witnessed.

Any wastage of these drugs should be recorded and the entry witnessed.

A signed record should be appropriately entered on the patient's file on PMRS and in the CD register, which must be signed by two healthcare staff members.

4. PRESCRIPTION:

The prescription for Schedule 2 and 3 drugs must:

- a. be in ink or otherwise so as to be indelible and signed by the practitioner with his usual signature and dated by him.
- b. specify in the prescriber's handwriting, the name and address of the person for whom the treatment is issued - (in the case of a prison, the address of the patient need not be specified provided the prescription is written on the patient's kardex)
- c. clearly indicate the name of the person issuing it and state that the person issuing it is a registered medical practitioner
- d. specify a telephone number at which the prescriber may be contacted
- e. specify (in the prescriber's handwriting)
 - the dose to be taken,
 - the form
 - the strength (when appropriate)
 - in both words and figures either the total quantity of the drug or preparation or the number of dosage units to be supplied
- f. in the case of a prescription for a total quantity intended to be dispensed by instalments, specify the quantity, the number of instalments and the intervals to be observed when dispensing

An electronic prescription recorded on PMRS is acceptable for use within the IPS.

5. REQUISITIONS/ORDERING PROCESS:

a). Ordering:

- A book of pre-printed requisition forms is available in each surgery, in duplicate form.
- A new requisition form must be used for each order. This may be completed by a healthcare staff member but must be signed by a doctor.
- The completed and signed requisition is then sent to the stores department, where it is assigned an order number and is then faxed to the supplier.

b). Receipt of Supplies:

- Ideally any supplies of methadone should then be delivered to the doctor and the delivery note signed by the doctor. This task can however be delegated by the doctor to another staff member, who has been named as an authorised messenger and who can accept delivery on behalf of the doctor.
- The order will then be accepted by an authorised member of the healthcare staff who will be required to sign the delivery note and return the top copy to the delivery person.
- The duplicate requisition must also be signed by the healthcare staff member who accepted the new supply.
- All new supplies received must then be recorded in the CD Register as per 1.1.d above

APPENDIX 4

Appendix 4.1:

PRESCRIPTION WRITING GUIDELINES:

All prescriptions should be recorded on the patients' file on PMRS

The following guidelines refer to hand-written prescriptions and are now incorporated within PMRS

Prescription kardex should have completed patient details, including PRIS and D.O.B.

All patient **known allergies** should be ascertained and recorded by both the Doctor and Nurse, on the front of the kardex

Prescriptions must be written legibly, **in capital letters**, using a ball-point pen.

Each prescription must be signed and dated by a registered medical practitioner, using their normal signature.

The prescription should specify the name, strength and form of the medication, and the route, dose and the frequency of administration.

The decimal point should be used when prescribing less than 1mg of a drug, i.e. place a "0" before the decimal point, e.g. 0.25mg.

Abbreviations are not to be used when writing the drug name.

Doses should follow the normal convention:
g for grams, mg for milligrams, micrograms written in full.

The period for which the prescription remains valid will be clearly indicated by the prescriber. **All prescriptions must be reviewed at no less frequency than 28 days.**

Where an instruction "as required" is used by a prescriber it must be qualified by a clear statement indicating the maximum dosage and frequency allowed per day, **and the maximum period for which the prescription remains valid.**

When discontinuing a drug, a line should be drawn through the prescription and a similar line through the administration recording panel, directly after the last dose given. This should be initialled and dated.

Only one chart and kardex should be in use for a patient at any one time.

Single dose drugs should only be prescribed on the lower section of the kardex.

Appendix 4.2

CONTROLLED DRUG PRESCRIPTION WRITING REQUIREMENTS:

All prescriptions for Controlled Drugs should be recorded on the patient's file in PMRS.

The following guidelines refer to hand-written prescriptions and are now incorporated or taken account of within PMRS.

As it is unlawful for a practitioner to issue, or for a pharmacist to dispense a prescription for a Schedule 2 or 3 drug unless it complies with the legal requirements, in addition to the guidelines set out above, to meet such legal requirements, a prescription for a Schedule 2 or 3 drug must:

- a. Be in ink or otherwise so as to be indelible and signed by the practitioner with his usual signature and dated by him
- b. Except in the case of a GMS prescription, specify the address of the person issuing it.
- c. Clearly indicate the name of the person issuing it and state that this person is a registered medical practitioner
- d. Specify a telephone number at which the prescriber may be contacted
- e. Specify in the prescriber's handwriting the name (including the given name) of the person for whose treatment it is issued
- f. Specify in the prescriber's handwriting:
 - i. The dose to be taken
 - ii. The form in the case of preparations
 - iii. The strength (when appropriate)
- iv. In both words and figures either the total quantity of the drug or preparation or the number of dosage units to be supplied
- g. In the case of a prescription for a total quantity to be dispensed by instalments, specify the amount of the instalments and the intervals at which the instalments may be dispensed

Ref: Misuse of Drugs Acts, 1977 and 1984

Misuse of Drugs Regulations 1998 and (Amended) Regulations 1993

APPENDIX 5

DENTAL SERVICES FOR PRISONERS - OPERATIONAL POLICY

This policy has been drafted on the basis of advice received from Dublin Dental Hospital regarding appropriate treatment provision in the context of community norms.

1. EMERGENCY TREATMENT

- 1.1 This refers to **acute trauma, pain, or infection** and will be referred for treatment by the Medical Officer, Prison Nurse, or Medical Orderly alone in the various prisons.
- 1.2 The patient will be seen as soon as possible, preferably on the day of referral, and treatment will mainly consist of extractions, fillings, or prescriptions (medication). Except in exceptional clinical circumstances, e.g., acute traumatic episode, emergency dental treatment will be limited to treatment on one tooth.

2. GENERAL TREATMENT

- 2.1 Routine basic dental treatment will be made available to prisoners. This will consist principally of examinations, x-rays, extractions, fillings, scaling, root filling of single rooted teeth only, and dentures (plastic).
- 2.2 This treatment will be available only to those **sentenced to a period of 16 months or longer** (see 2.3 below for exceptions) ***or where a prisoner has been on remand for 12 months or more.*** With the standard remission of $\frac{1}{4}$ of sentence this means any prisoner who might be expected to spend **more than a year in prison.**
- 2.3 If, in the clinical judgement of the dentist, routine basic treatment is required for a prisoner serving less than 16 months prior approval should be sought from the IPS Healthcare Directorate (through the Governor) outlining the reasons for such treatment. (In those prisons serviced by the Dublin Dental Hospital treatment in such cases will require the approval of the Consultant in Charge.
- 2.4 A waiting list will be in operation on a first come first served basis.
- 2.5 Only prisoners referred for dental treatment by the Medical Officer or Prison Nursing or Medical Orderly staff will be treated.

3. GENERAL RULES

- 3.1 A prisoner who is given an appointment but who subsequently refuses treatment twice, for no acceptable reason, will not be given a further appointment during his/her sentence. If a dental emergency as defined above arises, or if a special approach is made to the Consultant in Charge (or visiting dentist where appropriate) this bar on treatment may be lifted.
- 3.2 Scaling and polishing is only available to prisoners on an annual basis.
- 3.3 A prisoner will only be provided with one set of dentures in any given calendar year except in exceptional circumstances and with the approval of the Consultant in Charge.
- 3.4 Except in exceptional circumstances (see below) no advanced restorative treatment, e.g., chrome cobalt dentures, crowns or bridges will be undertaken within the Prison Dental Service for prisoners.

4. ORTHODONTIC TREATMENT

- 4.1 Orthodontic treatment (straightening of teeth) is not available within this service.

Advanced restorative Treatment

If it is thought necessary by the treating dentist that some form of advanced dental treatment is clinically necessary, this should be discussed with the Consultant in Charge, Dublin Dental Hospital. Only in extenuating circumstances should such a procedure be contemplated, for example, if a natural or artificial crown has been damaged whilst in prison. This should be discussed with the Consultant in Charge before an application is made to the relevant prison governor. (This is similar to the procedure adopted under the DTSS in terms of extenuating circumstances but it is not usual for such requests to be granted). Prior to any discussions, the following records should be collected in order to make a decision:

1. **Upper and lower models** of the mouth.
2. A **full periodontal screening** (to determine the condition of the gums and bony support of the whole mouth).
3. The **bleeding index** for the whole mouth - that is the level of gingival bleeding, which indicates the level of plaque control.
4. The **plaque index**, that is the amount of plaque and the number of surfaces of the teeth, which are covered in plaque. This can be worked out by staining the plaque by using a vegetable dye, counting the surfaces and then getting a ratio. In any patient with a **plaque score of over 20%**, this in itself is a contra- indication for proceeding with advanced restorative treatment, as in all likelihood the proposed treatment will

be unsuccessful. In cases where the score is over 20%, the treatment itself may well cause further deterioration of the gingival condition and so make things worse.

5. Is the **patient a smoker**. There is a very close association in the dental literature between smoking and periodontal disease and as such, may compromise the prognosis for any advanced restorative care.
6. **The reasons why** the request for this particular treatment is being proposed. It should not be sought on the basis that the patient just wants it
7. The **overall level of active dental disease** (both active and recurrent carious lesions) present in the patient's mouth at the time of the assessment.
8. The **degree of difficulty/skill** required to undertake the proposed treatment and whether this is available from within the Prison Dental Services, or what other considerations must be taken into account.
9. It would also be necessary to have access to **recent, relevant readable radiographic images**.

On the basis of the above, the Consultant in Charge will discuss the findings with the treating dentist and make a decision as to whether or not to approve the proposed treatment on the merits of the case presented, after which approval will be sought from the governor.

Healthcare Directorate
July 2007

APPENDIX 6

Methadone Treatment Programme Guidelines for the Irish Prison Service.

(based on the European Methadone Guidelines)

Summary

In most good programmes psychosocial interventions are considered a central part of methadone treatment. Research from the USA has demonstrated that there are several programme characteristics associated with treatment success such as comprehensive services and the integration of medical, psychosocial, counselling and administrative services (Ball & Ross, 1991). McLellan et al (1993) described that service users who receive counselling and other psychosocial services with their methadone had better outcomes than those who only received methadone.

The importance of creating and maintaining a therapeutic context in which methadone treatment programmes are delivered as part of the treatment of opioid dependence is widely accepted. As is the case with any other service user populations receiving any kind of treatment, individual methadone maintenance service users may vary in their needs and they may differ in their responses to components of treatment. The need for counselling and other interventions should therefore be assessed for each service user individually. Some service users need more assistance than others to get their lives in order. On the other hand, there is no reason why stable service users without major life problems should require counselling at all.

Service users with psychiatric disorders could benefit from psychotherapy. However, there is no reason to believe that psychotherapy is a treatment for all opioid dependants. *Individual assessment is the key to good service delivery.*

Assessment of addiction and the degree of dependence is essential before prescribing methadone. Induction, treatment plan and initial dosage should all be determined with care. Service users need to be informed not only about the actual pharmacological effects of methadone and the dangers of using other substances when on methadone, but also about the potential risk of overdose.

It is highly recommended that new entrants start receiving methadone in the morning and preferably early in the week, so that the peak blood methadone concentrations occur when the health care area is still open and staff are available for consultation and intervention.

In general, the initial dose will be between 10 - 20mg. In cases where tolerance to opioids is high, the normal dose will be between 25 - 40mg. When tolerance is low or uncertain, a dose between 10-20mg is more appropriate. **If in doubt perhaps it is best to err on the side of caution and prescribe a lower dose.** While too much methadone can be fatal, insufficient methadone is unlikely to be effective.

During the first week of induction scheme, service user should be seen daily where possible so that a stabilisation dose can be established. Where doses need to be increased during this first week, the daily increase should be a maximum of 5 to 10mg and not exceeding 20mg within a week of the initial dose.

Careful consideration should be given if a dose increase exceeds 20mg per week. It can take up to six weeks or more to be properly stabilised on methadone treatment. Compliance will only be maintained if both service user and doctor agree that a reduction scheme is desirable.

The majority of individuals in maintenance treatment will require 60 - 120mg per day. Although some individuals can be successfully maintained on lower doses, an average heroin dependent person will use less heroin and remain longer in treatment, if maintained on higher rather than lower doses of methadone.

Some groups such as pregnant women, people with HIV disease, service users with young children etc. (see emergency criteria for treatment), should be given priority to enter methadone treatment. They may also need special attention. Liaison should be co-ordinated with specific services as antenatal, infectious diseases, so that their immediate problems can be addressed.

Methadone treatment should not be seen as an isolated intervention but as part of a comprehensive programme of care. It is important to identify and address other problems such as medical, social, mental health or legal problems. This can be done either by the staff within the methadone programme or through liaison with other services and institutions. A multidisciplinary approach to methadone treatment is essential.

Prescribing is the sole responsibility of the doctor who signs the prescription. This responsibility cannot be delegated.

Apart from methadone, a range of other substitution medication is prescribed in different countries with success, such as Buprenorphine, long acting morphine and heroin.

People working in methadone treatment will require specific training which addresses the pharmacological, toxicological, medical and psychosocial aspects of treatment of opioid dependence. The attitude of the staff needs to be non-judgmental. Supervision and regular team meetings are important elements of good practice. To ensure high quality of the services delivered, continuous training is highly recommended.

Keeping records of prescribing and of any activity surrounding a service user is necessary as in any medical practice, this may be computerised, hand written and combination of both. A central list of service users in methadone treatment may prevent double prescribing. The information contained on this is confidential and access to the list is restricted to doctors and clinical team who provide the treatment.

A methadone treatment programmes should be a safe place. It should be easily accessible centrally located and clean. At all times, service users should be assured of the confidentiality of their information and that it will not be used for non-medical purposes (see policies regarding confidentiality). A good rapport between the staff and the service user is vital for the success of the treatment.

When planning and designing a new treatment service, it is important to involve users of this service in the process as well were possible.

Monitoring activities and evaluation of outcomes should be undertaken on a regular basis.

Chapter One. Introduction

Of critical importance is the recognition that, as in every other area of medicine, treatment must be tailored to the needs of the individual service user.

These guidelines are not intended to dictate, but rather provide guidance and recommendations for good clinical practice of methadone treatment programmes.

Methadone Substitutions Treatment in Europe

The type of methadone programmes varies from low threshold programmes in some countries to high threshold ones in others. Both high and low threshold are formed in the Northern Area Health Board.

Low threshold programmes:

- Are easy to enter
- Harm reduction oriented
- Have as primary goal to relieve withdrawal symptoms and craving and improve the quality of life of service users
- Offer a range of treatment options

High threshold programme

- Are more difficult to enter / may have selective intake criteria
- Abstinence oriented (including methadone abstinence)
- Have no flexible treatment options
- Adopt regular (urine) controls
- Inflexible discharge policy (illegal opioid use not consented)
- Compulsory counselling and psychotherapy

Most countries have seen a rapid expansion in the provision of substitution services, especially in Spain, France, and Greece and in some Central and Eastern European countries. A rapid expansion is even more evident in countries like Luxembourg, Finland and Greece, which had lower baseline levels of provision. The impetus for the expansion has largely been a response to the HIV disease epidemic among drug users. Whilst most countries have experienced few problems during this growth period, concern has been expressed in some member states. It concerned the lack of training and skills of some practitioners who are now involved in substitute prescribing. This is particularly notable among specialist services, including general practitioners and pharmacists (Department of Health UK guidelines, 1999; Farrell et al., 1999). There is also concern about controls on prescribing and the risk of possible diversion of methadone onto the black market (Farrell et al., 1999).

Chapter Two: The evidence for the effectiveness of methadone

Pharmacology

Methadone (*methadone hydrochloride*, or 6-dimethylamino -4, 4-diphenyl-3-hepatone hydrochloride) is a synthetic opioid agonist that has effect on humans similar to those observed with morphine. Methadone is well absorbed from the gastro-intestinal tract, irrespective of formulation type (e.g. syrup vs. tablet). It has very good bioavailability of 80 to 95%. The elimination half-life of methadone has been estimated to be 24 to 36 hours, with considerable variation across individuals (10 to 80 hours).

The rate of metabolism of methadone by the CYP3A4 enzyme affects the clearance of methadone from the body. The expression of the CYP enzyme is influenced by genetic and environmental factors and by certain medications. It is highly variable which can result in methadone toxicity and at the other extreme, in opioid withdrawal. Certain medications interact with the blood level concentration of methadone and special attention has to be given to people using other medications such as HIV medications, antibiotics, some anti-epileptics and medications that treat tuberculosis. For more information on the interaction of methadone and other medications we refer to appendix 14 of the UK Guidelines and to the Methadone Briefing by Andrew Preston, 1996. The UK Guidelines can be consulted on the Internet: <http://www.doh.gov.uk/drugdep>. The Drug Misuse and Dependence-Guidelines on Clinical Management.

Side effects of methadone occur in the neuro-vegetative and psychological area. The most common side effects include: increased transpiration, constipation, and disturbances of sleep, sex drive and concentration. Such undesirable side effects may persist over longer periods of treatment, but mostly remain without medical consequences. In total, these side effects affect less than 20% of methadone service users (Swiss Methadone Report, 1996).

Methadone treatment with full tolerance and stable doses does not usually impair the ability to drive or operate mechanical machinery. All service users that are not stable are strongly advised not to drive or operate mechanical machinery, and should be informed that if deemed at risk to others, confidentiality may be broken. Where service users are being prescribed further psychotropic medication, further consideration to their ability to drive or operate mechanical machinery should be questioned. However, before issuing or reissuing a driver's license, careful checking is advisable to determine whether the service user's situation is stable; whether there are any chances of relapse, and whether there is consumption or misuse of other substances. Especially the simultaneous use of alcohol and/or medications (e.g. benzodiazepines) should be taken into consideration (Swiss Methadone Report, 1996).

Research

Most research on methadone has been done in the USA. The National Institute on Drug Addiction (NIDA) has funded and co-ordinated several studies which have examined various treatment outcomes of methadone maintenance treatment in the United States. Some of these research projects were: the Drug Abuse Reporting Programme (DARP) studies with a 12-year follow-up; The Treatment Outcome Perspective Study. (TOPS) gathered data before, during and after treatment on a nationwide scale and The Methadone Research Project (The Ball and Ross Studies) looked at the effectiveness and status of MMT in six programmes in three cities (International Forum, 1994).

Opiate addiction is complicated and that has both metabolic and psychological components. It is important to deal with both aspects of this condition. Since it is a condition where a service user is prone to relapse, careful risk assessment of this possibility should preclude any decision to stop methadone prescribing.

Another important study is the British follow-up study of the National Treatment Outcome Research Study (NTORS), which monitored the progress of 1075 service users in residential and/or community treatment services over five years (Gossip *et al.*, 1998).

In conclusion, research supports the conclusion that methadone maintenance is more effective than no treatment or placebo in retaining people in treatment, reducing use of Heroin and other illicit drugs, preventing HIV infection, improving the health-related quality of life, and reducing involvement in criminal activity and imprisonment rates. Detoxification alone is seldom effective in producing long-term change. The benefits of methadone maintenance programmes can be maximised by retaining service users in treatment, prescribing higher rather than lower dosages of methadone, orientating programmes towards maintenance rather than abstinence, offering counselling, assessment and treatment of psychiatric co-morbidity and social treatments and the use of contracts and counselling to reduce the use of additional drugs (Preston, 1996; Farrell, 1994; Ward, 1998).

Chapter Three: Outline of Best Clinical Practice

Criteria for Treatment

There are two internationally accepted diagnostic criteria that cover drug dependence: the first criteria of ICD 10 which defines Dependency syndrome as: "*A cluster of physiological, behavioral and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had a greater value.....*"(WHO Expert Committee on Drug Dependence, 1998).

Substance dependency is diagnosed if at least three of the following criteria had been present in the previous year:

Psychological:

- Strong desire or compulsion to take the substances
- Difficulty in controlling behaviour regarding the onset, termination or levels of use

Physiological:

- Characteristic withdrawing syndrome or the substance if not taken
- Evidence of tolerance and need of increased dose to achieve effect

Social:

- Progressive neglect of alternative interests/pleasures and increased time necessary to obtain, take or recover from substance
- Persisting with substance use despite the negative harmful consequences

The criteria for entering methadone treatment differ widely between programmes.

High threshold programmes adopt strict criteria, such as:

- A minimum age of 18 (under in some cases)
- History of failed treatment attempts
- Strong motivation to enter treatment
- One of the international diagnostic criteria for opioid dependence

Some methadone programmes only accept heroin addicts for treatment if they suffer from illnesses, such as HIV disease or tuberculosis.

At the other end of the scale there are low-threshold programmes, which would welcome anybody with a proven addiction to opioid who wish to enter a treatment programme.

The criteria differ according to the type of treatment (maintenance or detoxification) because of the length of time a service user is expected to be in treatment. Other factors, such as the availability of places, may influence inclusion criteria. In areas where there are no waiting lists, programmes can adopt looser criteria than in places where there is a larger demand than supply of treatment possibilities.

In general, the best situation is where everyone who is opioid dependent and in need of treatment can enter methadone after appropriate assessment and treatment induction. It is recommended that the availability of treatment places be taken into account when adopting admission criteria. A minimum age, length of opioid addiction, physical and mental health and personal motivation of the service user, could all be taken into consideration. Some groups, such as pregnant women or service users with HIV/AIDS or other illnesses, should be given priority over the general opioid addicted population. This, however, should not entail compulsory HIV - antibody testing of service users.

Assessment

It is recommended best practice that all service users receive an initial nursing, counselling and doctors assessment before starting treatment. Before starting any type of methadone treatment it is necessary to determine whether the service user is taking opioids and to establish the presence and severity of opiate dependence. **The doctor should conduct a personal interview with the service user and carry out a physical and mental state examination and urine for toxicology.** The final decision for the type of treatment should be taken on the basis of the needs of the individual service user and the options open to the clinician. To ensure a successful treatment programme, the clinician or assessor is required to give the service user information on the full range of treatment options. It should be ensured that the service user is matched to the most appropriate treatment for their current needs. Further, when starting methadone or psychoactive substances, the doctor should give to the client detailed information on the treatment, on the possible side effects of the medication and the potential social consequences (such as long-term dependency and increased tolerance).

Part of the assessment process for new committals must include a minimum of one urine with specific test for heroin metabolites (6 A. Morph). The doctor before their initial assessment of the service user should review Nursing and counselling assessments.

Urinalysis can be helpful in confirming opioid use, however, this should be considered with care. It may encourage the use of opioids prior to an assessment. Furthermore, it can only confirm opioid use, but it does not provide any information about the extent of use or dependence. Its main usefulness may be in determining the use of other substances presently being used by the applicant (Ward et *al.*, 1998). The results of any urinalysis should be considered only with a thorough clinical examination.

Treatment plan and treatment goal (duration and dosage)

Although these guidelines cannot modify potential local restrictions in therapeutic options, it can be stressed that the international literature, as well as the experience overtime in different parts of the world, underline the importance of the availability of a room for individual treatment assessment. Restrictions in availability of places, in dosages and duration or type of treatment are counter-productive in the effective treatment of opioid dependent service users. Making decisions about the treatment of individual service users has to be based as much as possible on a thorough assessment of what will work for that person and on reliable information about what works (Preston, 1996). The decision about what treatment to offer is based on what treatment is available locally, on the service user's previous history, current situation, social support network and expressed wishes. The decision is also based on the clinician's judgement of the required degree of structure, monitoring and support of the service users needs.

Opioid use and dependence is associated with a range of medical, legal and psychosocial problems. Additional problems should be addressed from the very beginning, either by the methadone programme itself or through referral to an appropriate service.

Induction

The calculation of the right starting dose should take the following factors into account:

- That the right dose varies according to the treatment aim;
- That illicit heroin varies in purity from area to area and from time to time;
- That methadone is a long acting opiate;
- That too much methadone can be fatal but insufficient methadone is unlikely to be effective.

Starting service users on a dose of methadone that is too high may result in toxicity and death. However, there is some danger inherent in the administration of a dose of methadone that is too low, in that withdrawal may occur. The experience of withdrawal symptoms may prompt service users to seek relief from other sources, such as illicit opiates and benzodiazepines. The combination of methadone with other substances may result in toxicity and death. Furthermore, some service users may metabolise methadone quite rapidly and may also be in danger of withdrawal and self-medication (Humeniuk *et al.*, 2000). There is evidence that people entering treatment have a higher risk of dying during the first month than before they entered treatment (Caplehorn, 1999).

Once opioid dependence has been confirmed in a service user, tolerance and methadone dose need to be assessed. The usual way to determine tolerance is by clinical assessment of the service user's medical and drug use history upon presentation. Accuracy of clinical assessment may be improved by using corroborating evidence such as examining veins for evidence of injecting opioid use or urine tests. A good rapport with the service user is vital in obtaining the necessary information. It is important that enough time is allocated

for the clinical interview as well as communication with other practitioners whom [service users may have seen.

The absolute condition for an effective start of methadone treatment is to provide the service user with relevant information, which should include the following:

- The delay of 2 to 4 hours before methadone has a peak effect;
- The accumulation of methadone over time resulting in a greater effect over 3 to 5 days or more, even on a fixed dose;
- The risk of poly-drug use while on methadone, particularly other opiates, cocaine, benzodiazepines and alcohol;
- The effect of medications that induce or inhibit activity on subsequent methadone concentrations. (for more information we refer to appendix 2).

One more of the following criteria can identify service users with a higher risk of methadone toxicity:

- *It is their first presentation to that practitioner and their medical and drug use history is unclear;*
- *They are at high risk of poly-drug use or dependence*
- *Their degree of neuro-adaptation is uncertain*
- *There is risk of overdose on methadone or any other drug*
- *They have a clinically significant respiratory disease*
- *They have clinical evidence of the end stage of liver disease*
- *They are currently being administered drugs that inhibit the CYP3A4 enzyme(*)*.

Clinical titration of dosage needs to keep in mind the possibility of liver disease.

It is highly recommended that methadone is commenced in the morning and preferably early in the week, so that the peak blood methadone concentrations occur when health care area is open and fully staffed enabling staff to intervene. It is not recommended to start a new service user immediately before a holiday period.

The aim of induction is to eliminate withdrawal. In general, the initial dose is between 10 - 20mg. If tolerance of opioids is high the usual dose is between 20 - 40mg. In cases where tolerance is low or uncertain, a dose between 10 - 20mg is more appropriate. If in doubt it is best to err on the side of caution.

Where possible in the first week of induction the service user should be seen daily in order to establish stabilisation dosage.

For a longer period of detoxification and for maintenance treatment, it is recommended that increased doses do not exceed 20mg per week up to a total of between 60 - 120mg. The time needed to properly stabilise on methadone treatment can take up to six weeks or more.

Induction

In general, the initial dose will be between 10 - 20mg. In cases where tolerance to opioids is high, the normal dose will be between 25 - 40mg. When tolerance is low or uncertain, a dose between 10-20mg is more appropriate. **If in doubt perhaps it is best to err on the side of caution and prescribe a lower dose.** While too much methadone can be fatal, insufficient methadone is unlikely to be effective.

During the first week of induction scheme, service user should be seen daily where possible so that a stabilisation dose can be established. Where doses need to be increased during this first week, the daily increase should be a maximum of 5 to 10mg and not exceeding 20mg within a week of the initial dose.

Careful consideration should be given if a dose increase exceeds 20mg per week. It can take up to six weeks or more to be properly stabilised on methadone treatment. Compliance will only be maintained if both service user and doctor agree that a reduction scheme is desirable.

The majority of individuals in maintenance treatment will require 60 - 120mg per day. Although some individuals can be successfully maintained on lower doses, an average heroin dependent person will use less heroin and remain longer in treatment, if maintained on higher rather than lower doses of methadone.

Detox regime suggestions

The present policy in the IPS is to detox clients with a proven drug history *unless they fall into the following categories.*

- Currently on methadone maintenance.
- HIV positive.
- Pregnancy.

On committal to the institution the individual must be assessed by the nurse, if there is a history drug use, particularly if the person has not been treated with methadone before, a urine must be taken for toxicology specifically testing for heroin metabolites (**6 Acetyl-Morphine**), the results of which must be available to the doctor examining the person prior to prescribing methadone.

- **The day of committal the person will not receive methadone.**
- **Day 2. - The individual will be seen by the doctor with the results of the test. A maximum of 20 mgs Methadone to be dispensed.**
- **Day 3. - Following assessment 20 mgs will be administered.**

· **Day 4. - Reassessed by the doctor and dose triturated based on clinical findings.**

Extreme caution to be used in concurrent prescribing of benzodiazepines and other psychotropic drugs. Caution should also be exercised when assessing the 16 – 19 y.o. During this induction period the person should be kept under regular nursing and medical observation.

Many service users, despite requesting detoxification, are more suitable for maintenance treatment. Options should be sensitively explored with the service user, and the overall goal should be to maximise the service user's potential health gain.

Undertaking a regular clinical review will ensure that the potential goal of abstinence can always be reconsidered. Yearly case plan review is strongly recommended for all service users.

Maintenance programme suggestions

Research suggests that the majority of individuals require 60-120mg per day. Although some individuals can be successfully maintained on lower doses, an average heroin dependant person will use less heroin and stay in treatment longer, if maintained on higher rather than lower doses of methadone. In situations where high daily doses fail to prevent withdrawal during the full 24 dosing cycle, it should be determined if the individual is taking enzyme - inducing drugs concurrently, or if the individual metabolises methadone at a faster rate than average and higher methadone doses will be needed (Humenuik *et al*, 2000; Preston, 1996; Ward *et al*, 1998). Methadone levels should be performed on any service user receiving more than 100mgs.

Although the majority of service users can be adequately treated with a daily dosage of between 60-120mg there are no objective data (include methadone plasma concentration) to suggest an adequate daily dose for an individual service user. Asking the service user's opinion about methadone dosage can have a positive effect on the treatment.

Caution needs to be observed about high doses if there is associated alcohol/Benzodiazepine dependence that could be the result of an under-medication with methadone. In this case the stabilisation dosage needs to be reconsidered (Maremmani & Shinderman, 2000)

In the prison setting when an established methadone maintenance patient is committed the following procedure should be followed.

- **Verify with the Central Treatment List (CTL) where the patient is registered as receiving his/her methadone.**
- **Having verified where the patient is attending, contact should be established to ascertain the current dose of methadone, when it was last administered and any other relevant medical information.**
- **This information should be furnished to the doctor and continuation of his/her prescription should ensue as appropriate.**

- **Urine should be screened for methadone and other illicit drugs.**

Initially, service users may need to be seen by the doctor weekly and if stable fortnightly and then monthly. A more thorough review may be useful every three months to consider what has been achieved and to set new goals. **Twice weekly urines are recommended in the initial stages and thereafter weekly.** Co-existing physical, social, psychiatric and legal problems should be addressed as much as possible.

Detoxification from Methadone Maintenance Treatment

The available research suggests that the slower the course of diminishing doses, the better. However, like all other decisions regarding the treatment plan, this can best be set individually in consultation with the service user. One option is to reduce the dose blindly, as some people may prefer not to know the reduction details in order to prevent anxiety or expectancy effects. Supportive counselling is also considered an important part of withdrawing for maintenance and this should be continued after service users have finished the reduction regime because of the post-methadone syndrome. This syndrome is associated with mild symptoms of the protracted withdrawal phase as well as with issues related to leading an opioid-free life. The development of aftercare services in some places is an answer to these problems and involves a mix of education, skills training and features derived from self-help groups like Narcotics Anonymous (Ward *et al*; 1998).

Specific Groupings

Pregnant Women

Attracting and maintaining pregnant women in treatment services is vital. Where possible the partner should be taken on as well. It is advisable to give pregnant women priority to enter Methadone treatment because of the health risks for both the mother and the foetus associated with substance abuse, such as premature labour. Multiple drug use, poor nutrition and unsafe injecting can damage the foetus. The long term outcome of women who enter methadone treatment programmes during pregnancy is better in terms of their pregnancy, childbirth and infant development, irrespective of continuing illicit drug use. Women attending treatment services usually have better antenatal care and better general health than drug-using women not in treatment, even if they are still using illicit drugs (Finnegan, 2000)

Once a stable treatment programme has been established, liaison with other medical services, particularly for antenatal care, can be initiated. This can be facilitated particularly through the Drug Liaison Midwife.

Although many women would wish to detox, long-term methadone maintenance treatment is considered the best option for most opioid dependant pregnant women. In the third trimester, many women will need higher doses because of weight gain and other physiological changes.

If a woman wants to detoxify, it is recommended not to do this in the period prior to week 12 or after week 32 of pregnancy (Council of Europe, 2000). Withdrawal symptoms should be avoided but particularly during the first trimester of pregnancy because of the risk of premature labour in this period. The normal maximum reduction in the daily dose is between 1 –5mg weekly, fortnightly or monthly, depending on the woman's response. Women should not be encouraged to detox in the final trimester of pregnancy.

If detoxification is unsuccessful and the service users drug use becomes uncontrolled, methadone dosage should be re-assessed until stability is regained.

Neonates of Opioid Dependiant Women

Over 60% of neonates born to opioid dependant mothers have symptoms of neonatal abstinence syndrome (NAS) that tend to occur 24-74 hours after delivery and include the following: high-pitched cry, rapid breathing, hungry but ineffective sucking and excessive wakefulness. Hypertonicity and convulsions can also occur. The intensity of the NAS does not directly correlate with the dose of the methadone or other opioids used by pregnant women. The use of Benzodiazepines by the mother in the anti-natal period and diarrhoea in the neo-nate can considerably prolong the period of withdrawal and may result in respiratory depression.

They can usually be cared for in a normal maternity environment on condition that in case of emergency, they could be transferred to special care units.

If medication is required, a range of opioid and non-opioid drugs can be used. An oral morphine concentrate is the drug of choice and phenobarbitone may be used if the mother had been taking other substances, such as benzodiazepines.

Breast feeding is encouraged not only because of its general advantages but also because some methadone may pass to the baby in very low doses and this in turn may help to reduce any withdrawal symptoms of the baby. In case of HCV infection, the benefits of breast-feeding should be considered according to the mother's viral load (Council of Europe, 2000). Contra- indications for breast-feeding however are: if the mother has HIV disease or if she uses high doses of Benzodiazepines or if she continues illicit drug consumption.

Finally, because pregnant women and young mothers may suffer from severe guilt feelings, psychosocial care and counselling is highly recommended.

Parents of young children

Drug use is not a reason to introduce care proceedings. The needs of young children of drug dependant parents are, however, paramount. Workers in methadone programmes will need to include the care of the children in their treatment plan and have some means of supervision. There are special programmes co-ordinating the care of the parents and young children, case management of these service users is a key issue and the specific needs of the children should be considered explicitly (Children First, Department of Health & Children - September 1999)

Young People

Methadone is unlikely to be an appropriate treatment for people under 16 years of ages as they are unlikely to fit the criteria of:

- Long term opioid use
- Significant tolerance
- Level of problematic opioid use which would not be possible to treat with another form of treatment and help.

If methadone treatment was nevertheless considered, specialist assessment and management is advised. Parental consent is required. In very rare circumstances treatment may be initiated after multidisciplinary/specialist review and legal opinion.

People with HIV Disease

It is strongly recommended that all people in treatment should be tested for Hepatitis B and those without protective antibodies, should be vaccinated (See Vaccination Schedule – ERHA Publication March 2001)..

Hepatitis C is a serious health problem for injecting drug users, both in terms of prevalence and its clinical effects. There is a great need for improved methods of diagnosis and management of people with hepatitis C. The dose of methadone will have to be reviewed and analysed, according to the liver function of the service user. Specialist referral should be arranged for assessment and possible treatment of HCV. People who are stable on methadone can be very compliant with HCV treatment. Finally, as is in the case of people with HIV, it is important to reiterate the avoidance of sharing injecting equipment.

People with mental health problems

A significant percentage of opioid users may suffer from mental health problems, including anxiety and depression. A percentage of opioid users presenting at services have suicidal and self-harm risk. Entry into treatment has a significant positive impact on their psychological well being. A minority (circa 10%) have severe enduring mental

health problems that require close collaboration with mental health services (Marsden, et al., 2000).

Dually diagnosed opioid dependant service users who survive early attrition, tend to stay in treatment longer than those without psychiatric co-morbidity do, when treated with higher methadone doses during the stabilisation phase (Maremmani et al, 2000).

Poly Drug Users

In order to deal with additional substance misuse, the health worker must be aware of other poly substance misuse including alcohol and benzodiazepines, so appropriate intervention can be made. It is vital to establish a good therapeutic relationship if these issues are to be addressed. A good rapport based on trust and co-operation between prescriber and service user makes for good treatment.

Strategies to reduce risk behaviour include: increasing the methadone dose and possibly other medication, the frequency of collection, supervised consumption, setting realistic treatment goals and finally, in some programmes, the suspension of methadone prescribing.

Minority ethnic groups

In many areas, opioid dependence can be a problem among ethnic minorities. Often, services are developed for and run by people from the mainstream population and culture. In order to make services more attractive to ethnic minorities, it is important to offer culturally appropriate services.

People in hospital

It is important that general hospitals recognise and treat service user with opioid dependence. After proper assessment and communication with the drug treatment service, service users should be able to continue their methadone medication and all other medications in such a way as to ensure the completion of the medical treatment for which the service user entered the hospital. It is worth noting that general hospitals should not be considered as detox centres. The drug treatment offered in hospital should allow for full treatment of the medical problem.

The emergency department of a hospital will mainly encounter two situations:

- The management of severe abstinence and or overdose;
- The management of other drug related problems.

Liaison between drug services, prison drug services and emergency departments are essential and joint policies between the two departments should be developed at local level.

Steps in Methadone Treatment -

Individual committed to prison

Assessment by nurse
(day of committal)

Urinalysis (6 A. Morph)

Verification with Central treatment list

Doctors' assessment

Treatment plan (maintenance, detoxification)

Contract signed (copy to service user).

1. Service user given detailed information on the treatment and on the risks of using other drugs
2. Listed medications not to be used

Psycho-social follow up by Counsellor / Key Worker (where possible)

Stabilisation period to establish the right dose

Maintenance or detoxification regimen

Regular review to set new goals (depending on type of treatment)

Chapter Five (extract).

Role of the medical doctor

A doctor prescribing controlled drugs including methadone for the management of drug dependence should have an understanding of the basic pharmacology, toxicology and clinical indications for the use of the drug, dose regime and therapeutic monitoring strategy if they are to prescribe responsibly.

Irrespective of the composition of the staff of a methadone treatment programme, prescribing is the sole responsibility of the doctor signing the prescription. The responsibility cannot be delegated.

It is the clinicians' responsibility to make sure that the service user receives the correct dose and that efforts are taken to ensure that the drug is used appropriately and not diverted onto the illegal market. Particular care must be taken with induction, especially in case of self-reporting dosage.

Clinical reviews of service users should be undertaken regularly.

Role of the nurse

As part of a multidisciplinary team the nurse provides a standard of nursing care to service users in a primary health care setting conforming to best practice, An Bord Altranais code of professional conduct.

In addition to carrying out the initial assessment, prioritising for treatment, managing the treatment waiting lists and co-ordinating care, the nurse completes a nursing assessment, initiates interventions and evaluates nursing care delivery to a caseload of service users.

The nurse works in a variety of settings, which can influence the degree of primary care delivered. However, the following common interventions and educational inputs are provided by the nurse to all service users:

- Ø Family planning and safe sexual practices
- Ø Education on HIV/Hepatitis
- Ø General health promotion
- Ø Virology for HIV/Hepatitis screening
- Ø Vaccination regime as per protocol
- Ø Assessment, treatment and management of tissue viability

The Pharmacist provides advice for clinicians and nurses on pharmacology and drug interactions of medications.

Record keeping

Each intervention should be properly recorded and thorough, clearly written or computer records of prescribing should be kept (In accordance with ERHA Guidelines). A service user- held record countersigned by those involved in care, can be a useful adjunct to treatment. Other medical staff members who may see the service user should be informed of current treatment.

There is enormous variation in regulations about confidentiality throughout Europe. A central register where people receiving methadone are notified exists in some areas. This register should not entail notification to any non-medical service or institution, as there would be repercussions for the service user, such as a loss of civil liberties. Its main purpose should be to protect the service, the service users and the service providers as well as to prevent multiple prescribing and to facilitate research or funding decisions (Irish Guidelines, 1997)

In areas where there is no register, there should be some form of control and monitoring of the prescription and supply of methadone.

Physical setting

A first condition for a programme is that it is safe. Safe in the sense that people can trust the workers and that personal information is treated according to medical standards and is not given to third non-medical parties. It may seem obvious, but essential for a successful programme is that people are being treated with respect and that their privacy is ensured.

A non-judgmental attitude of treatment staff is important. Some research has shown that in a methadone maintenance programme where the staff can be identified as “abstinence orientated” service users will leave quicker than when a programme is maintenance orientated. This difference ensued after correcting for methadone dosage. (Vosseberg, 1998)

Another obvious pre -requisite for any medical service is that premises are clean. It is recommended that all staff involved in the treatment of opioid dependence be immunised against hepatitis B and undergoes tuberculosis screening.

The location of the programme should meet some important conditions. Because service users will have to attend the programme regularly, and in many cases daily, it is important that it should be centrally located.

Opening hours should be flexible to accommodate service users who work. Ideally, the programme should open in early morning.

When starting a new service in a given area, it is recommended to seek contact with community groups and representatives. Clear information should be given on the rules and regulations within the centre.

CLINICAL POLICIES

- C/1. SCREENING FOR INFECTIOUS OR COMMUNICABLE DISEASES
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- C/14. REVISED PRESCRIPTION KARDEX
- C/15. HAND HYGIENE
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C/17. ADMINISTRATION OF EXISTING PRESCRIPTION
MEDICATION TO PRISONERS ON COMMITTAL TO PRISON

C/18. AVIAN FLU - POTENTIAL RISKS

C/19. PATIENT REFUSAL OF MEDICATION

SCREENING FOR INFECTIOUS OR COMMUNICABLE DISEASES

In view of the long-standing association between I/V drug use, infection with communicable diseases (in particular Hepatitis B,C, and HIV), and criminality with the risk of incarceration it has been long-standing healthcare policy and practice to regard the prison population as being at high risk for such conditions. In view of the requirement on healthcare staff to do all possible to safeguard the health of those in their care appropriate screening, immunisation, and referral to specialist services has been undertaken over a considerable time.

In this context it is recommended that -

- 1) All persons entering prison who volunteer a background history with risk factors for any infectious disease should be offered any available screening for that condition. In line with current clinical practice it is considered that pre-test counselling is not relevant when considering HIV screening of at-risk individuals. Irrespective of the results of any screening all at-risk prisoners should be offered post-test counselling and advice regarding recommended life-style changes, etc.
- 2) Any therapeutic intervention (screening, treatment, and referral) should be provided on the basis of informed consent.
- 3) Where vaccination or immunisation is available on an equivalent basis to the general community this should be offered to the prisoner (see HC Policy C/2 - Hepatitis Vaccination Policy). Where any such process occurs over a period steps should be taken to ensure continuity of provision, either within the prison system or in conjunction with community health agencies following release.

HC Policy C/2

Re: NOTIFIABLE DISEASES

As is the case in the general community there is a legal and professional obligation on Prison Doctors to inform the relevant local statutory public health authority of any cases of notifiable disease coming to notice in the prison population. A current List of Notifiable Diseases is available from the National Disease Surveillance Centre, 25-27 Middle Gardiner St, Dublin 1 (Tel.: 01-8765300; Email: info@ndsc.ie; Web: www.ndsc.ie).

Your co-operation in this matter would be appreciated.

Healthcare Directorate
April 2004

FOOD REFUSAL WITHIN PRISON - MANAGEMENT PROTOCOL

Where a prisoner informs the prison authorities that s/he intends to refuse food or does so:

1. The reasons for this refusal should be established.
2. Where it is considered that his/her refusal is based on delusional beliefs or other psychiatric illness a full psychiatric assessment (with psychiatric hospitalisation, if necessary) should be arranged and the underlying illness treated without delay.
3. Where there is no evidence of psychiatric illness then the wishes of the prisoner (in refusing food) should be respected. Force-feeding is not an option. This fact should be explained to the prisoner by the doctor with clinical responsibility for his/her medical care.
4. The prisoner's medical condition should be monitored by a doctor on a daily basis. Monitoring should include the following:
 - 1) Daily fluid intake and urine output
 - 2) Pulse and blood pressure both lying and standing each day
 - 3) Urine tested for ketones each day
 - 4) Weight recorded on a weekly basis

The effects of continuing food refusal on his/her health should be explained in terms the patient understands. The progress of the situation, together with any interventions considered appropriate on medical grounds, should be communicated by the doctor to the prison management without delay.

5. The prisoner should continue to be offered meals at the appropriate times and note made of his refusal.
6. It is desirable that the prisoner be admitted to a single room in an appropriate medical facility when there has been a significant loss of weight with ketonuria. The prisoner should be admitted immediately if he/she refuses fluids.
7. Bearing in mind the likelihood that if the food refusal continues the prisoner will, at a certain stage lose consciousness, he/she should be asked at an early stage to nominate a legal advisor or family member to act on his/her behalf in relation to resuscitation in the event that unconsciousness or incoherence occurs.

The prisoner should be given the opportunity at an early stage to instruct the legal advisor or family member regarding his/her wishes. This is to safeguard the doctor from any accusations of negligence (in failing to resuscitate the unconscious patient) or assault (by providing treatment without the consent and contrary to the express wishes of the patient).

8. The fasting prisoner should be assessed by a psychiatrist at least twice weekly to establish that his/her capacity for rational judgement is unimpaired.

9. Medical supervision and advice, together with appropriate food and fluids, should continue to be made available to the prisoner.

10. At all times it should be made explicit to the prisoner by the responsible doctor that there is no rule of medical practice which requires the doctor to resort to artificial feeding and that the inevitable deterioration in his/her health may be allowed to continue without medical intervention unless he/she specifically requests it.

Healthcare Directorate
April 2004.

HC Policy C/4

NICOTINE REPLACEMENT THERAPY

Treatments available under the GMS, including Nicotine Replacement Therapy (NRT), are made available to prisoners subject to clinical considerations. Given the very high prevalence of smoking among prisoners we would seek to assist anyone genuinely motivated to give up cigarettes in any way possible. Giving up cigarettes requires more than replacement therapy alone and the evidence is that combined approaches are more successful than single focussed ones. In this context NRT prescription is fully justified in those indicating serious motivation, including active participation in any associated counselling programme. Where such motivation is lacking a more cautious approach to prescribing NRT is recommended.

Any decision to supply such therapy from within the prison healthcare budget should take this into account.

Healthcare Directorate
April 2004.

HC Policy C/5

Re: **HEPATITIS VACCINATION POLICY**

It is IPS Healthcare policy to offer vaccination to prisoners in line with DOHC policy.

1. Hepatitis B

It has been long standing policy to offer Hepatitis B vaccination to all prisoners who are likely to remain in prison long enough to complete a scheduled vaccination course.

In the case of prisoners who are Hepatitis C positive vaccination against Hepatitis A is also offered. The following vaccination schedules have been suggested by the ERHA Drug Treatment Services (Dr. Keating) on the basis of practice with at-risk drug users in the general community -

Proposed Vaccination Schedules:

There are four client groups who require vaccination in the Drug Clinics. They are as follows:

1. Hepatitis C negative, hepatitis B negative
2. Hepatitis C positive, hepatitis B negative, on long term program
3. Hepatitis C positive, hepatitis B negative on short term program
4. Hepatitis C positive, hepatitis B positive

1. Hepatitis C negative, *hepatitis B negative*

Present recommendations suggest vaccination against hepatitis B only - This may change if all drug users are to be vaccinated against hepatitis A and B irrespective of Hepatitis C status

Give:

Hepatitis B vaccine - HBvaxPRO (Aventis Pasteur MSD) or Engerix B (GlaxoSmithKline)* at elected date

Hepatitis B vaccine - at one month

Hepatitis B vaccine - at 6 months

*The interchangeability of Hepatitis B vaccines has been demonstrated

Measure anti HBsAb six to twelve weeks after the end of schedule

2. Hepatitis C positive, *hepatitis B negative*, on long-term program

Vaccinate against hepatitis B and A

Give:

Twinrix (GlaxoSmithKline - combined hepatitis A and B vaccine) at elected date

Twinrix - at one month

Twinrix - at 6 months

Or

Hepatitis B vaccine - HBvaxPRO (Aventis Pasteur MSD) or Engerix B (GlaxoSmithKline) and at elected date and hepatitis A vaccine - Avaxim (Aventis Pasteur MSD) or Havrix (GlaxoSmithKline)

Hepatitis B vaccine - at one month

Hepatitis B vaccine and hepatitis A vaccine - at 6 months

Measure anti HBsAb six to twelve weeks after the end of schedule

3. Hepatitis C positive, hepatitis B negative on short-term program

Vaccinate against hepatitis B and A

Give:

Twinrix (GlaxoSmithKline - combined hepatitis A and B vaccine) at elected date

Twinrix - at one month

Twinrix - at 6 months - *recall if not on program*

Or

Hepatitis B vaccine - HBvaxPRO (Aventis Pasteur MSD) or Engerix B (GlaxoSmithKline Kline) and at elected date hepatitis A vaccine with Avaxim (Aventis Pasteur MSD) or Havrix (GlaxoSmithKline Kline)

Hepatitis B vaccine - at one month

Hepatitis B vaccine and hepatitis A vaccine - at 6 months - *recall if not on program*

Measure anti HBsAb six to twelve weeks after the end of schedule

4. Hepatitis C positive, hepatitis B positive (natural infection or vaccination)

Vaccinate against Hepatitis A only with Avaxim (Aventis Pasteur MSD) or Havrix (GlaxoSmithKline Kline)

Give:

Hepatitis A vaccine at elected date

Hepatitis A vaccine at 6-12 months

Post Vaccination Testing (6-12 weeks after the end of the vaccination schedule):

Anti-HBs level	Action Required
0 or <10miu/ml	<p>Non responder.* Exclude past infection or chronic carriage.</p> <p>Repeat 3 dose course of Hepatitis B vaccine (a different brand of vaccine may be considered). Double dosing should also be considered.</p> <p>Recheck Anti-HBs at 2 -4 months post completion.</p>
10 - 99miu/ml	<p>Poor responder.</p> <p>Immediate booster and retest at 2 - 4 months using 2 assays; if both assays are > 10miu/ml, this indicates an adequate response.**</p> <p>The results should be discussed with the reference laboratory.</p>
100miu/ml or greater	Adequate response

* check anti-HBc and HBsAg to exclude past infection or chronic carriage before repeating 2nd course of vaccine.

** For those at high occupational risk of contracting Hepatitis B, efforts should be made to achieve a response of greater than 100miu/ml

Healthcare Directorate
April 2004

HC Policy C/6

Re : **MENINGOCOCCAL C IMMUNISATION PROGRAMME**

As you are aware in 2000 the Department of Health and Children launched the above national programme aimed at minimising the incidence of Meningitis C. The aim has been to vaccinate, on a phased basis, all citizens up to the age of 23 years. This process should have been significantly achieved by this time. Given that prisons contain significant numbers of individuals between the ages of 15 and 23 (particularly between 17 and 23) it is important that the opportunity to offer this vaccine to those within this age cohort while in prison is not lost.

I am writing to recommend to you that as a matter of Prison Service Health policy steps should be taken to offer this vaccine to any prisoners under the age of 23 within your establishment if they have not already received it elsewhere. Given the transient nature of the prison population it is important to maintain thorough records of those receiving the vaccine with, ideally, the prisoner's own GP being informed on release from prison.

If you have any difficulty accessing supplies of the vaccine I would suggest that you should contact your local health board or the Office for Health Gain (01-670 5194 or 623 4783).

Healthcare Directorate
April 2004.

HC Policy C/7

Re: **INFLUENZA VACCINATION FOR PRISONERS**

Policy in relation to the provision of Influenza Vaccination to prisoners is as follows -

It is practice to offer Influenza Vaccination to prisoners on the same basis as it is provided in the general community under Dept. of Health guidelines.

Essentially it is DOHC policy that Influenza Vaccine should be offered to the following groups

- 1) Persons aged 65 years or over (including residents of nursing homes, old peoples homes, and other long stay facilities);
- 2) Younger People with chronic illness requiring regular medical follow-up (e.g. chronic respiratory disease, cystic fibrosis, moderate or severe asthma, chronic heart disease, diabetes mellitus, etc.),
- 3) Persons with immunosuppression due to disease or treatment;
- 4) Children and teenagers on long-term aspirin therapy.
(not likely to be relevant in the prison context)

It is important to note that under current guidelines **vaccination is not recommended for healthy adults**. Consequently, it is not recommended for the vast majority of prisoners and prison staff.

Healthcare Directorate
April 2004.

IPS POLICY ON MEDICATION ADMINISTRATION:

- Medication may only be given as prescribed or under protocol.
- Only Nurse Officers and Medical Orderlies are entitled to administer medication
- Before administering a medicine to a prisoner, the nurse/medical orderly must:
 - a) check the prisoners name, number and location
 - b) check the medication against the prescription
 - c) check the strength
 - d) check the quality i.e. not defective in any way
- In order to ensure the safe and effective use of medication, where possible all oral medication should be administered as a **solid dose** i.e. tablet or capsule. There are a number of orodispersible formulations available now, such as Zispin Soltab, Zyprexa Velotab etc. and it is recommended that they be used where necessary to ensure compliance, particularly for medications with overdose or abuse potential.
- All medication administration must take place in front of the Nurse/Medical Orderly.
- To ensure that the prisoner has swallowed the medication, the following procedure should apply at all times:
 - a) All medication should be administered with a glass of water - therefore a supply of water and plastic cups should be available during medication administration rounds.
 - b) The patient should be supervised, in so far as is possible, to ensure that the medication has been swallowed.
 - c) The patient should be engaged in conversation following medication administration, to assist in confirming that the medication has been swallowed.
- If the patient cannot/will not swallow a tablet/capsule, then a properly formulated liquid preparation should be prescribed and used.
- Solid dose medication should never be administered in water, as this practice is unlicensed, unsafe and ineffective.
- Where there is a problem with hoarding/abuse of medication, the patient should be referred to the doctor, who will consider the appropriate action - discontinuing prescription etc.

- Administration of all medication should be recorded in the prisoners 'kardex'.

Healthcare Directorate

April 2004.

HC Policy C/9

Re: **USE OF BENZODIAZEPINE HYPNOTICS**

In line with the 'Report of the Benzodiazepine Committee' and associated 'Benzodiazepines: Good Practice Guidelines for Clinicians' which were widely circulated to all prescribers following their publication by the Department of Health & Children in August 2002 IPS supports the principles contained therein.

These drugs should only be used for short periods (no more than one to two weeks) for the treatment of acute insomnia. The use of these drugs in high dosage for prolonged periods of time (especially in the prison population as it exists) is contraindicated. It would be difficult to claim, were questions raised or criticism made in any forum, that the use of these drugs in such a fashion conformed to good practice or enjoyed the support of a substantial body of medical opinion.

Healthcare Directorate
April 2004.

HC Policy C/10

**Re: ADMINISTRATION OF MEDICATION TO PRISONERS FOLLOWING
RETURN FROM TEMPORARY RELEASE**

Where prisoners with a background history of substance abuse are absent from the prison (temporary release, court appearance, etc.) and on their return concern exists regarding the possibility of consumption of illicit drugs then it would appear judicious to withhold the administration of sedative medication until medical review (usually the following morning).

Healthcare Directorate
April 2004.

Re : **PRECAUTIONS IN RELATION TO INITIATING METHADONE TREATMENT FOR OPIATE ABUSERS**

Arising from the evidence presented at an inquest into the death of a prisoner it is considered appropriate to again re-iterate the need for an adequate assessment and clinical caution in relation to the prescription of methadone for detoxification purposes. In particular it is advised that two particular steps be taken.

1. Given the range of proprietary and prescribed drugs that can mimic a positive opiate urine, I would recommend that, where practical, analysis for 6-acetylmorphine (6AM) be undertaken. This is a specific metabolite of heroin and indicates that heroin was consumed recently. Most of the laboratories undertaking toxicology for drugs of abuse indicate that they are able to undertake this test routinely where specified.
2. Where a prisoner is to be detoxified using methadone the following regime is recommended to minimise overdose risk.

Day of committal	-	No prescription
Day 1 following committal	-	20 mg methadone.
Day 2	-	20 mg methadone
Day 3 et seq	-	clinically appropriate dosage for detox.

These steps are recommended to ensure that any prescription to a prisoner of methadone for detoxification minimises the risk of cumulative overdose developing.

HC Policy C/12

RE : PRESCRIPTION OF METHADONE TO PATIENTS UNDER 18 YEARS

Clarification has recently been sought regarding the prescription of methadone to a detainee under the age of 18 years. Current advice (as outlined in the Methadone Guidelines) is that caution should be used in any consideration of methadone prescription to this age group. In particular it would be advisable to consider obtaining parental agreement for treatment, though this may not always be practical in the prison context. In line with current community protocol such prescribing should only be undertaken when the prescribing doctor has sought advice from a Consultant in Substance Abuse.

I would be grateful if you would bear these considerations in mind should you be contemplating the prescription of methadone for someone under the age of 18 years.

Healthcare Directorate
22/01/2004.

Re: **CLINICAL RISK MANAGEMENT**

As you are probably aware Healthcare is increasingly functioning in an environment where appropriate Clinical Risk Management (CRM) structures are required. This applies right across the healthcare environment and is not in any way specific to prisons. Most Health Boards, Hospitals, etc., now have established mechanisms in place to address the issue of CMR.

Clinical Risk Management is an approach to improving the quality and safe delivery of health care by -

- 1) Placing special emphasis on identifying circumstances that put patients at risk of harm, and
- 2) Acting to prevent or control those risks in a 'no blame' cultural environment.

The reporting, monitoring, and analysis of risk incidents is best fostered within a non-blame culture as there is good evidence that blaming individuals for adverse events does little to improve safety and tends to encourage staff to hide mistakes and near misses rather than manage them.. The purpose of clinical risk analysis is to identify organisational deficiencies which may have contributed to the cause of the event, to develop strategies which reduce the chance of a similar event occurring again, and to promote the development of a proactive safety culture.

Clinical risk may occur in a variety of areas - Facilities; Equipment; Procedures; and Organisation.

To encourage and facilitate the development of an acceptable Clinical Risk Management environment in the prison context the following steps are recommended -

- 1) All incidents should be recorded in the patient's medical record. This should include date, time, nature of incident, and witnesses (if any) and be clearly signed.
- 2) Healthcare staff should report any untoward clinical incident involving a patient to Healthcare Directorate by e-mail. This will facilitate analysis.
- 3) Depending on the potential or actual seriousness of the event further investigation may be required.
- 4) Arising from analysis of an incident it may be possible to eliminate possible risk or reduce the likelihood of recurrence. This step may have resource implications.
- 5) Arising from any remedial steps taken ongoing re-evaluation of the potential risk is required to assess whether the risk has been adequately addressed.

It is intended to undertake a process of consultation with Healthcare staff with a view to designing a process to facilitate the needs of Clinical Risk Management at local level and to clarify requirements in this respect.

Healthcare Directorate
15/10/2004

HC Policy : C/14

Re: **REVISED PRESCRIPTION KARDEX**

Supplies of a new revised kardex to record the prescription and administration of medication to prisoners are currently being supplied to all prisons. This kardex (printed blue on a white background) is designed to be forwarded with the patient on transfer and to remain valid in the receiving prison until the patient is seen by the doctor.

It is essential that all staff administering medication to prisoners clearly record having done so and the attached guideline outlines the procedure to be followed in this respect. Recording of medication administration is essential to safeguard the integrity of the process and also to protect staff.

Please ensure that all new prescriptions are entered on this new kardex form and that use of previous kardexes or other recording mechanisms is discontinued. A guidance document on the use of the kardex is attached.

Further supplies of the kardex document are available from the Print Unit, Arbour Hill Prison (ref. AH 0207).

Healthcare Directorate
19 April 2005.

HAND HYGIENE

Hand hygiene is acknowledged to be the single most effective and most cost-effective, intervention to promote infection control in clinical settings (Reybrouck 1983, Voss & Widmer 1997). Awareness of its critical role in reducing morbidity and mortality predates the discovery of bacteria and the germ theory of infection (Newsom 1993). Evidence that hand decontamination helps to prevent cross infection emerged from the epidemiological studies initiated by the Obstretician Ignaz Semmelweis during the mid-19th Century (Newsom 1993).

However, the timely publication of two important documents (National Audit Office 2000, and Plowman et al 1999) has reaffirmed the importance of controlling HAI. The benefits of ensuring that all clinical staff adhere to hand decontamination protocols to safeguard infection control should now be regarded as an important component of risk management and clinical governance (Desai et al 2000).

1.1 ORGANISM PRESENT ON THE HANDS MAY BE DIVIDED INTO TWO CATEGORIES

1.1.1 Resident micro –organisms (normal Flora)

Resident micro organisms are those that are deep seated within the epidermis and are not easily removed.

1.1.2 Transient organisms

Transient organisms; These are located on the skin surface. They are easily removed with hand washing.

1.2. CHOICE OF PRODUCT

As a general rule, soap and water are adequate for routine activities, but the added protection of an antiseptic is desirable when performing invasive procedures and during the care of immuno-compromised patients.

1.2.1 **Soaps** have a detergent effect. They remove transient micro organisms physically, but have no effect on the resident microbial population unlike antiseptics. Soaps do not kill micro organisms or inhibit growth. Their effectiveness is limited, but they are perfectly adequate when performing routine hand hygiene and are inexpensive. Liquid soap should be used. (Bar soap is unsuitable)

1.2.2 **Antiseptics** cause a greater reduction than soap in the number of transient and resident organisms on the skin, either by killing them or by inhibiting their growth. They are also likely to be more effective than soap against potentially pathogenic bacteria. Some antiseptics have a detergent effect, or are marketed in a formulation that includes a detergent, and are suitable for use on hands that are physically soiled. The aqueous antiseptic solutions available in your clinical setting are likely to include Chlorhexidine gluconate, Triclosan or Povidone iodine as the active agent.

1.2.3 **Hand Rubs.** The active ingredients in these products are ethyl alcohol (ethanol), isopropanyl alcohol (isopropanol) or n-propyl alcohol. These products might sometimes contain other antiseptics such as chlorhexidine or triclosan. When combined with chlorhexidine, residual action is provided, but on their own, alcohols do not display this property. They should always incorporate an emollient to protect their skin from dryness. They have excellent bactericidal activity against most Gram-positive and Gram-negative bacteria, but have no effect on spores. Alcohols destroy bacteria more swiftly than the aqueous solutions described above, but have no detergent effect and are not suitable in the presence of heavy contamination. They are extremely useful at times when physically clean hands require rapid decontamination.

1.3. HAND DECONTAMINATION

All wrist and ideally hand jewellery should be removed at the beginning of each clinical shift before regular hand decontamination begins. Cuts and abrasions must be covered with waterproof dressings.

Hands should be washed:

- Before commencement of duty.
- Before moving from one patient to another.
- Before any aseptic procedure.
- After handling any patient.
- After handling any item that is or might be soiled.
- After using the toilet.
- Before handling food.
- After removing gloves.
- As soon as hands become visibly soiled.
- Prior to leaving the work area at the end of each duty roster.

1.4. TYPES OF HAND DECONTAMINATION

Routine: this renders the hands socially clean and removes most transient micro organisms.

Surgical: Surgical hand washing is intended to remove transient organisms and to reduce resident organisms by using antiseptic hand wash solution. Surgical hand wash is essential before all surgical or invasive procedures.

1.4.1 Routine hand wash

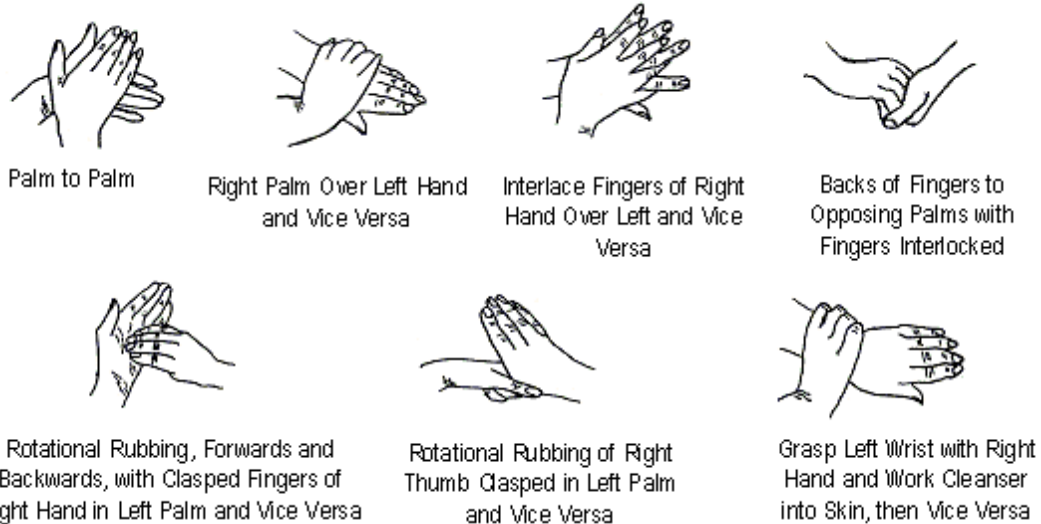
Technique A sink with elbow-or foot-operated taps should be used if possible. This helps to avoid direct touching and the transfer of micro organisms either to clean hands or the next person. Moisten hands before adding aqueous solution then vigorously rub hands together. Ensure contact of the solution with all

surfaces: the palm, dorsum, tips of fingers, inter digital spaces, wrists and thumbs. When using an alcoholic solution, add 3 to 5mls to your cupped hands and then massage thoroughly to contact all surfaces.

Duration of routine hand wash. If all hand surfaces are to be adequately covered with the chosen product, the duration of decontamination must be sufficient. The hands must be rubbed together vigorously for a minimum of 10-15 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers has all been suggested as ideal.

Drying. Wet surfaces transfer micro organisms more effectively than dry ones and organisms will be removed by friction on the paper towel. Hands should be dried thoroughly because they will become sore. Soft, absorbent paper towels are more acceptable to most people than hard ones. The use of communal towels should be avoided because their damp surfaces can harbour bacteria and transfer them between hands.

Protecting the skin Bacterial counts rise when the skin is damaged and this increases the risk of cross-infection. Hands should be protected by applying soaps and aqueous antiseptic solutions to skin that has already been moistened; they should not be allowed to contact dry skin. Thorough rinsing is necessary after washing. Hands can be further protected by applying good quality hand cream at the end of the shift and before retiring, with special attention paid to areas that look or appear dry or red. Large, communal jars of hand cream are not desirable as the contents can become contaminated, promoting cross infection.



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2. GUIDELINES FOR GLOVE USAGE

2.1 Reasons for Glove Wearing

Expert opinion agrees that there are two main indications for the use of gloves in preventing Hospital Acquired infections. (ICNA 2002, & DOH U.K. 1994)

1. To protect hands from contamination with organic matter and micro organisms.
2. To reduce the risks of transmissions of micro organisms to both patients and staff.

2.1.1 Types of Gloves

Disposable gloves are manufactured in a variety of materials and have to conform to various national and international standards. They include:

Natural Rubber Latex. (NRL)

- Combination NRL with hydrogel lining.
- Synthetic materials
- Nitrile (acrylonitrile)
- Tactylon (multipolymer synthetic styrene-ethylene-butadiene- styrene)
- Neoprene (Polychloprene)
- Vinyl (Polyvinyl chloride-pvc: synthetic co-polymer)
- Polythene (ethylene co-polymer/plastic)

2.1.2 General principles of glove wearing.

- Gloves should not be worn unnecessarily as their prolonged use and indiscriminate use may cause adverse reactions and skin sensitivity. (Yassin et al 1994)
- Gloves should be worn as single use items. They must be discarded after each care activity for which they were worn in order to prevent the transmission of micro organisms to other sites in that individual or to other patients.
- Hands should be decontaminated following the removal of gloves.
- Powdered and polythene gloves should not be used in health care facilities

2.1.3 Glove Selection

As with all items of personal protective equipment, the need for gloves and the selection of appropriate materials must be subject to careful assessment of the task to be carried out and its related risks to patients and health care workers. When choosing appropriate gloves perform risk assessment and refer to charts 1 and 2.

2.1.4 Risk Assessment

Risk Assessment should include consideration of:

- Who is at risk (patient or HCW) and whether sterile or non-sterile gloves are required.

- The potential for exposure to blood, body fluids, secretions and excretions.
- Contact with non-intact skin or mucous membranes during general care and invasive procedures

**CHART 1.
RISK ASSESSMENT AND GLOVE USE CHART**

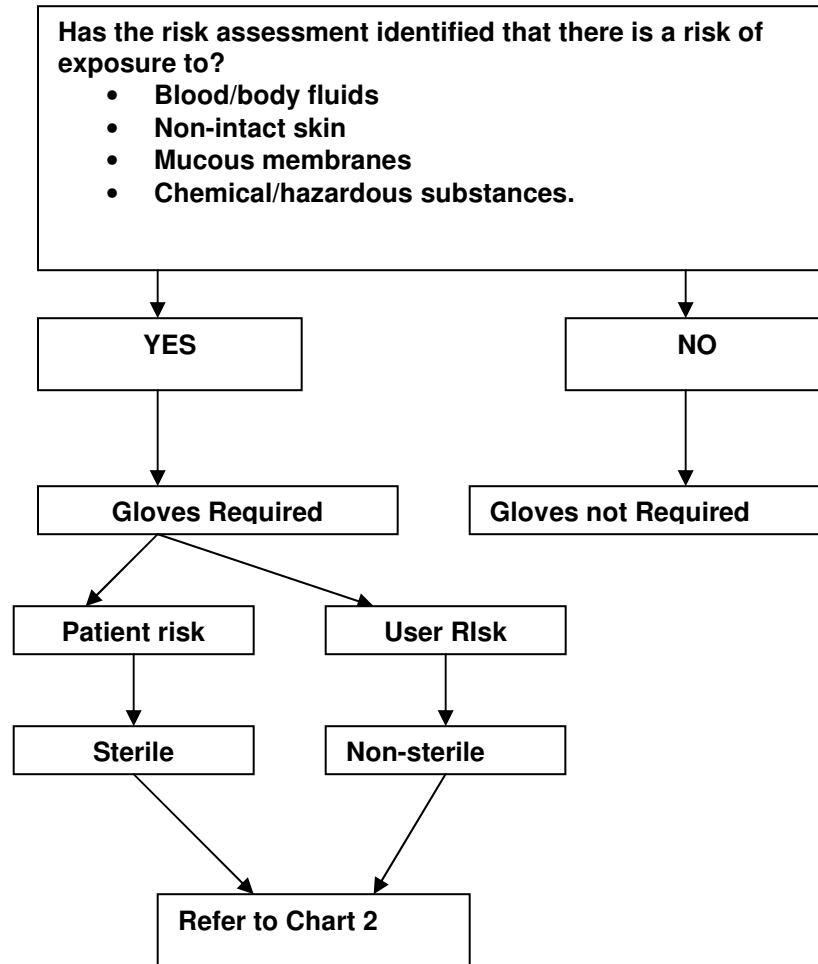
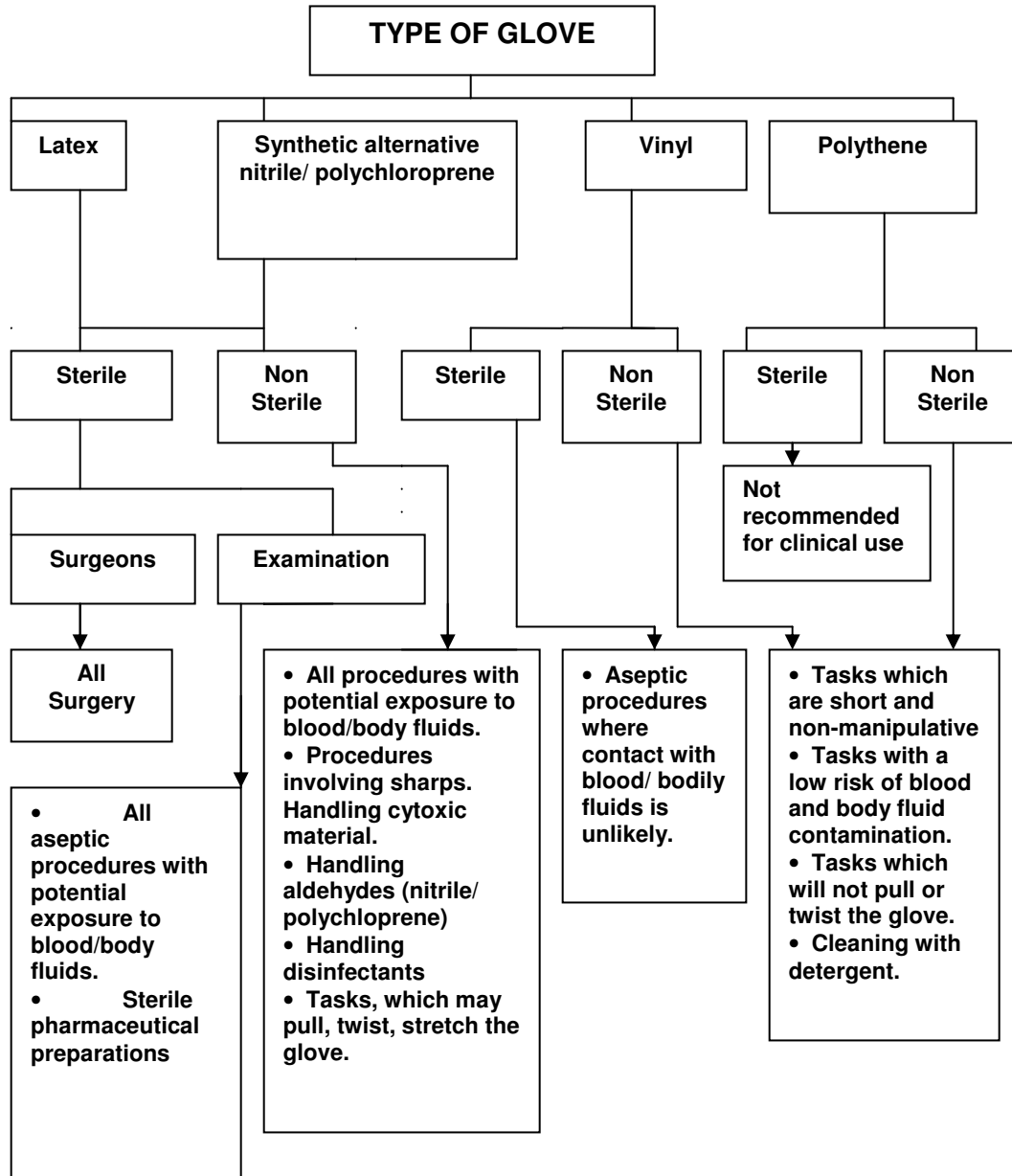


CHART 2:
MAKING THE CORRECT GLOVE CHOICE



MRSA POSITIVE WOUNDS OR ULCERS

- Refer to Prison Doctor as patient may need systematic antibiotic.
- Clean wound with NaCl - cleans surface organisms.
- Apply Bethadine dressing to wound e.g. Inadine Tulle.
- To prevent spread of infection; Apron and gloves must be worn when attending to dressings.
- A known MRSA positive wound or ulcer should be attended to last in series of dressings, where possible.
- Hand washing as per C/15.
- Wash couch and trolley with soap and water then disinfect with hypochlorite e.g. Actichlor or Presept.
- All staff should be advised to apply Universal Precautions.
- Patient should be accommodated in a single cell where possible.
- Wound should remain covered at all times when patient is recreating.
- Patient should be advised re importance of him/her exercising good hand washing procedures.
- When prisoner is moved or released, arrangements should be made to have the entire cell completely washed down with soap and water and disinfected with hypochlorite e.g. Actichlor or Presept.

HC Policy : C/17

Re: **ADMINISTRATION OF EXISTING PRESCRIPTION MEDICATION TO PRISONERS ON COMMITTAL TO PRISON.**

Guiding Principle:

To ensure the continuity of quality healthcare provision while in the custody of the prison service, in as safe a manner as is possible.

This policy pertains to medications other than Methadone, as it is covered under a separate policy/ procedure (IPS Healthcare Standards - Policies C/11 and C/12).

It is the policy of the Irish Prison Service to continue the administration of legitimately prescribed and dispensed medications to prisoners on committal until they are seen and clinically assessed by the Prison Doctor.

Procedure.

Where in the course of committal assessment by a member of the healthcare team it becomes evident that a prisoner has been, or was about to be, in receipt of medication legitimately prescribed and dispensed, every effort should be made to continue this prescription until the prisoner is seen the prison doctor.

It is imperative for continuing health in many cases, such as treatment of insulin dependant diabetes that medication be continued.

The following procedure should be deployed -

1. Take history of medication use.
2. Record name of prescriber, contact if possible.
3. Record name of dispenser, contact if possible.
4. Note any other supporting documentation. In the case of diabetes the prisoner may have in his possession the official record of his currently prescribed long-term medication (the green book). Others with long term illnesses may have similar documentation.
5. In as far as is possible ensure that the medication as presented by the prisoner is the same as stated on the label on the prescription bottle. This may be facilitated by use of the Mims or BNF.
6. Record date and time of previous administration of medication and if this information complies with administration schedule, administer and record, from the prisoners own medication supply, prescribed dosage.
7. Prisoner should see the doctor as soon as possible for a review of all medication.

This procedure is not intended to override the clinical judgement of the healthcare staff member involved in the assessment procedure. It is intended to act as an aid to minimise the risk to the prisoner until full medical assessment occurs while continuing to provide care in a prison setting. The ultimate decision will, and has to, be with the person at first point of contact in assessing the risk.

Healthcare Directorate
13/09/2005.

HC Policy C/18

Re: AVIAN FLU - POTENTIAL RISKS

As you are aware there has been much media interest and publicity surrounding the potential risks associated with a case or outbreak of Avian Flu in this and other countries. While the risk is minimal at present it is undoubtedly the situation that outbreaks have spread from original points in East Asia to the point where there was recently a fatal outbreak in Turkey.

Given the nature of this condition and the facility for long-distance travel now existing, it would seem reasonable to conclude that cases are possible closer at hand. This would particularly apply in the case of people arriving in this country from one of the affected countries (see HSE Guidance attached) presenting with a 'flu like illness and who have been in contact with domestic or other fowl in the period immediately prior to their arrival here.

The relevance of this particular matter is the possibility that individuals outlined above might, for whatever reason, be committed to a prison establishment here. To assist with the immediate assessment of any such case I am attaching the HSE algorithm for initial management.

As you will be aware the much greater risk to international community health is the possibility that mutation of the H5N1 strain may facilitate human to human transmission and the subsequent development of a pandemic of new variant influenza. If this occurs it is likely to lead to very significant social disruption in many countries. We have been in contact with the National Disease Surveillance Centre in respect of overall national plans to deal with such eventuality and highlighting the need for the Prison Service to be regarded as an essential public service in such planning. As yet there is no definite advice forthcoming from the national emergency planning forum on practical steps that we might seek to take at this stage.

Further information is available on the Health Protection Surveillance Centre (formerly the National Disease Surveillance Centre) website (www.ndsc.ie) which provides up to date clinical guidance and information in relation to questions currently being asked regarding these risks.

As further information or advice relevant to the prison situation becomes available we will forward same to you.

If you have any further queries on this matter please feel free to contact HC Directorate.

Healthcare Directorate
23/01/2006.

HC Policy: C/19

PATIENT REFUSAL OF MEDICATION

It has come to light that only some prisons use a disclaimer form signed by the patient (prisoner) in the event of a patient refusing to take his/her prescribed medication or other treatment.

It is good practice and IPS policy, Health Care Standard 7.5.8, that all refusals of medication/treatment be documented on the Kardex or PMRS. It is also recommended that the patient also sign a refusal of medication disclaimer form. Where possible the patient's signature should be witnessed by a third party. See attached an example of a disclaimer form.

The request for a third party signature is on foot of a recommendation from the Dublin City Coroner following a rider in a coroners case July of last year, this may not always be feasible but should be aimed for.

Health Care Directorate
28 February 2006

Confirmation of Investigation/ Treatment/ Medication Refusal.

Name Institution _____

Date _____

I _____ born on _____

A prisoner in _____ Prison confirm that I have refused to consent to the 1) Investigation. 2) Treatment, 3) Medication (please circle relevant item), recommended by Dr _____

Specify Treatment/ Investigation, Medication.

The reason(s) for refusal is/are as follows

1. _____
2. _____
3. _____

The consequences of this refusal have been fully explained to me and I accept full responsibility for any negative effects that may follow.

Signature of Prisoner _____

Date _____

Signature of Witness _____

Date _____

Signature of Second Witness (where possible)

Date _____

Original to be held in prisoner's medical file.

ADMINISTRATIVE POLICIES

- A/1 COMPLAINTS FROM PRISONERS REGARDING MEDICAL TREATMENT
- A/2 GUIDANCE FOR HEALTH CARE STAFF IN RELATION TO THE RESPONSIBILITY TO SAFEGUARD THE CONFIDENTIALITY OF MEDICAL INFORMATION CONCERNING PRISONERS
- A/2a GUIDANCE FOR HEALTH CARE STAFF IN RELATION TO REQUESTS FOR THE RELEASE OF CONFIDENTIAL MEDICAL INFORMATION CONCERNING PRISONERS
- A/3 HEALTH RESEARCH PROJECTS INVOLVING PRISONERS
- A/4 MEDICAL ASSESSMENT OF NEW RECEPTIONS
- A/5 PRIVATE MEDICAL ARRANGEMENTS BY PRISONERS
- A/6 ACQUISITION OF MEDICAL EQUIPMENT
- A/7 RECRUITMENT / ENGAGEMENT OF MEDICAL OR THERAPEUTIC STAFF
- A/8 PROVISION OF PARA-MEDICAL THERAPIES AT STATE EXPENSE
- A/9 REQUESTS FOR MEDICAL REPORTS ON PRISONERS
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- A/11a FREEDOM OF INFORMATION ACT
- A/11b FREEDOM OF INFORMATION ACT - MEDICAL
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- A/13 ANNUAL MEDICAL REPORTS
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- A/16 SPECIAL OBSERVATION LISTS (MEDICAL)

- A/17 NOTIFICATION OF THE IMPENDING TRANSFER OF A PRISONER TO HEALTHCARE STAFF.
- A/18 ACCESS TO MEDICAL FILES ON TRANSFER
- A/19 POTENTIAL CONTAMINATION OF URINALYSIS RESULTS FOR DRUGS OF ABUSE
- A/20 PEOPLE ENTERING PRISON WITH METHADONE SUPPLIES
- A/21 NURSING CLINICAL RECORDS
- A/22 PROCEDURE PENDING EMERGENCY TRANSFER TO EXTERNAL HOSPITAL.
- A/23 POLICY ON DISPOSAL OF PATIENTS LEGALLY DISPENSED METHADONE
- A/24 ARRANGEMENTS FOR THE CONTINUATION OF METHADONE TREATMENT FOR CLIENTS ON RELEASE FROM PRISON
- A/25 GUIDELINES ON SAFE AND APPROPRIATE SETTINGS FOR METHADONE ADMINISTRATION.
- A/26 GUIDELINE ON PROCEDURE TO BE FOLLOWED IN CASES OF ALLEGATION OF ILL-TREATMENT BY PRISONERS

HC Policy A/1

Re : **COMPLAINTS FROM PRISONERS REGARDING MEDICAL TREATMENT**

Where prisoners make complaints directly to Healthcare Directorate significant resources are required to clarify information, consult with doctors or other staff, draft responses, etc. It has become apparent that in many cases the local prison doctor is not aware of the complaint and usually would have been best placed to respond directly to the prisoner. This applies particularly where issues regarding appropriate treatment, external hospital appointments, etc., arise.

1. Where a prisoner requests through Governor's parade, half-sheet, etc., the facility to make complaint or seek clarification regarding any aspect of his/her medical treatment in prison this matter should be directed to the prison doctor or other appropriate member of healthcare staff in the first instance.
2. Only in situations where, following the involvement of the local doctor, the prisoner remains dissatisfied with the situation should the matter be directed to Healthcare Directorate. **In such cases it is requested that the written comments of the doctor on the matter raised should accompany any correspondence forwarded.**

The procedure outlined above will both expedite the addressing of any concern or complaint a prisoner may have regarding his/her medical situation and ensure that the responsible doctor is appropriately involved from the outset.

Your co-operation in this matter would be appreciated.

Healthcare Directorate
April 2004.

GUIDANCE FOR HEALTH CARE STAFF IN RELATION TO THE RESPONSIBILITY TO SAFEGUARD THE CONFIDENTIALITY OF MEDICAL INFORMATION CONCERNING PRISONERS

Introduction

The Irish Medical Council¹, An Bord Altrains², and the Pharmaceutical Society of Ireland³ in their various guidance's highlight the fact that confidentiality is a time honoured principle of professional healthcare ethics and is fundamental to the therapeutic relationship. Developments in various aspects of the practice and administration of health care have led to reconsideration of the issues involved^{4,5,6}. Various national¹ and international statements^{7,8} on the issue of ethical behaviour as applied to prisoners clarify that prisoners must be treated in the same way as other patients. There is no diminution or derogation of professional responsibility in this respect when providing care to prisoners.

Notwithstanding the fact that patient confidentiality is difficult to maintain in the prison setting it is, nevertheless, the responsibility of healthcare staff to ensure that a patient's right to confidentiality is respected. While a sick prisoner cannot easily prevent the nature of an illness being known to others sharing a cell or by prison officers this process should not be facilitated by unauthorised disclosure by healthcare staff. Any presumption that discipline staff or others, because of their position, are entitled to unimpeded access to information regarding a prisoner's health status must be clarified.

Core Principles -

1. Information relating to a prisoner's health status should be restricted to those with a genuine need to know.
2. Any sharing of information amongst those who do need to know should ordinarily be with the prisoner's consent, though exceptions may arise (see below).
3. All clinical interviews and examinations should be conducted out of the hearing and sight of prison officers unless the doctor or nurse concerned requests otherwise in a particular case.

Exceptions -

1. Notification of infectious diseases under the relevant Health Acts.
2. Disclosure ordered by a Court.
3. Disclosure to prevent risk to the patient - should be case specific and limited to relevant staff.
4. Disclosure to prevent risk to others - would require an real and imminent risk to an identified individual. The risk would have to be considered life threatening to sustain a decision to disclose confidential information.
5. Child protection - under terms of relevant child protection legislation.

Healthcare Directorate
June 2003.

References -

1. A Guide to Ethical conduct and Behaviour. 5th Edition 1998. Medical Council.
2. Code of Professional Conduct for each Nurse and Midwife. January 1988. An Bord Altrainais.
3. The Practice of Pharmacy Guide. Pharmaceutical Society of Ireland, 1999.
4. Confidentiality : Protecting and Providing Information. September 2000. General Medical Council.
5. Confidentiality : A Code of Practice for NHS Staff (Consultation Draft). October 2002. Department of Health (London).
6. Protecting Patient Confidentiality - Final Report. (Confidentiality and Security Advisory Group). Scottish Executive Health Department, 2002.
7. Recommendation No. R (98) 7 of the Committee of Ministers to Member States concerning the Ethical and Organisational Aspects of Health Care in Prison. Council of Europe.
8. Guidelines for Health Care Services in Prisons. CPT 3rd General Report (1993).

GUIDANCE FOR HEALTH CARE STAFF IN RELATION TO REQUESTS FOR THE RELEASE OF CONFIDENTIAL MEDICAL INFORMATION CONCERNING PRISONERS

- Best practice in the release of confidential medical information dictates that the consent of the patient to the release of medical information should be secured in advance wherever possible.
- No original medical files should be released from the prison surgery except with the written approval of the Director of Healthcare. However, where such approval is granted for the release of an original file, a complete copy of the file must be retained within the prison surgery.
- All medical information to be released has to be requested in writing and brought to the attention of the prison doctor (and nurse manager, where applicable). The request should ideally indicate the reason for the release and the consent of the patient where available.
- Where legal proceedings have been formally instigated by a prisoner against the IPS, the rules relating to formal discovery should be applied as is implicit in the nature of the request. In such cases a copy of any information released as part of legal proceedings should also be released under seal to the IPS legal team. It is desirable that all such disclosures be governed by formal court ruling as to the nature and extent of the disclosure required in the circumstances.
- In the event that the medical information in question is on a patient who has died, the information is protected by the Coroner until such time as the inquest is complete. All requests for the release of information in such circumstances has to be directed to the Coroner. The Coroner still only ever receives a copy of the medical file. Once the inquest is complete, the responsibility for the medical records reverts back to the doctor in the prison.
- In the case of a deceased prisoner – where the inquest is completed – it is also reasonable to release medical information to the next of kin upon formal signed application.
- Only members of the surgery staff may have unsupervised access to the medical files held in the surgery or on PMRS. This includes access to the file room containing medical information on prisoners who have already left custody.

HC Policy A/3

Re: **HEALTH RESEARCH PROJECTS INVOLVING PRISONERS**

All proposals or requests to undertake Healthcare related research involving prisoners must be referred to the IPS Research Ethics Committee for consideration in the first instance. On no account should any such project be facilitated or undertaken prior to receiving ethical approval.

While the IPS would wish to foster and encourage research which may be of benefit (either directly or indirectly) to prisoners or their management it is necessary to ensure that we are aware of any such projects together with their possible ramification for the management of prisoners. It is also essential that we be in a position to ensure that any possible accusation that prisoners are being exploited in any way can be countered.

Healthcare Directorate
April 2004

HC Policy A/4

Re : **MEDICAL ASSESSMENT OF NEW RECEPTIONS**

Potential difficulties have arisen in relation to the misunderstanding that it is appropriate to defer initial medical assessment and examination for a number of days (e.g. over a weekend, etc.). All new receptions to prison should be medically examined as soon as possible. **In practical terms this means on the day of reception or the morning following such reception.** It is not appropriate to leave new receptions unexamined for a number of days.

Among the reasons for this are -

- 1) It is important to assess any healthcare risk (particularly possible communicable disease or psychological vulnerability) prior to the placement of a prisoner on a general prison location.
- 2) It is important to note and assess any injuries which might be complained of at the time of reception. This is important in protecting staff and others from accusation that such injuries might have occurred after reception into the particular prison.
- 3) A fortunately rare occurrence is the risk of sudden illness or death occurring in a recently received prisoner who has not been medically assessed. While it might be possible to defend such a situation where the time between reception and illness/death is short this would be increasingly problematic where a number of days had elapsed.

On a practical note the Prison Doctor's Common Contract [section 6 (d)] makes provision for extra payment for any work involved in medically assessing receptions at weekends or other times.

Healthcare Directorate
April 2004.

Re: **PRIVATE MEDICAL ARRANGEMENTS BY PRISONERS**

The situation regarding the provision of medical service to prisoners is that it is policy that prisoners are provided with equivalent standards to other citizens. In this context 'equivalent' is interpreted as being the same as other citizens covered by the Health Acts (i.e. GMS Medical Card holders). Effectively, prisoners are regarded as public patients, irrespective of their personal resources, private medical insurance cover, etc. In relation to the overall smooth running of prison establishments it is felt appropriate that, to avoid friction and resentment, situations which might give rise to inequity (in this case access to preferential or more immediate healthcare) should be avoided. While this might be considered disadvantageous to the (present) small minority of prisoners with the means to access private healthcare it is felt, on balance, to be a justifiable corollary of imprisonment.

With regard to the matter of access to external or second medical opinion or treatment the following approach is advised -

1. All referrals to external medical or healthcare resources should be through the Prison Doctor (the medical person with statutory responsibility for the primary healthcare of prisoners in the particular prison), based on his/her clinical assessment of the medical situation.
2. Where a person is committed to prison with an outstanding private medical appointment steps should be taken to convert this to a public clinic appointment. If, for clinical or other reasons, this is not possible or it is considered by the Prison Doctor that the pre-existing private appointment should be facilitated this should be discussed in the first instance with Healthcare Directorate. Where this situation arises an undertaking should be sought from the prisoner to be personally responsible for the medical costs of any private treatment. Any subsequent appointments should be in a public clinic (it might be appropriate to clarify this with the external medical consultant or service). Otherwise, where a prisoner requests private medical referral this should be refused and the reasons (as outlined above) explained.
3. Given the statutory clinical responsibility of the Prison Doctor for prisoners while they are in prison it is not considered that there would be any onus on the IPS to facilitate any medical appointment obtained by a prisoner, by whatever means, independent of the knowledge or referral of the particular Prison Doctor involved.

While the advice above is intended to apply to sentenced prisoners the same broad criteria would apply to remand prisoners. Given the fact that remand prisoners remain innocent until convicted by a court there might, conceivably, arise situations where a remand prisoner sought, and was granted permission, to access private healthcare. As

indicate above clear commitment should be sought from any such prisoner to be responsible for the medical costs associated with such treatment.

If you have any further queries on this matter please do not hesitate to contact Healthcare Directorate.

Healthcare Directorate
April 2004.

HC Policy A/6

Re : **ACQUISITION OF MEDICAL EQUIPMENT**

Where the acquisition of medical equipment for use in surgeries, etc., is being requested consideration should be given to the envisaged use of the equipment requested. The need for such equipment should be clearly outlined to the Governor's office / Stores, with a copy to Healthcare Directorate. The provision of this information at the time of request will help to expedite the matter, particularly where the sanction of Finance Directorate is required. This applies especially where functioning medical equipment of a similar nature already exists.

Healthcare Directorate

April 2004.

HC Policy A/7

Re : RECRUITMENT / ENGAGEMENT OF MEDICAL OR THERAPEUTIC STAFF

Where it is necessary to consider the engagement of therapists or counsellors at establishment level for the purpose of providing medical or therapeutic services to prisoners it is suggested that the following procedure be followed.

1. Where it is considered locally that a particular therapeutic need exists and a service input is required within the prison this matter should be raised in the first instance with Human Resources Directorate and any other relevant section within IPS HQ. This applies both to any new service and to recruitment on the resignation / retirement of any existing provider. It is particularly important where financial allocation has to be made to support the post that approval is obtained from Finance Directorate. In all cases it should be clearly established that the service is required, or continues to be required, and that it cannot be provided from existing staff resources.
2. Following discussion it may be considered advisable or appropriate to advertise and hold a competition to ensure that the best qualified person is obtained and to safeguard the IPS from subsequent accusation that a potential candidate who might consider him/herself suitably qualified was denied the opportunity to compete for a position which is paid out of the public purse.
3. In all situations an appropriate selection procedure should be cleared and approved Human Resource Directorate.
4. In all cases, whether voluntary or remunerated, it should be borne in mind that security clearance may be needed and steps should be taken to obtain this clearance.

Healthcare Directorate
April 2004

HC Policy A/8

Re : PROVISION OF PARA-MEDICAL THERAPIES AT STATE EXPENSE

While it is policy that prisoners should be provided with an equivalent level of health care to citizens in the general community covered by the public health schemes it would appear that in situations have arisen where the level of treatment being provided is, arguably, considerably more (in terms of access, extent, duration, or frequency) than would pertain on the outside. This would apply to services such as Physiotherapy, Chiropody, and various types of Counselling. In general these services are provided by external providers with payment from the Prisons budget.

Where such services are provided on the basis of medical referral it is requested that

- 1) where an individual prisoner is receiving same for over **two months** there should be review by the referring doctor to ensure that continued provision is clinically justified (either on the basis of actual clinical improvement or active prevention of deterioration), and
- 2) that written confirmation to this effect be provided to the Governor.

Your co-operation in this respect would be appreciated.

Healthcare Directorate
April 2004

HC Policy A/9

Re : **REQUESTS FOR MEDICAL REPORTS ON PRISONERS**

On a number of occasions recently queries have arisen in relation to the procedure for the provision of medical reports on prisoners. As you are aware medical opinion may be sought from the prison doctor in a variety of circumstances (Court, Parole Board, concern over fitness for imprisonment, etc.). The disclosure of medical information requires the consent of the patient. Ideally, consent should be in writing and this is particularly the case where there is any possibility of subsequent dispute regarding the validity of such consent. **Consent is only valid for the stated purpose.** In other words consent to disclose information to A is for that purpose alone and should not be implied as consenting to A passing the same information to B, C, or D.

It is advised that where medical information or a report concerning a prisoner is being sought from a doctor or other member of the healthcare team a written request should be supplied indicating -

1. Who, or what body, is seeking the information; and
2. For what purpose is the information or advice being sought.

The provision of this information from the outset will help ensure that the appropriate consent is obtained and that the medical report or advice addresses the particular issues of concern.

Healthcare Directorate
April 2004.

HC Policy A/10

Re : **REQUESTS FOR MEDICAL INFORMATION ON PRISONERS BY THE
PAROLE BOARD**

The Parole Board has been established to advise the Minister in relation to the administration of longer term prison sentences. In undertaking its role it is likely that medical information or reports will be sought to inform and assist the deliberations of the Board.

In relation to providing information in any requested reports I would advise that it is important for healthcare personnel to limit themselves to matters specifically within their competence, i.e. health status and health related issues. In general comments on the general conduct of a particular prisoner, suitability for release or transfer, etc., are more appropriately addressed by other disciplines. Where a prisoner has been seen by a psychiatrist, psychologist, or other therapist it is appropriate where opinion or comment is sought on the nature or extent of any such interaction that this be from the relevant professional.

Should you require any further information concerning the functioning of the Parole Board an information leaflet for prisoners has been prepared and is available from the Governor.

Healthcare Directorate
April 2004.

HC Policy A/11a

Re : **FREEDOM OF INFORMATION ACT**

As you are probably aware the Freedom of Information Act 1997 came into effect in relation to public bodies, government departments, Health Boards, public hospitals, etc., in 1998. Effectively, the Act gives the right of access to personal information, including medical information, to the person involved.

While S. 28 of the Act does allow exemption from the obligation to disclose personal medical or psychiatric information on the grounds that the information ' might be prejudicial to his or her physical or mental health, well being or emotional condition ' in practice the justifiable application of this clause is likely to be a rarity in the prison context.

The net effect of this is that prisoners or ex-prisoners are entitled to seek access to their medical files. In cases of requests for personal information there is no limit to how far back the information sought can apply. Any such requests should be directed to the Freedom of Information Officer in this Department for processing rather than being addressed locally. Obviously the application of this Act in no way excludes the good clinical practice of informing and involving any patient in relation to their own medical care. As you are aware the Medical Council and medical defence bodies recommend that patients seeking information in relation to their medical situation should, if possible, be facilitated. The new Act gives a right of access and the applicant does not have to indicate why access is being sought.

If you have any further queries on this matter please do not hesitate to contact Healthcare Directorate.

Healthcare Directorate
April 2004.

HC Policy A/11b

Re: **FREEDOM OF INFORMATION REQUESTS - MEDICAL**

All FOI Healthcare requests are to follow the guidelines set out below -

1. Any request received locally (either through half-sheet or direct application to the prison) stating that the request is being made under the terms of the FOI Act should be directed without delay to the FOI Office, Department of Justice, Equality, and Law Reform. This is necessary so that the request can be formally acknowledged and distributed to relevant sections.
2. No attempt should be made to respond directly at local prison level to any FOI request. This is necessary because of the formal nature of the FOI application and appeal process and the need to formally document the process.
3. Healthcare staff should be aware that, under the FOI process, an applicant may request the entirety of his/her healthcare record. Where, in the course of normal clinical interaction information is being provided by, or solicited from, third parties (relatives, etc.) it should be made clear to informants that such information may subsequently be divulged under FOI application.
4. Where clinical information (often the prisoner's medical file or copy) is requested this should be forwarded **directly** by local healthcare staff to Healthcare Directorate where a decision will be made regarding the extent of response to any FOI request. This is necessary to ensure that confidential clinical information remains so.
5. Given that FOI requests have to be responded to within 28 days of receipt (by the FOI Office) the need for rapid response to requests for files, etc., will be apparent.

Healthcare Directorate
27/07/2004

HC Policy A/12

Re : **REPATRIATION OF PRISONERS UNDER THE TERMS OF THE EUROPEAN CONVENTION ON THE TRANSFER OF SENTENCED PRISONERS**

As you are probable aware the above Convention has been in operation for a number of years and has led to the transfer of a number of sentenced prisoners to other jurisdictions to complete their sentences. In processing requests from prisoners it has been administrative practice to seek various reports, including medical, for transmission to the receiving jurisdiction.

It is requested that medical reports be forwarded directly with the prisoner/patient at the time of transfer (rather than to the central prison healthcare administration as formerly). With this in mind any medical summaries or reports relating to a transferring prisoner being transferred under the Convention should accompany the prisoner directly at time of transfer rather than being forwarded in advance.

Healthcare Directorate
April 2004.

HC Policy A/13

Re : ANNUAL MEDICAL REPORTS

Current Prison Rules, together with the Doctor's Common Contract (item 5h) require that an annual report dealing with medical issues within the prison is forwarded on a regular basis. Copies should be forwarded to HC Directorate and to the local Prison Governor.

As you are aware there are very significant changes in the management of the Prison Service currently in train with the development of an independent authority to run the Prison Service. You will be aware that a Prison Service Strategy Statement together with the associated Business Plans which have been prepared at establishment level will impact on health care provision. In all likelihood there will, over time, be a greater requirement for accurate account of workloads, healthcare problems, etc. Accurate, comprehensive annual reports are a necessity not only for statistical purposes but also in formulating longer term strategic planning of future developments in the prison healthcare field.

For future reports it is suggested that information under the following broad headings should be included -

General Health of Prisoners

Mental Health of Prisoners

Infectious Diseases - in particular TB, Hepatitis B & C, and HIV.

Drug Misusers - numbers presenting, particular drugs being abused, management strategies, liaison with external agencies, etc..

Deaths / Suicides

Medical Documentation - including the adequacy of standard sheets, transfer of medical information , etc.

Health Care Accommodation - adequacy of existing surgery accommodation and equipment, need or access to in-patient medical or psychiatric facilities.

Health Care Staffing - adequacy of number and training of staff, etc.

Visiting Specialists - numbers, frequency, adequacy of service, etc.,

Health Education / Promotion - any local initiatives or plans for the future?

Medical Standards - any difficulties in providing prisoners with a standard of medical care equivalent to that available in the general community.

Other matters.

While the above list may appear lengthy not all issues will pertain to each establishment. The benefit of a broadly standard format is that it will facilitate rapid identification of common issues or problems. Furthermore, in endeavouring to obtain adequate resources for prison health care it will be increasingly necessary to establish and verify where problems exist and to what degree.

Annual Reports dealing with Healthcare issues should be submitted by end-February of the following year at latest.

Healthcare Directorate
April 2004.

HC Policy A/14

Re: **EXTANT MEDICAL APPOINTMENTS ON COMMITTAL**

Whenever a prisoner is received into prison initial health care screening should query existing medical conditions or appointments pending.

Any pre-existing appointments for essential medical procedures through the public health system should be maintained and implemented. Where such arrangements relate to what would be considered elective or non-essential treatment consideration should be given to postponing or deferring these arrangements until such time as the person is again at liberty. Given the very significant cost of escorting prisoners to external hospitals together with the associated security risks all possible steps should be taken to limit referral to what is considered essential on clinical grounds.

As it is policy to provide prisoners with access to health care on an equivalent basis to public patients in the general community any pre-existing arrangements for private health care should, if appropriate, be converted to provision through the public health mechanism or, if not considered essential, deferred.

Your cooperation in this matter is appreciated.

Healthcare Directorate
April 2004.

HC Policy A/15

Re : **REFERRAL FOR SPECIALIST MEDICAL ASSESSMENT**

Concern has been expressed that prisoners are being referred to specialist medical services, in particular in-house psychiatric clinics, without having been assessed by the prison doctor.

Medical protocol (which will be familiar to Prison Doctors) is that access to secondary specialist service is following primary assessment by a general practitioner. This procedure should also operate within prisons. You will appreciate that, as the physician with primary healthcare responsibility for prisoners, it is necessary for the prison doctor to be aware and involved in referral decisions.

Your co-operation in this matter would be appreciated

Healthcare Directorate
April 2004.

Re: **SPECIAL OBSERVATION LISTS (MEDICAL)**

While Special Observation of prisoners may be indicated for a variety of reasons (many of which have no healthcare implication) where such observation procedures are considered necessary on healthcare grounds the following procedure should be observed to ensure that this is only engaged in for specified reasons and for the minimum time possible -

- 1) Special Observation **on medical grounds** must be authorised by a doctor (the Prison Doctor, Visiting Psychiatrist, or other appropriate doctor). Where, on the grounds of urgent need, another member of staff initiates Special Observation procedures (citing medical reasons) the doctor must be consulted as soon as possible. The doctor should review the circumstances necessitating the Special Observation and, if appropriate, authorise it in writing.
- 2) The rationale for Special Obs. (on medical grounds) should be entered in the prisoner's medical file and, subject to the requirements of medical confidentiality, be communicated to the Governor and other relevant staff. Communication with staff should offer advice regarding the frequency and method of observation.
- 3) The need for on-going (medical) Special Obs should be reviewed on a daily basis by the doctor.
- 4) Where, in the opinion of the doctor, Special Obs. is no longer indicated s/he should enter a note to this effect in the prisoner's medical record and communicate this lapsing of medical authority to the Governor.
- 5) Where Special Obs. is maintained on a prisoner for a **continuous period of 14 days or more** formal consultation should occur between the Healthcare team and Prison Management to assess whether medical or organisational factors can be brought into play to resolve such an on-going need.

HC Policy A/17

**Re: NOTIFICATION OF THE IMPENDING TRANSFER OF A PRISONER TO
HEALTHCARE STAFF.**

Efficient healthcare provision in prison would dictate that arrangements be in place to ensure that healthcare staff are informed of all impending transfers. This is essential to facilitate the transfer of appropriate information and medical notes.

Suitable arrangements should be in place in all establishments to ensure that this occurs.

Healthcare Directorate
April 2004.

HC Policy A/18

Re : **ACCESS TO MEDICAL FILES ON TRANSFER**

Where a prisoner is being transferred to a new prison the medical staff in the forwarding prison should ensure that information regarding medication due accompanies the prisoner. Concern has been expressed that confidential medical files accompanying prisoners on transfer are being opened by non-medical staff in the receiving prison. This applies particularly in relation to transfers to open centres which do not have 24 hour medical orderly cover. Ostensibly, this practice is justified on the grounds that it is necessary to determine what (night) medication a prisoner might be due on arrival in the receiving prison.

Where a prisoner is going to a centre where there is unlikely to be a medical member of staff on duty to receive the file on arrival it would be appropriate to attach information regarding medication due under separate cover to the main medical file. While it is highly unlikely that the omission of a single dose of any medication that a prisoner suitable for an open centre might be prescribed would have a significant detrimental effect this procedure would obviate any need for lay staff to be seeking to access the confidential medical file.

Your co-operation in this matter would be appreciated.

Healthcare Directorate
April 2004.

HC Policy A/19

Re : POTENTIAL CONTAMINATION OF URINALYSIS RESULTS FOR DRUGS OF ABUSE

As you are probably aware there is increasing resort within the prison system to undertaking urinalysis for various illicit drugs. In many cases it is to determine drug use prior to prescribing a detoxification regime whereas in other cases it is part of an on-going therapeutic programme. In further cases demand for urinalysis may be court driven or related to security concerns within a prison establishment and so, strictly, not part of any medical procedure. In these cases there may be no involvement of prison healthcare personnel.

In this context it is essential to minimise potential challenges to the accuracy of test results. One possible reason for a false-positive result is the presence of prescribed medication or other adulterant in a sample. In the case of all samples submitted to an external laboratory for analysis it is important to indicate any prescribed medication which might be present. It goes without saying that a procedure should be in place to ensure the integrity of all samples which may have a detrimental or other effect on a prisoner.

If you have any further queries regarding this issue you should direct them to Mr. John O'Sullivan, Biochemistry Section Head at Claymon Laboratories who can be contacted at 01- 295 8545.

Healthcare Directorate
April 2004.

HC Policy A/20

Re : **PEOPLE ENTERING PRISON WITH METHADONE SUPPLIES**

As a safety measure and to assist in risk management it has been agreed that as and from 1 April 2004, individuals who enter the prison system with supplies of Methadone (which may, of course, be in legitimate possession) should **NOT** have any such supply returned on release.

Any prisoner who requests the return of such property should be advised that it will be necessary for him/her to attend their local community drug treatment centre for the renewal of prescription and supply of this medication.

Any such quantities of methadone being retained in the prison system should be disposed of by approved means.

* See A 23 Policy on Disposal of Patients Legally Dispensed Methadone*

Healthcare Directorate
12/03/2004

HC Policy A/21

Re : **NURSING CLINICAL RECORDS** - First issued 10/01/02.

If not already in place, it is now policy that all health care areas maintain a nursing journal, similar to a ward report book. Depending on the size and operation of the institution, it may be appropriate for the nurses covering particular wings to maintain a written report for that wing; this will facilitate hand over between shifts and ensure that no relevant data is omitted at hand over. It is each nurses responsibility to familiarise themselves with the contents of the nursing journal relevant to their area of duty.

Nursing notes regarding any aspect of patient care, (Statutory duty under Nurse's Act 1985) can be subpoenaed for Courts of Law and or Professional Conduct Committee or accessed under the Freedom of Information Act. The records are there to facilitate good communication and effective patient care; they also afford nurses protection if properly maintained. "Remember if it is not recorded it didn't happen".

Records should be accurate, precise, relevant and concise, "making and keeping records, is an essential and integral part of care and not a distraction from its provision." (Nursing and Midwifery Planning and Development Unit SEHB 2001).

Nursing records are confidential and should be maintained in a safe area.

Best Practice Guidelines for Record Keeping modified for the prison service.

- Record keeping should provide a record on committal against which improvement or deterioration may be judged. Where present identify and record risk factors on committal.
- Records should provide evidence of care planned, decisions made, the care delivered and information shared.
- Records should follow in chronological order of events and reasons for decisions made.
- Records should provide accurate, correct, comprehensive and concise information concerning the condition and care of the patient and associated observations.
- Records should record physical, psychological and social factors that appear to affect the patient.
- Records should be made as soon as possible after the action or event to which they relate.
- Records should be written legibly and indelibly using the patients name and a unique identifier, e.g. PRIS No.
- Records should be clear and unambiguous.

- Records should be accurate in each entry as to date, time, (24 hr clock) and signed.
- Ensure any alterations are scored through with a single line followed by the signed, dated and timed correct entry. A record should never be erased; Tippex or erasing fluid should **never under any circumstances be used.**
- Ensure additions to existing records are individually dated, timed and signed.
- Records should not include jargon or subjective statements.
- Only approved abbreviations should be used.
- NO abbreviations should be used on nursing documentation that is to be used for discharge or transfer purposes.
- Records must be objective and describe what is observed. If an incident has not been observed but is relevant to patient care, then this must be clear e.g. Patient states.....
- **Pencil, red, green or coloured pens other than black or blue should not be used.**
- Instructions regarding patient care from a doctor via a telephone should be documented. If no instructions are given this should also be documented. Where possible a fax machine should be used and the fax signed by the doctor at the earliest possible opportunity and filed in the patient's chart.
- NEVER chart an action for someone else or allow someone to chart an action for you.
- Abnormal test results should be charted in the patient's medical notes and the doctor informed.
- Records, where possible, will be written in terms the patient will be able to understand.
- When decisions are made that your patient does not like; record the reasons for the decision; explain the reasons to the patient and try and ensure he/she understands.
- All medications should be written up and recorded on a medical kardex prescription.
- A signature bank, i.e. sample of signature and initials of all healthcare staff, should be maintained in each surgery and a copy in the Governors.

Records are currently made in hand written form - at some stage in the future this may be done electronically, until that time the above guidelines are to be followed.

This document may be amended from time to time to reflect best practice.

Please find attached a list of approved abbreviations.

AAA	Abdominal Aortic Aneurysm		
AIDS	Acquired Immune Deficiency Syndrome	LMP	Last Menstrual Period
APTTR	Activated Partial Thromboplastin Time Ratio	LIF	Left Iliac Fossa
AL	Activities Of Living	LFT's	Liver Function Tests
ARDS	Adult Respiratory Distress Syndrome	L.A.	Local Anaesthetic
ABC	Airway Breathing Circulation	L.S.C.S.	Lower Segment Caesarean Section
ABG'S	Arterial Blood Gases		
	PRN		
	As required		
		MRI	Magnetic Resonance Imaging Scan
		MRSA	Methicillin Resistant Staphylococcus Aureus
Ba enema	Barium Enema	MSU	Midstream Specimen of Urine
Ba meal	Barium Meal	mmHg	Millimetres Mercury
B.d.	Twice daily	MDA's	Misuse Of Drugs Act
BPM	Beats per minute	mane	Morning
BHCG	Beta Human Chorionic Gonadotrophins	MI	Myocardial Infarction
BPD	Bipartial Diameter		
B/P	Blood Pressure	N.G.T.	Naso Gastric Tube
		NG	Naso - gastric
C.B.T.	Cognitive Behaviour Therapy	nocte	Night time
CPR	Cardiopulmonary Resuscitation	NPU	Not passed urine
CVS	Cardiovascular System	NPO	Nil Per Orum
CSU	Catheter Specimen of Urine	NaCl	Sodium Chloride
CNS	Central Nervous System	NAD	No Abnormality Detected
CVP	Central Venous Pressure	N.M.S.	Neuroleptic Malignant syndrome
CSF	Cerebro Spinal Fluid		
CVA	Cerebrovascular accident	OGD	Oesophago - Gastro Duodenoscopy
CXR	Chest Xray	O2	Oxygen
COAD	Chronic Obstructive Airways Disease		
COPD	Chronic Obstructive Pulmonary Disease	PARA	Parity
CRF	Chronic Renal Failure	P.U.	Passed Urine
COAG Screen	Coagulation Screen	PCA	Patient Controlled Analgesia
CT	Computerised Tomography	P.O.	Per Oral
CCF	Congestive Cardiac Failure	PR	Per Rectum
CPAP	Continuous Positive Airway Pressure	PV	Per Vagina
CABG	Coronary Artery Bypass Graft	PEG	Percutaneous Endoscopic Gastrostomy
CJD	Creutzfeldt - Jakob Disease	PEJ	Percutaneous Endoscopic Jejunostomy
C&S	Culture and Sensitivity	P.K.U.	Phenylketonuria
CMV	Cytomegalovirus	PFA	Plain Film Abdomen
		P.O.P.	Plaster of Paris
D.V.T.	Deep vein Thrombosis	POST OP	Post Operation
DT's	Delirium Tremens	P.P.H.	Post Partum Haemorrhage
DIC	Disseminated intravascular coagulation	KCL	Potassium Chloride
DHS	Dynamic Hip Screw	P.E.T.	Pre Eclamptic Toxaemia
D.S.H.	Deliberate self harm	PRE OP	Pre Operation
		P.I.H.	Pregnancy Induced Hypertension
ECHO	Echocardiogram	P.R.O.M.	Preterm Rupture of Membranes
ECG	Electrocardiogram	PT	Prothrombin Time
ECT	Electroconvulsant Therapy	PFT's	Pulmonary Function Tests
EEG	Electroencephalogram	PEARL	Pupils Equal and Reacting to Light
E.T.	Endo Tracheal	PUM	Person unsound mind
ERCP	Endoscopic Retrograde Cholangiopancreatograph		
ET tube	Endotracheal Tube	qid	four times daily
ESR	Erythrocyte Sedimentation Rate		
ERPC	Evacuation of Retained Products of Conception	RCC	Red Cell Concentrate
EUA	Examination under Anaesthetic	RTI	Respiratory Tract Infection
E.D.D.	Expected Date of Delivery	R.I.P.	Rest in Peace
		RH	Rhesus
FOB	Faecal Occult Blood	RIF	Right Iliac Fossa
FFP	Fresh Frozen Plasma	RTA	Road Traffic Accident
FBC	Full Blood Count		
		SBR	Serum Bilirubin rate
GIT	Gastrointestinal Tract	STD	Sexually Transmitted Disease
GA	General Anaesthetic	S.V.D.	Spontaneous Vaginal Delivery
G.P.	General Practitioner	SC	Subcutaneous
GUM	Genito Urinary Medicine	S/L	Sublingually
GO	Genitourinary	stat	Immediately
GCS	Glasgow Coma Scale	SLE	System Lupus Erythematosus
G.T.T.	Glucose Tolerance Test		
GTN	Glyceryl Tri-nitrate	T.P.R.	Temperature Pulse Respiration
		Tid	Three times daily
HB	Haemoglobin	TEDs	Thrombo Embolic Deterrent Stockings
HC	Head Circumference	TFT's	Thyroid Function Tests
H.V.S.	High Vaginal Swab	TSH	Thyroid Stimulating Hormone
Hx	History	TAH	Total Abdominal Hysterectomy
HRT	Hormone Replacement Therapy	TPN	Total Parenteral Nutrition
HCG	Human Chorionic Gonatrophin (Pregnancy Test)	TURP	Trans Urethral Resection Prostate
H.I.V.	Human Immunodeficiency Virus	T.VU/S	Trans Vaginal Ultrasound
		TENS	Transcutaneous Electro Nerve Stimulation
INR	International Normalised Ratio	TIA	Transient Ischaemic Attack
I.U.G.R.	Intra Uterine Growth Retardation	RX	Treatment
		T.L.	Tubal Ligation
Im	Intramuscular	TB	Tuberculosis
I.V.	Intravenous		
IVI	Intravenous Infusion	US	Ultrasound
IVP	Intravenous Pyelogram	USS	Ultrasound Scan
IVT	Intravenous Therapy	U&E	Urea and Electrolytes
		UTI	Urinary Tract Infection

JVP

Jugular Venous Pressure

KVO

Keep Vein Open

KUB

Kidney Ureter Bladder Xray

V.E.

Vaginal Examination

VQ

Ventilation Perfusion Scan

WBC

White Blood Count

WCC

White Cell Count

ZN

Ziehl Neelsen Stain

HC Policy A/22

Re: **PROCEDURE PENDING EMERGENCY TRANSFER TO EXTERNAL HOSPITAL**

It is recommended that all prisoners who are awaiting transfer to external hospitals (usually to A& E departments) for emergency assessment should be placed on Special Observation pending transfer, whether this be by ambulance or by prison escort. This procedure is recommended to minimise the risk that further injury or illness occurs before transfer.

Your co-operation in this matter is appreciated.

Healthcare Directorate
02/12/2005

POLICY ON DISPOSAL OF PATIENTS LEGALLY DISPENSED METHADONE

This policy assumes that any green liquid whether labelled as Methadone or not, found on the person of a prisoner, is and will be treated as Methadone.

1. Should a quantity of legally dispensed Methadone be found on the person of a prisoner on committal to prison, this should be immediately taken from the prisoner.
2. It should then be taken to the surgery and handed to a member of the healthcare staff.
3. The approximate volume should be estimated by the healthcare staff member.
4. An entry should be made in a separate section of the Controlled Drug Register, stating:
 - Date received in surgery.
 - Name, DOB, PRIS of prisoner on whose person Methadone was found.
Name of clinic/pharmacy where supply dispensed
 - Date on which dispensed.
 - Approximate volume.
 - Signature of two members of healthcare staff.
5. This supply should then be stored in the controlled drugs safe, separate from surgery stock.
6. **Disposal - All Dublin prisons:**
 - Pinewood Healthcare have agreed to accept, for disposal, all such Methadone stock from each of the Dublin prisons.
 - At regular intervals, when there is a reasonable amount of such Methadone in stock, David Brannigan, Pinewood Healthcare should be contacted on 087 8118209
 - He will then, by arrangement, call to the prison surgery to collect this Methadone.
 - He will supply the necessary paperwork, which should be completed, and signed by both a healthcare staff member and himself.
 - An entry should then be made in the register, stating:
 - 1) Date supply collected by Pinewood.
 - 2) Total quantity collected.
 - 3) Signature of two staff members.
 - A copy of the completed Pinewood paperwork should be retained in the surgery, in the Controlled Drug Register.

7. Disposal - all other prisons:

Please inform the Co-ordinator of Pharmacy Services at 01 4616121 or 087 9292539, whenever there is a supply for disposal and appropriate local arrangements will be made.

ARRANGEMENTS FOR CONTINUATION OF METHADONE TREATMENT FOR CLIENTS ON RELEASE FROM PRISON.

- Methadone is subject to control under the Misuse of Drugs Regulations 1988 and 1993 and the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998.
- While prisons are not specifically include in legislation relating to the use of methadone, the 1998 Regulations provide for administration of methadone to patients while in hospital, but does not allow for supply of methadone on a take-away basis from a hospital. Advice from the Department of Health and Children is that, in this regard, prisons equate with hospitals and so methadone take-aways for use outside the prison may not be provided from the prison.
- In addition, in the interest of safety, methadone may only be supplied from one source and so when a client is released from prison further supplies must only be obtained from the community services.
- Effective and efficient communication between both the IPS and the HSE is essential to ensure seamless care and safe and effective treatment for our patients.
- The release of patient's medications information must be confirmed by fax to the requesting service, by means of the "**PRISON/COMMUNITY TRANSFER OF INFORMATION**" form (Appendix 2) which must be completed and faxed to the requesting service.
- Appendix 1 provides the relevant contact details in each area.

Appendix 1 : Community services contact details:

Dublin Area	GP Co-ordinator	Contact details	Chief Pharmacist	Contact details
NAHB	Dr Des Crowley	087 2198094	Nihal Zayed 2 nd Floor Phibsboro Tower Dublin	087 2252860 01 8820309/327 nihal.zayed@mailc.hse.ie
SWAHB	Dr Margaret Bourke	086 8177112	Denis O'Driscoll Bridge House Cherry Orchard Hospital Ballyfermot Dublin 10	087 2904852 denis.odriscoll@mailf.hse.ie
ECAHB	Dr Cathal O'Sullivan	087 2937570	Helen Johnston Centenary House Dun Laoghaire Co. Dublin	086 8543733 01 2803335 Helen.johnston@maild.hse.ie

AREA	Contact person:	Contact details
Midlands	Dr Paul Gallagher The Old Maltings Coote Street, Portlaoise Co. Laois	086 8511356 057 8692516 (Portlaoise Clinic) Portlaoise Clinic: Open Tuesday afternoon and all day Wednesday Athlone Clinic : Open Thursday and Friday afternoons
Mid-Western	Rory Keane A/Regional Drug Co-ordinator, HSE West, Limerick	061 483751 087 2464393
North Eastern	Liz Hctor MPSI Primary Care Unit HSE/NE, Navan, Co. Meath	046 9076400 087 2704823 046 9071052(fax)

	Paula Loughran Addiction Services Chapel St, Dundalk	042 9357518
	John Taaffe, Drogheda	041 9843531
North Western	Patricia Garland Addiction and Counselling Services NWHB 12 Johnston Court Sligo	071 9143316
Southern	1. Dr Catherine Murphy or 2. Willie Collins Co-ordinator, Drugs and Alcohol Services St Finbarrs Hospital Douglas Road Cork	021 4923937 021 4923135
South Eastern	Carlow/Kilkenny: Catherine Lawlor Waterford: Pat O'Neill Wexford: Chris Parnell Tipperary: John Casey	056 7784638 051 301201 051 426600 052 77900
Western	Western Health Board Drugs Services West City Services 64 Dominic Street Galway	091 561299

Appendix 2: Prison/Community Transfer of Information Form

PRISON/COMMUNITY TRANSFER OF INFORMATION FORM

This form must be faxed from the dispensing pharmacist in the community to the healthcare staff in the prison and vice versa as appropriate, before a new prescription is written or the next dose of methadone /medicines is administered.

Client Name	DOB	Prison/Clinic	Methadone dose (in words and figures)	Date last dose dispensed	Other medication	Date last dispensed

Confirmed by:

Name: _____ Signature: _____
Pharmacist/RGN/RPN/MO/GP

Date: _____

This form must be retained as per HSE/IPS policy.

GUIDELINES ON SAFE AND APPROPRIATE SETTINGS FOR METHADONE ADMINISTRATION.

1. It is essential that all supervised medication administration takes place in a safe manner, to ensure that the right medication is given to the right patient in the right dose in the correct form at the correct time.
2. Within the prison setting it is essential that all such medication is administered in a secure area and as set out in Healthcare Policy C/8 (Policy on Medication Administration) and that all administration is recorded appropriately in a timely manner.
3. Due to the stricter controls governing the use of Controlled Drugs such as methadone, and the increased possibility of diversion/abuse of this drug, it is essential that administration of methadone takes place only in a secure area, (i.e. the prison surgery or pharmacy, or designated secure administration areas in the prison (i.e. behind a hatch in a dedicated room on a wing).
4. **All prisoners prescribed methadone should attend the surgery/designated administration area each day** and methadone should never be taken in individual doses to a prisoner's cell, except in very exceptional circumstances such as when, for reasons of serious ill-health, the prisoner cannot attend the surgery or designated area.
5. Should it be necessary for a patient's dose of methadone to be brought to his/her cell in the circumstances set out above, this should only be done at an appropriate time when no other prisoners are out of their cells, and there is adequate staff available to ensure that this can be done safely.

GUIDELINE ON PROCEDURE TO BE FOLLOWED IN CASES OF ALLEGATION OF ILL-TREATMENT BY PRISONERS .

HC Policy A/4 'Medical Assessment of New Receptions' provides guidance in relation to the timely assessment of new committals to prison, including the necessity to specifically make enquiry regarding any injuries alleged at that time, how these are alleged to have occurred, whether the clinical findings are consistent with the history.

This present guidance is to confirm that a consistent procedure should be applied in any case where a prisoner alleges that s/he has been the subject of ill-treatment irrespective of the origin of any such treatment. At all times it should be borne in mind that that the clinical findings associated with any such allegation may be the subject of subsequent legal proceedings.

- 1, Any allegation of injury or ill-treatment should be clinically assessed without delay.
2. A thorough history of the alleged injury should be documented on PMRS. This will assist in confirming the timing of clinical intervention. Assessment should include the means by which the injury is claimed to have occurred, the timing of the incident causing the injury, any other parties involved, etc.
3. Any associated clinical findings, whether confirmatory or otherwise, noted at the time of assessment should be thoroughly documented. It is appropriate for the assessing doctor to offer a qualified clinical opinion on whether the findings noted are consistent with the history.
4. Any immediate steps deemed appropriate or necessary to safeguard the health or welfare of the prisoner or prisoners involved should be instigated.
5. All clinical involvement by members of the prison healthcare team should be thoroughly documented on the basis that these may be required for subsequent legal proceedings.