



**Department of Juvenile Justice
Health Services Operating Procedure**

HSOP VOL IV – 4.3 – 4.10	Statutory Authority: Title 66 of the <u>Code of Virginia</u>
Subject: Diagnostic Services	Regulations: None.
	Board Policy: None.
	ACA # None.
	NCCHC # Y-D-04

4.10-1.0 PURPOSE

To provide diagnostic services in a timely manner to assist in the diagnosis, care, and treatment of medical conditions.

4.10-2.0 SCOPE

These procedures apply to all Juvenile Correctional Center (JCC) employees and staff assigned to the JCCs by other units, agencies, or departments.

4.10-3.0 DEFINITIONS

Local Health Authority – The designated Registered Nurse (RN) (e.g., head nurse) who has been delegated the responsibility for management of all of the facility's health services, including medical, nursing, and dental and ensuring the quality and accessibility of all health care services provided to residents. Final medical judgments shall be the sole province of the Chief Physician.

4.10-4.0 PROCEDURES

4.10-4.1 Lab Reporting

1. Lab testing conducted by the health services staff at the facility shall be reported to the provider in accordance with the established protocols.
2. The following information will be kept in a log for all lab draws: Date of Draw, Resident Name, Labs Drawn, Date Results Received, and special comments related to the lab if applicable.
3. The nurse shall monitor incoming lab results during each shift. If preliminary lab results are not received within 1 day for regular labs, 3 days for cultures, or within documented expected time frame for special lab draws the nurse shall contact the laboratory company to follow-up on the outstanding results. The nurse shall notify the provider by the next clinic of any labs that were not processed.
4. Upon receipt of the lab results, the nurse shall date/time stamp each lab result and document with his/her initials.

5. The nurse shall notify the provider regarding all lab “alerts” and “critical” results within fifteen (15) minutes of receiving the lab results. Normal lab results shall be reviewed by the provider at the next scheduled health clinic.
6. The nurse shall notify the nursing supervisor regarding all lab “alerts” and “critical” results and update the nursing supervisor of the provider’s recommendation.
7. The nurse shall document the following in the progress notes:
 - a. The date and time the lab “alerts” and “critical” results were received;
 - b. The date, time and the name of the provider contacted, if applicable; and
 - c. The date, time and name of the nursing supervisor contacted, if applicable.
8. The nurse shall document the provider’s orders on the Physician’s Order in the medical record.
9. The nurse shall ensure that the provider reviews the lab with the “alerts” and “critical” values at the next scheduled health clinic.
10. The laboratory results shall be maintained in the resident’s medical record.

4.10-4.2 Imaging Study Reporting

1. The nurse shall monitor incoming imaging study report during each shift. If imaging study results are not received within 1 day, the nurse shall contact the imaging company to follow-up on the outstanding results.
2. Upon receipt of the reports, the staff shall date/time stamp each report and document with his/her initials.
3. The nurse shall check the impression section on the x-ray report and notify the provider within 24 hours if the findings are suggestive of a fracture, dislocation or other major problem or if the nurse is concerned about the reports.
4. The nurse shall check the impressions section(s) of the imaging study report and immediately notify the provider if the findings are suggestive of an acute or a major problem or if the nurse is concerned about the report.
5. The nurse shall notify the nursing supervisor regarding all abnormal imaging study reports and update the nursing supervisor of the provider’s recommendation.
6. The nurse shall document the following in the progress notes:
 - a. The date and time imaging study reports were received;
 - b. The date, time and the name of the provider contacted, if applicable; and
 - c. The date, time and name of the nursing supervisor contacted, if applicable.
7. The nurse shall document the provider’s orders on the Physician’s Order in the medical record.

- 8. The nurse shall ensure that the provider reviews the imaging study reports at the next scheduled health clinic.
- 9. The imaging study results shall be maintained in the resident's medical record.

4.10-5.0 RESPONSIBILITY

The Local Health Authority shall be responsible for implementing this procedure.

4.10-6.0 INTERPRETATION

The Health Services Administrator shall be responsible for the interpretation and the exception approval to this procedure.

4.10-7.0 CONFIDENTIALITY

All procedures and bulletins are DJJ property and shall only be used for legitimate business purposes. Any redistribution or the documents or information contained in the procedures or bulletins shall be in accordance with applicable state and federal statutes and regulations and all other DJJ procedures. Any unauthorized use or distribution may result in disciplinary and/or criminal action, as appropriate and applicable.

4.10-8.0 REVIEW DATE

This procedure shall remain in effect until rescinded or otherwise modified by the appropriate authority.

Approved by Director: <i>Max A. Seal</i>	Date: 8/22/13
Approved by Health Administrator: <i>Mark H. Murphy</i>	Date: 8/26/13
Approved by Chief Physician: <i>[Signature]</i>	Date: 8/27/13
Effective Date: October 1, 2013	Office of Primary Responsibility: Health Services
Supersedes: None.	Forms: